

Embodied Safety and Resilience in Child and Adolescent Mental Health: A Conceptual Commentary on Dance/Movement Therapy

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Abstract

Contemporary children and adolescents are exposed to increasing psychosocial stressors, including social instability, educational pressure, digital overstimulation, disrupted relational environments, and global uncertainty. These conditions contribute to rising levels of emotional dysregulation, anxiety, behavioral disturbance, somatic distress, and relational withdrawal. Such difficulties are frequently communicated through bodily states, movement patterns, and nonverbal behavior rather than through explicit verbal articulation. This conceptual commentary examines Dance/Movement Therapy (DMT) through a developmental-relational and neurobiological framework, drawing on attachment theory, embodied cognition, affective neuroscience, and movement-based therapeutic practice. The article explores mechanisms through which DMT may support affect regulation, relational attunement, embodied self-awareness, resilience-building, and developmental integration in children and adolescents. Particular emphasis is placed on embodied safety, nonverbal therapeutic alliance formation, sensory attunement, rhythmic regulation, creativity, and agency development. Clinical examples are included to contextualize theoretical arguments. While empirical evidence remains comparatively limited relative to established verbal psychotherapies, DMT demonstrates conceptual and clinical relevance as both a complementary and, in selected contexts, primary intervention within multidisciplinary child and adolescent mental health care.

Keywords: Dance/movement therapy, Child and adolescent mental health, Embodied psychotherapy, Affect regulation, Resilience, Nonverbal intervention

Methodology

This article follows a conceptual commentary methodology grounded in integrative theoretical analysis. It synthesizes established literature from developmental psychology, attachment theory, affective neuroscience, embodied cognition, and dance/movement psychotherapy. The commentary draws additionally on practice-informed clinical reflection to bridge conceptual understanding and therapeutic application.

Clinical vignettes included in this article are illustrative examples intended to demonstrate therapeutic processes rather than provide empirical evidence. Their purpose is heuristic and explanatory. This methodological orientation reflects reflective-conceptual scholarship commonly employed in clinical mental health discourse to explore emerging therapeutic frameworks and articulate clinically relevant hypotheses for future empirical investigation.

Introduction

Child and adolescent mental health services internationally report increasing prevalence of anxiety disorders, emotional dysregulation, behavioral challenges, social withdrawal, and stress-related somatic complaints [1]. These developments reflect not only individual vulnerability but also broader sociocultural changes affecting developmental environments.

Children and adolescents today often grow up within contexts characterized by accelerated performance demands, reduced opportunities for spontaneous physical play, heightened digital engagement, relational fragmentation, and chronic uncertainty. Such conditions may interfere with developmental processes essential for emotional regulation, secure attachment formation, sensory integration, and embodied self-awareness.

Many psychological difficulties in childhood emerge initially not as verbally formulated distress but as disturbances of movement, posture, rhythm, sensory regulation, impulse control, and relational responsiveness. Developmentally, bodily experience precedes language as the primary medium through which internal states are organized and communicated [2]. Consequently, psychotherapeutic approaches relying predominantly on verbal reflection may encounter limitations when working with young clients whose emotional experience remains pre-symbolic, somatically encoded, or relationally disorganized.

Dance/Movement Therapy (DMT) offers a therapeutic modality uniquely positioned to address such challenges. It conceptualizes movement not merely as expression but as a central medium of relational communication, emotional regulation, developmental integration, and therapeutic transformation [3].

This commentary examines the theoretical foundations and clinical implications of DMT in child and adolescent mental health care, emphasizing embodied safety and resilience as central organizing concepts.

Theoretical Framework

Attachment theory and embodied co-regulation

Attachment theory proposes that emotional security develops through repeated experiences of responsive attunement within early caregiving relationships [4]. Through such interactions, children internalize regulatory capacities that later support self-soothing, affect modulation, and interpersonal trust.

Importantly, attachment processes are initially nonverbal and embodied. Regulation emerges through touch, rhythm, facial expression, movement synchrony, proximity, and vocal contour. These pre-verbal experiences shape internal working models of safety and relational expectation.

Dance/Movement Therapy directly engages this embodied dimension of attachment. Therapeutic attunement is often communicated through mirroring, pacing, movement resonance, and spatial responsiveness. Such embodied relational experiences may offer corrective regulatory encounters for children whose developmental histories include disruption, neglect, inconsistency, or relational trauma.

