8-2010

A Dance/Movement Therapist's Experience of Vicarious Trauma and Burn-Out: An Autoethnography

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A DANCE/MOVEMENT THERAPIST'S EXPERIENCE OF VICARIOUS TRAUMA AND BURN-OUT: AN AUTOETHNOGRAPHY

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Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Dance/Movement Therapy and Counseling Department

August, 2010

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Abstract

This thesis is an autoethnography investigating how the dance/movement therapist can experience and recover from vicarious trauma and burn-out. The purpose of this research is to provide an example of how theories from the latest research have played out in real life and to call for further research and education on the topic in the dance/movement therapy (DMT) field. The author outlines in narrative form significant moments from her master's internship work with a traumatized child to demonstrate this phenomenon. What is found is that two core components of DMT, somatic attunement and empathy, contribute to the acquisition of vicarious trauma. The findings also reveal how recovery from and prevention of vicarious trauma is possible through increased personal awareness.

Acknowledgements

I would like to thank and commend for their ceaseless patience and support: the members of the thesis committee in the department of Dance/Movement Therapy and Counseling of Columbia College Chicago: my thesis advisor, Lenore Hervey; my husband and best friend, John; my beloved parents and brother; and finally my dance/movement therapy supervisor, Kris Larsen and our supervision group. I would never have finished this paper without constant and consistent support of these individuals, thank you.

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Chapter 1: Introduction

Vicarious trauma and burn-out is a growing concern in the field of psychology. Vicarious trauma is described as a condition in which a psychotherapist is "impacted by working with [a] traumatized individual in [her] workplace…Even when a therapist [is] not actually involved in the client's trauma, she can still vicariously experience it in her nervous system" (Rothschild, 2006, p. 15). This trauma can be damaging professionally, personally, physically, mentally, emotionally, and financially. When a therapist is debilitated in any of these realms it will often be referred to as burn-out. Burn-out "describes anyone whose health is suffering or whose outlook on life has turned negative because of the impact or overload of their work" (Rothschild, 2006, p. 14). This does not have to result from vicarious trauma, but certainly can.

Dance/movement therapists are not exempt from experiencing vicarious trauma and burn-out. "Dance/movement therapy is the psychotherapeutic use of movement to promote emotional, cognitive, physical, and social integration of individuals" (ADTA, 2009). Given the unique nature of dance/movement therapy (DMT) and its differences from traditional verbal psychotherapy, there might also be a unique way dance/movement therapists can experience vicarious trauma and burn-out.

I believe I experienced vicarious trauma and burn-out while practicing as a DMT intern. During my internship I conducted individual DMT sessions with a child who had experienced a significant amount of trauma. During and after my sessions I struggled with many intense emotions that defied rational explanation. The further my internship progressed the more I struggled to manage these emotions. I knew that something in these sessions was significant but I struggled to understand or articulate what was happening.

After my internship ended I was overwhelmed and frozen. I made various attempts to create a thesis around these sessions, but each attempt fizzled out due to my ambivalence, overwhelming emotional response, and unresolved issues. Something had happened in these sessions with which I was still struggling. Each attempt brought opportunities for illumination where I learned something new about my experience and myself. In the four years after my internship and while finally writing this thesis I slowly learned how to recover from my experience and subsequently look back at my internship and find out what happened; I had experienced vicarious trauma and burn-out. I found that as I analyzed my experience further I became suspicious that two techniques of DMT might have contributed: somatic attunement and empathy. Under the advisement of my DMT supervisor I examined some literature that supported my suspicions; one of my most basic skills as a dance/movement therapist facilitated my experience of vicarious trauma and burn-out. I was astonished! I decided that this discovery was important enough to share with the DMT community and began to channel my process into the creation of this thesis in response to the research question: How does a dance/movement therapist experience and recover from vicarious trauma and burn-out?

Theoretical orientation

To contextualize my research it is necessary to identify my theoretical framework, which is eclectic. I draw from the three major traditions of psychology: psychodynamic, humanistic and cognitive-behavioral. Further influencing my framework are the movement traditions of *Laban Movement Analysis*, *Bartenieff Fundamentals*, and modern dance. I utilize the psychological traditions to inform three functions: understanding and contextualizing the client or situation, compassionately accepting the client or situation

without judgment, and developing realistic and measurable goals and interventions. For understanding and contextualization I utilize a psychodynamic approach. This tradition helps me to conceptualize the development, patterns, and reasoning of the client or situation. For compassionate acceptance without judgment I utilize a humanistic approach. Finally, I utilize a cognitive-behavioral approach to inform treatment and intervention planning. This helps me maintain organization and reasoning in my development and implementation of appropriate tasks and challenges for the client or situation.