Polyvagal theory and neuroception of safety

Polyvagal theory emphasizes that physiological states of safety or threat fundamentally shape emotional regulation and social engagement capacities [2]. The autonomic nervous

system continuously evaluates environmental cues through neuroception, influencing access to social connection, defensive mobilization, or shutdown states.

Children experiencing chronic stress, trauma exposure, or relational instability may remain physiologically organized around hyperarousal or hypo arousal, limiting their capacity for reflective engagement.

Movement-based relational interventions may influence these states through rhythm, predictability, co-regulation, and embodied synchrony. In DMT, therapeutic movement interaction can support autonomic stabilization by offering structured sensory experiences that communicate safety at a neurophysiological level.

Embodied cognition and developmental integration

Embodied cognition proposes that cognitive and emotional processes are grounded in sensorimotor experience [5]. Thinking, feeling, and relating are not separable from bodily action but emerge through ongoing bodily-environmental interaction.

This perspective is particularly relevant for child therapy. Developmental integration depends on sensorimotor exploration, spatial orientation, movement experimentation, and bodily interaction with others.

Dance Therapy operationalizes embodied cognition therapeutically by engaging movement as both diagnostic and intervention medium.

Discussion

Embodied safety as therapeutic foundation

Across psychotherapeutic modalities, therapeutic alliance consistently predicts outcome [6]. However, alliance formation in child and adolescent therapy frequently requires pathways beyond verbal exchange.

In DMT, safety is not primarily explained cognitively but experienced bodily. Predictable rhythm, respectful spatial boundaries, movement attunement, and nonintrusive presence create conditions in which clients may gradually reorganize defensive bodily patterns.

Children who initially avoid verbal engagement often respond to movement-based relational invitations because such encounters bypass pressures associated with linguistic self-disclosure.

For example, a child presenting with school refusal and severe anxiety may initially remain physically withdrawn. Through therapist mirroring of subtle movement patterns

at an appropriate distance, relational contact can emerge gradually without overwhelming demand. Over time, shared rhythmic engagement may support increased exploratory movement, signaling emerging regulation and trust. This process illustrates how embodied safety often precedes verbal reflection.

Nonverbal communication and neurodevelopmental conditions

For children with autism spectrum conditions, communication frequently occurs through sensory organization, movement patterning, and nonverbal relational signaling.

Traditional verbally mediated interventions may insufficiently access these expressive channels. DMT offers alternative pathways through movement synchrony, sensory attunement, rhythmic adaptation, and spatial responsiveness.

Research suggests movement-based interventions may support social engagement, body awareness, and affective reciprocity in neurodivergent populations [7].

Clinical observation indicates that when therapists adapt to a child's sensory rhythm rather than imposing external structure prematurely, relational trust often develops more organically. Such work requires high sensitivity to sensory thresholds, pacing, and regulation needs.

Rhythm, music, and regulatory organization

Rhythm represents a foundational organizing principle in human development. Early caregiver-infant interaction is inherently rhythmic, involving patterned cycles of movement, vocal exchange, and affective timing.

Rhythmic synchrony has been associated with social bonding, emotional regulation, and physiological coordination [8].

Within DMT, rhythm can provide external scaffolding for internal organization. This is especially relevant for children with ADHD, trauma histories, and dysregulation-related conditions.

Structured rhythmic movement may support:

- impulse modulation
- temporal organization
- affect containment
- attentional stabilization
- relational synchrony

Equally important is the therapeutic use of silence and

stillness. For highly sensory-sensitive children, minimal stimulation may better support regulation than externally imposed music.

Clinical responsiveness requires ongoing assessment of how auditory and movement input affect arousal states.

Creativity and development of agency

One of DMT's distinguishing features lies in its integration of creativity as therapeutic process. Creativity, within the context of Dance Therapy, is not conceptualized as artistic achievement or performance excellence. Rather, it represents the developmental capacity to initiate, shape, transform, and experiment within embodied interaction.

From a developmental perspective, creative movement exploration enables children and adolescents to experience themselves as active agents capable of influencing both internal and external realities. This is particularly relevant for young clients whose developmental histories may include experiences of helplessness, chronic dysregulation, emotional invalidation, relational inconsistency, or trauma-related loss of control.