These three functions are all supported by my use of Laban Movement Analysis (LMA), Bartenieff Fundamentals, and modern dance. As a dance/movement therapist I observe and use the body and its movement to gather information, make decisions, and put my decision into action. LMA gives me a language to talk about movement and the body. Bartenieff Fundamentals allows me to understand the function and expressivity of movement and the body through its theory of internal connections. The composition and improvisation of modern dance has given me a creative process to propel my therapeutic work.

It is important to note that this was not always my theoretical orientation, especially during my internship. In fact, my orientation was poorly defined. I understood the interpersonal development of the individual through the psychodynamic approach as well as the necessity for positive regard through the humanistic approach, but I struggled with the application of these ideas and developing interventions. At the time of my internship I was resistant to the use of cognitive-behavioral techniques and ideas. I had not yet discovered how to be a directive but compassionate "expert" with clients. I found it intimidating to challenge my clients; I took any reaction, rejection, or lashing out personally, as if it were

my fault they could not accept my challenge. I felt wholly responsible for the client, instead of accountable for challenging the *client* to take responsibility for their treatment. This cognitive-behavioral piece was certainly missing from my underdeveloped framework and is important to keep in mind while reading this paper.

Summary

In this thesis I will first present the literature about vicarious trauma and about several significant elements that contribute to the development of and recovery from vicarious trauma: countertransference, somatic attunement, boundaries, and therapist self-care. Secondly, I will define and describe autoethnography and explain how I used this methodology. Thirdly, I will present a narrative of my internship and recovery experience to illustrate my findings. Finally I will discuss how my findings correlate with the reviewed literature to answer the research question: How does a dance/movement therapist experience and recover from vicarious trauma and burn-out? I will then propose questions to guide further research and discourse. A glossary of technical terms will be found in Appendix A. This may be useful to look at prior to further reading to clarify the italicized concepts in this text.

Chapter 2: A Review of the Literature

It has been well documented that practitioners in the stressful and rewarding field of psychotherapy and counseling are prone to vicarious trauma. Sometimes the stress of helping others outweighs the rewards. There has been a growing body of literature in the past fifteen years that looks at how vicarious trauma happens, but some of the work also looks at how to recover from and prevent this ever-growing concern.

As this writer has personally discovered, dance/movement therapists are not exceptions to this phenomenon. However, the collection of dance/movement therapy literature regarding vicarious trauma is small and mostly unpublished. The manner in which dance/movement therapists practice is somewhat different from traditional psychotherapy and counseling. Dance/movement therapists make use of creative movement and the bodies of client and therapist to gather information and facilitate change. Therefore the manner in which dance/movement therapists experience vicarious trauma might also be different.

This review of literature on vicarious trauma is compiled to address how dance/movement therapists experience, recover from, and prevent vicarious trauma. Since the scope of the literature on vicarious trauma is large, I will be looking at four contributing factors that relate to the research this paper is addressing: How did I, a dance/movement therapist, experience and recover from vicarious trauma? These factors include countertransference, somatic attunement, boundaries in the therapeutic relationship, and therapist self-care and recovery. My experience has convinced me it is possible to prevent, or experience and recover from vicarious trauma. What does the literature say about this? I aim to examine literature from the fields of relational psychotherapy, trauma therapy,

somatic psychology, and dance/movement therapy and contribute to this body of work an example: a cautionary tale to the dance/movement therapist.

Vicarious Trauma of the Therapist

Most of the literature about vicarious trauma and related topics comes from a psychodynamic orientation to therapy and its offshoot, relational psychotherapy. This seems to be because psychodynamic and relational therapies emphasize in the therapeutic work the dynamics of the relationship, especially between therapist and client. Problems, such a vicarious trauma, that arise for the therapist might then affect the client and subsequently the outcome of the therapeutic work. Therefore the acknowledgement and treatment of vicarious trauma could be significant in the success of the therapeutic relationship. There is a weak undercurrent of influence from the humanistic orientation to therapy on the topic of vicarious trauma. The field of humanistic or person-centered psychology does not look directly at vicarious trauma as the field is centered almost exclusively on the experience of the client. It does focus positively on the ideas of self-actualization, health, and hope, which support the concepts of therapist self-care and good mental health. This influence is seen in much of the literature geared towards therapist self-help. The cognitive behavioral orientation to therapy also fails to look directly at vicarious trauma but has also influenced the literature. The organizing, goal-oriented qualities of this field are also found in the therapist self-help literature.

The following authors are those who have made significant contributions to the field of vicarious trauma. They could be called eclectic therapists and researchers, but most often draw from the traditions of psychodynamic psychology to explain and support the concept of vicarious trauma. It is important to note that the term vicarious trauma is not consistently

used across the field. Many authors have decided to label the phenomena differently and this seems to reflect their approach to and concerns within the field. Some authors are focused on legitimizing and defining vicarious trauma as an issue the psychology field needs to address. Other authors are focused on how vicarious trauma develops. Others yet are focused on the treatment or prevention of vicarious trauma. A majority of the authors address all of these points, but clearly contribute to one or two in a more significant manner.

Figley's edited collections (1995 and 2002) compile research from a variety of viewpoints about how what he refers to as *compassion fatigue* is understood and categorized and what factors contribute to its incidence. Figley's 1995 edition marks the beginning of a fifteen-year span of significant literature being published on vicarious trauma. Therefore, the chapters addressing the treatment and prevention of vicarious trauma are at the beginning stages of research and are more fleshed out in the 2002 edition as well as in other publications. The researchers represented in Figley's compilations hail from a theoretical approach that Figley refers to as traumatology, or specialists in trauma work. These specialists have worked first-hand with the traumatized client and have turned their focus to examine how this work affects the trauma therapist. Those who appear to be missing from Figley's collections are the therapists who do not specialize in trauma work. As suggested earlier, his research marks the advent of the field of vicarious trauma and its pioneers hailed from trauma research. It will be discussed later how those who do not specialize in trauma work also have a contribution to make to the research.

What is most pertinent to the research of this paper from Figley's compilations is his initial perception and definition of vicarious trauma. His work brought the issue into the forefront of psychotherapeutic thought and legitimized it as a concern for the modern

counselor. Figley prefers the term compassion fatigue, but refers to it also as *secondary traumatic stress disorder* (STSD) and equates it to *post-traumatic stress disorder* (PTSD), citing the APA's description of PTSD to support this clinical assertion:

> The italicized sections emphasize that people can be traumatized without actually being physically harmed or threatened with harm. "The person has experienced an event outside the range of usual human experience that would be markedly distressing to almost anyone: a serious threat to his or her life or physical integrity: serious threat or harm *to his children, spouse, or other close relative or friends*: sudden destruction of his home or community: or *seeing another person seriously injured or killed in an accident or by physical violence*." Thus, there is a fundamental difference between the sequelae or pattern of response, during and following a traumatic event, for people exposed directly to harm (primary stressors) and for those exposed to those in harm's way (secondary stressors). (1995, p. xv)

By aligning compassion fatigue with PTSD, Figley gives weight to the seriousness of a therapist's exposure to stress. He blows the whistle on the occupational hazard of working with distressed and traumatized people. However, by focusing on the debilitating symptoms of PTSD that STSD shares, Figley deemphasizes the more subtle red flags that the therapist might encounter on her way to a STSD diagnosis. He also may repel those therapy practitioners who do not perceive their response to occupational stress as trauma.

Norcross and Guy (2007), eclectic psychotherapists, acknowledge those red flags along the way to vicarious trauma. Their focus is more on preventing the counselor from ever reaching the severity of vicarious trauma and on distinguishing what those red flags are. They outline the progressing factors that lead to vicarious trauma and categorize them

into three phases: wear-out, brown-out, and burn-out. For Norcross and Guy, burn-out seems to be equivalent to Figley's STSD. This use of the term burn-out does not portray the same level of seriousness that Figley's use of STSD does; but burn-out may capture a broader audience in the counseling field, which might be the intent. The work of Norcross and Guy is in the realm of therapist self-help instead of academic study. Their work will be examined further under therapist self-care.