Experiences of embodied agency are closely associated with resilience-building processes because they counteract passivity and restore a sense of effectiveness within interpersonal and environmental contexts [9]. Through improvisational movement, symbolic enactment, and spatial experimentation, children and adolescents are offered opportunities to test possibilities, modify interactional patterns, and experience themselves as capable of initiating change.

Movement-based materials such as scarves, ropes, balls, elastic bands, sticks, mats, and symbolic spatial objects often function as mediating elements that expand expressive possibilities while simultaneously reducing direct relational pressure. Such materials may facilitate symbolic projection, emotional externalization, sensory regulation, imaginative play, and transitional relational experiences.

Creative movement processes may support:

- development of self-efficacy
- flexible problem-solving capacities
- emotional experimentation
- symbolic integration
- adaptive relational reciprocity
- embodied self-awareness

Importantly, creativity within DMT is not understood merely as an aesthetic component but as a developmental and regulatory process through which therapeutic transformation may occur.

For many children and adolescents, verbal reflection initially remains insufficient to organize emotionally overwhelming or fragmented internal experience. Movement-based creativity therefore provides an alternative pathway through which psychological material can emerge in symbolized and tolerable form. Through repetitive transformation of movement themes, children may gradually reorganize defensive patterns and expand their capacity for emotional flexibility.

Affect differentiation and emotional processing

A central challenge within child and adolescent mental health concerns the differentiation, modulation, and integration of affective experience.

Children frequently communicate emotional distress behaviorally through impulsivity, agitation, aggression, withdrawal, collapse, hyperactivity, avoidance, or somatic complaints. Such expressions often reflect diffuse physiological activation rather than consciously differentiated emotional awareness.

Dance/Movement Therapy supports affect differentiation by externalizing internal states through observable movement qualities. Variations in muscular tension, force, tempo, rhythm, directionality, expansion, contraction, and spatial use provide concrete channels through which emotional processes become embodied, visible, and therapeutically modifiable.

The therapist's attuned mirroring and gradual modulation of these movement qualities can help transform diffuse activation into increasingly organized emotional experience. For example, abrupt forceful movement patterns may gradually evolve into more rhythmically contained expressions of anger, frustration, assertiveness, or protective activation.

This movement-based processing allows affective states to become tolerable before they are cognitively analyzed or verbally interpreted.

Such sequencing corresponds with neurobiological models emphasizing bottom-up processing in emotional regulation. Sensorimotor organization frequently precedes higher-order reflective integration, particularly in children with trauma-related dysregulation or developmental vulnerabilities.

Importantly, not every emotional process requires immediate verbalization. In some cases, symbolic movement expression and embodied co-regulation may themselves constitute the primary therapeutic intervention.

Dance therapy and school refusal

School refusal has become an increasingly significant concern within child and adolescent mental health care. Across many countries, clinicians, educators, and families report growing numbers of children and adolescents who experience severe emotional distress associated with school attendance. These difficulties are frequently linked to anxiety, social overwhelm, perfectionistic pressure, bullying experiences, sensory overstimulation, family stress, trauma-related symptoms, or broader challenges in emotional regulation and belonging.

Importantly, school refusal should not be understood merely as oppositional behavior or lack of motivation. In many cases, it reflects profound dysregulation of the child's stress and attachment systems. Physiological hyperarousal, anticipatory anxiety, shame, exhaustion, and relational insecurity often manifest somatically long before they can be verbally articulated. Children experiencing school refusal frequently describe bodily symptoms such as stomach pain, nausea, panic reactions, muscular tension, shutdown states, or overwhelming fatigue.

Within this context, Dance/Movement Therapy may offer clinically relevant pathways for therapeutic engagement because it addresses the embodied dimensions of distress directly. Through movement-based attunement, rhythmic regulation, sensory grounding, and nonverbal relational safety, DMT can support gradual restoration of regulation capacities that are often compromised in school refusal presentations.

The therapeutic focus is typically not on behavioral pressure toward immediate school reintegration, but on rebuilding embodied experiences of safety, agency, emotional tolerance, and relational trust. Through movement exploration, symbolic enactment, and carefully paced co-regulation, children may gradually regain flexibility within their nervous system and increase their capacity to tolerate external demands.

Creative and movement-based processes can also support expression of emotions that often remain difficult to verbalize directly, including fear, shame, anger, loneliness, or feelings of inadequacy associated with academic and social expectations.