Wicks (2008) follows in the same vein of Norcross and Guy by focusing on the warning signs leading up to vicarious trauma. He labels the topic as burn-out and sub-categorizes it into burn-out levels 1, 2, and 3. Wicks proposes that, if allowed to progress, burn-out could lead to the phenomenon of *acute secondary stress or vicarious PTSD*. His use of this term is equivalent to Figley's term of STSD. Wicks acknowledges that there are serious consequences that can be a result of burn-out Wicks is also an eclectic therapist, drawing from traditional psychotherapy and modern Buddhist thinking. His work also falls under the category of therapist self-help and offers readers questions to assess and research their own burn-out. He too will be examined further under therapist self-care.

Pearlmutter and Saakvitne (1995), who align with relational psychotherapy, use the label vicarious trauma. They discuss how the terms compassion fatigue, secondary traumatization, vicarious traumatization, and burn-out are used interchangeably within the literature. They examine how vicarious trauma develops through the function of countertransference and the therapeutic relationship.

Rothschild (2006), a trauma specialist and body psychotherapist, is the most pertinent author I have found for the focus of this paper. She expands the relational work of Pearlmutter and Saakvitne to include the body-based understanding of how the trauma

response emerges in the therapist through the process of empathy. Rothschild makes use of the terms compassion fatigue, burn-out, primary traumatization, secondary traumatization, and vicarious traumatization, distinguishing the differences between them. She explains Figley's label, compassion fatigue, as "…a general term applied to anyone who suffers as a result of serving in a helping capacity" (p. 14). Burn-out "describes anyone whose health is suffering or whose outlook on life has turned negative because of the impact or overload of their work". (p. 14). These phenomena can occur as a result of exposure to traumatized clients as well as workplace stressors. "Primary traumatization is understood as the impact of a traumatic incident on the obvious victim of that incident." (p. 14). Whereas:

> secondary trauma has two categories. The first involves family members and close associates who may suffer from their loved one's trauma as a result of the closeness of the relationship. An example would include the spouse of a rape victim. The second category of secondary trauma involves therapists who are eyewitnesses to the incident they are meant to mediate. While not primary casualties of the event, they may become secondary victims by becoming overwhelmed by what they see and hear in person. Theirs is not a vicarious experience, but a direct experience of witnessing. (p. 14)

Finally, the term vicarious trauma is used "With regard to psychotherapists impacted by working with traumatized individuals in their workplaces…Even when a therapist was not actually involved in the client's trauma, she can still vicariously experience it in her nervous system" (p. 15). To understand this definition, one must understand the nature of trauma. Rothschild provides a detailed explanation about neurological mechanisms behind trauma.

She educates the reader about the nervous system and the branch that regulates the involuntary movements and functions of the body, especially the body's response to stress. This branch is referred to as the autonomic nervous system (ANS). The ANS itself has two branches, the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS). Rothschild explains that these systems developed in humans to ensure the individual is able to react to potential environmental dangers as well as maintain general functioning when not in danger. When the SNS is activated the brain sends information to the body to allow the functions necessary to fight off or run away from the potential danger that threatens survival. This process is often called fight or flight response. When this happens all energy is directed to efficient muscle activation and heightened spatial awareness. When the body is safe and free from danger the PNS is activated. The body gets back to work maintaining itself; digesting food, repairing tissue, eliminating waste. These systems are meant to work symbiotically, when one is active, the other is deactivated. How does this relate to a client who has been traumatized? Rothschild indicates that when the balance of these functions or the functions themselves are interfered with, the nervous system becomes confused,

> Difficulties can develop in this sequence, however, when fight or flight are not successful, or if they are not possible. Under such circumstances…the SNS continues to activate and prepare the body for fight or flight. The result is what I identify as the hallmarks of post-traumatic stress disorder (PTSD): Persistent symptoms of hyperarousal in the ANS. These include hyperstartle response, hypervigilance, difficulty staying asleep, and others listed for PTSD in the DSM-IV. Another difficulty can occur. When, under extreme threat, neither fight nor flight is

> possible, the limbic system can direct the body, instead, to go into a state of freeze, sometimes called *tonic immobility*… Many researchers have found (and I concur) that it results from a simultaneous activation of the PNS and the SNS…Freezing is characterized by paralysis, with either slack muscles…or stiff muscles…During freezing there is an altered sense of time and space, reduced registration of pain, and dampened emotion. Those who have frozen under threat report a kind of dissociative experience: Time slows down and they are no longer afraid…Studies demonstrate that those who dissociate during trauma (including freezing) have a greater chance of developing PTSD than those who do not. (p. 101-102)