Particularly in contemporary contexts characterized by increasing performance pressure, digital overstimulation, social comparison, reduced free play, and heightened uncertainty, school refusal may be understood not only as an individual symptom but also as an expression of broader developmental strain affecting children and adolescents today.

These developments highlight the growing importance of therapeutic approaches capable of addressing emotional distress at embodied, relational, and neurophysiological levels rather than exclusively through cognitive or behavioral frameworks alone.

Individual and group applications

Dance Therapy may be implemented effectively in both individual and group settings, each offering distinct therapeutic possibilities.

Individual sessions provide highly individualized pacing, intensive co-regulation, and carefully adapted sensory engagement. Such settings may be especially beneficial for:

- trauma-related presentations
- autism spectrum conditions
- severe anxiety
- profound dysregulation
- relational distrust
- selective mutism

The individual therapeutic frame allows precise adaptation to the child's developmental and regulatory capacities.

Group settings, in contrast, create opportunities for:

- peer mirroring
- social experimentation
- collective rhythm formation
- shared symbolic enactment
- interpersonal learning
- belonging experiences

Within movement groups, children and adolescents may experience themselves as part of a regulating social field. Shared rhythmic experiences often strengthen cohesion, reciprocity, and mutual recognition.

However, group work also requires careful structuring. Overstimulation, social comparison, exclusion dynamics, or sensory overload may occur if group processes are insufficiently contained.

Clinical indication, developmental readiness, and regulatory capacity should therefore guide decisions regarding therapeutic format.

Dance/Movement therapy within multidisciplinary care

Dance/Movement Therapy is best understood not as a replacement for established psychotherapeutic or psychiatric interventions, but as a complementary modality contributing

a distinct embodied perspective.

Its integration may be particularly valuable alongside:

- psychotherapy
- cognitive behavioral therapy
- occupational therapy
- speech and language therapy
- music therapy
- psychiatric treatment
- educational and psychosocial support systems

Interdisciplinary collaboration enables verbal, cognitive, sensory, relational, and embodied dimensions of treatment to inform and strengthen one another.

In many cases, DMT may help establish the regulatory and relational foundation necessary for effective engagement in verbally mediated therapies.

Limitations and research constraints

Despite increasing conceptual and clinical interest, Dance/Movement Therapy continues to face limitations within the empirical evidence base.

Existing studies are often characterized by:

- small sample sizes
- methodological heterogeneity
- inconsistent intervention protocols
- limited longitudinal data
- variability in outcome measures

These limitations require caution regarding generalized efficacy claims.

Further research is needed to investigate:

- mechanisms of embodied therapeutic change
- differential indications across diagnostic groups
- neurobiological correlates of movement-based intervention
- long-term developmental outcomes
- comparative effectiveness relative to verbal therapies

Additionally, DMT may require modification or temporary contraindication in contexts involving acute psychosis, severe destabilization, extreme sensory defensiveness, or psychiatric emergencies requiring immediate medical containment.

Professional competence, trauma-informed training, supervision, and interdisciplinary coordination remain essential.

Clinical implications

Current theoretical and practice-informed evidence suggests DMT may be particularly indicated when:

- emotional distress is predominantly expressed somatically
- verbal symbolic processing is limited
- relational trust requires nonverbal pathways
- dysregulation interferes with verbal psychotherapy access
- resilience-building requires embodied experiences of agency

Broader implementation will require strengthened training standards, increased interdisciplinary recognition, and further evidence-informed clinical guidelines.

Conclusion

Dance/Movement Therapy represents a theoretically coherent and developmentally sensitive therapeutic modality for children and adolescents experiencing emotional, relational, and regulatory difficulties.

Its emphasis on embodied safety, movement-based attunement, creativity, rhythm, and relational synchrony aligns closely with contemporary developmental and neurobiological understandings of emotional organization.

By engaging the body as a primary site of therapeutic transformation, DMT addresses dimensions of experience often insufficiently accessible through language-centered interventions alone.

Particularly during developmental phases in which movement, play, rhythm, and sensory exploration remain central to self-organization, Dance/Movement Therapy offers clinically meaningful pathways toward resilience, integration, and psychological growth.

Future research should prioritize rigorous outcome studies, mechanism-focused investigation, and interdisciplinary collaboration in order to strengthen evidence-based implementation within child and adolescent mental health care systems.

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