A client who has been traumatized has experienced some disruption or imbalance in the process of responding to serious stress. The symptoms seen as PTSD are a result from a nervous system that is continuing this disrupted or imbalanced response. A client might not be in this state all the time, but when faced with stress she might be more likely to respond in an incongruent manner. How does this state transfer to the therapist without experiencing the same trauma? Rothschild cites empathy. More about the process of empathy and its development through somatic attunement will be discussed later. For now it is important to understand that the therapist's nervous system is itself activated in the same or similar manner as the traumatized client's nervous system. It is important to distinguish that this activation is in the absence of any activating factors; meaning that there appears to be no obvious threat to the therapist or current threat to the client. This understanding of vicarious trauma is significant to the focus of this paper. We will later look at Rothschild's explanation of how the mechanisms of countertransference and somatic attunement function

to transfer the experience of trauma to the therapist's nervous system and what can be done to prevent or manage this transfer with therapist self-care.

Forester (2007), a somatic psychotherapist, draws on all of the aforementioned authors, especially Rothschild, to point out the precaution clinicians in body-based psychotherapies should take to prevent vicarious trauma. She defines vicarious traumatization as "the traumatizing effect of work with traumatized patients on the clinician's 'mind' and 'body' " (p. 124). Forrester ultimately condenses into an article format the same information Rothschild presents, however she does not cite Rothschild's 2006 work, which may not have been published at the time she was writing her own 2007 work. Forrester seems to simultaneously tap into the same pool of consciousness as Rothschild, but takes a smaller dip.

Drawing from these significant contributors in the field of vicarious trauma, I have chosen to look more deeply into the topics of countertransference, somatic attunement, boundaries, and therapist self-care and recovery to support the research of this paper. It is in understanding these phenomena that vicarious trauma can be further understood, managed, and prevented.

Countertransference

There is a large amount of psychological literature that addresses the topic of *countertransference*. Countertransference is typically understood as the triggering of the therapist's issues by the client or the client issues (Rothschild, 2006). Some of this work is devoted entirely to the topic, but most of it addresses countertransference as one subtopic amongst many. Much of this work is grounded within the psychodynamic school of thought, as it is a concept used almost exclusively in psychodynamic training and technique.

Therefore, theorists from the humanistic and cognitive behavioral traditions rarely address the subject at all. If it is addressed, it is re-conceptualized in the context of empathy (humanistic) or boundaries (cognitive behavioral). As exemplified by Gelso and Hayes (2007), the psychodynamic literature looks at how countertransference can be used to better improve treatment for the patient. The authors provide a detailed historical and theoretical background of the term, especially as it relates to its therapeutic usefulness. The most significant contribution that Gelso and Hayes make to the research of this paper is a definition of the term that emphasizes the collaborative partnership of countertransference:

> The relational theorists…emphasize co-construction; that is, whatever happens in the hour is jointly constructed by therapist and patient. Both shape the nature of transference and both shape the nature of countertransference, as well. Countertransference then is a product of the inevitable interaction of the patient's dynamics (his or her transference, realistic expression, personality, et.) and the therapist's dynamics (unresolved conflicts, personality, needs, realistic expression, etc.). (2007, p. 12)

Although they do not address vicarious trauma, their examination into the subject does make space for the idea that the therapist could be affected by the therapeutic relationship and is not just a blank slate for the patient as the more traditional psychoanalytic perspective espouses. The patient and therapist co-choreograph their dance of therapy together, interacting in a dynamic interplay of relationship in which both can be affected by the work.

Dosmantes-Beaudry (2007) provides a small but compelling example of this relational dance of transference and countertransference as a pycho-dynamically oriented

dance/movement therapist. She too focuses on the understanding and treatment of her client and not on how the countertransference affects the therapist.

While they do not call it vicarious trauma, psychodynamists Turner, McFarlane, and van der Kolk describe some of the adverse affects countertransference can have on therapists when working with trauma:

> Working with people who have been traumatized confronts therapists as well as patients with intense emotional experiences; it forces them to explore the darkest corners of the mind, and to face the entire spectrum of human glory and degradation. Sooner or later, those experiences have the potential to overwhelm therapists. The repeated exposure to their own vulnerability becomes too intense, the display of the infinite human capacity for cruelty too unbearable, the enactment of the trauma within the therapeutic relationship too terrifying. (1996, p. 552)

Here the authors give voice to the experience of treating traumatized patients while addressing how to treat trauma.

Finally, dance/movement therapist Lewis (1993) mentions countertransference when talking about embodying and containing the psychic material of a patient, "The walls [between therapist and client psychic content] need to be elastic but also sturdy thus protecting from contamination from either side, i.e., so the therapist's personal countertransference doesn't interfere nor does the patient's material ooze into the therapist's life" (p. 13). She injects a somatic, or body-based, perspective when talking about countertransference and alludes to the ideas of somatic attunement, somatic countertransference, and psychophysical boundaries. This will be further examined in the boundaries section.

Countertransference as it relates to vicarious trauma.

The following resources on vicarious trauma address the potential pitfalls and emotional consequences of countertransference for the therapist. Countertransference is a common topic in the literature on vicarious trauma, however in the following literature countertransference is highlighted as a significant factor in the development of vicarious trauma. I have selected the following literature for this reason. There is no published DMT literature found that focuses on countertransference and vicarious trauma. There are titles that could contribute to the field of DMT, such as Rothschild and Forrester, but more DMT specific research in this vein is required.

Countertransference is addressed in some of the literature as one of several contributing factors to vicarious trauma. Some of these sources address it as one of many tasks or topics to examine when assessing the burn-out potential of one's work (Norcross & Guy, 2007; Wicks, 2008).

Other sources describe how countertransference affects the therapist and the relational factors supporting its existence and impact (Figley, 1995). Pearlman and Saakvitne (1995) develop this concept further by arguing that countertransference is the cornerstone for vicarious trauma. They advocate for and encourage intensive relational work for the therapist through supervision and therapy in order to manage countertransference effectively.

The examinations of countertransference and vicarious trauma most relevant for dance/movement therapists come from Rothschild (2006) and Forester (2007). Rothschild builds on Pearlman and Saakvitnes' relational view of countertransference, but argues that there is a neurophysiological nature to countertransference, relationship, and trauma

between the client, therapist, and their past and current experiences. She does not limit these concepts to cerebral constraints but, as a body-psychotherapist, includes the body and bodily experience as factors that allow the development of countertransference and the activation of the trauma response to take place. Rothschild is very careful to provide a basic but specific definition of countertransference. She states, "…countertransference will refer to the practitioner's reactions to his client that have roots in his own past" (2006, p. 18). Rothschild's intent is to isolate the practitioner's unresolved issues and maintain those as the source of countertransference. One could argue, though, that everything in a person's past makes up the essence of who they are, so that everything in a practitioner's past will influence his or her reaction. Rothschild's definition is a stark contrast to the definition of Gelso and Hayes, which is more inclusive of an individual's entire past. Much debate could be had about what constitutes countertransference (see Gelso & Hayes, 2007), but to serve the research of this paper, the definition of Gelso and Hayes will continue to be used (see Appendix A).

As a somatic psychotherapist, Forester's work (2007) reflects Rothschild's, but contrasts and combines some of her ideas when she proposes the use of the term *somatic countertransference* as a separate concept from countertransference. It is important to clarify that somatic means in relation to the body. Forrester states that "somatic countertransference is the effect on the therapist's body of the patient and the patient's material." (2007, p. 129). This is an interesting addition to the collection of previous definitions that have been discussed. Forrester explains,

> As with body awareness in general, somatic countertransference can be thought of as occurring on a continuum, from pure sensation to sensory experiences that are

affectively or cognitively involved. The experiences may appear to embody something that "belongs" to the patient through a form of communication by impact…or may be a somatic reaction to something about the patient and their material that evokes the therapist's material. (p. 129)

Forrester's explanation seems to align with the definition of Gelso and Hayes, but focuses on the bodily experience.

Despite the variety of opinions about the meaning of countertransference, it is well supported in the literature that countertransference is a significant factor in the development of vicarious trauma.

Somatic Attunement

In this section I will review the literature regarding somatic attunement, its meaning and use in psychotherapy and DMT, and its relationship to the development of vicarious trauma. For this thesis I use the term somatic attunement, which is a word not often used in the literature. There are a many terms used in the literature that are similar to somatic attunement, but that end up being too specific, too vague, or inaccurate in their meaning. Rand (2002), a somatic psychotherapist, defines somatic attunement and relates it to psychotherapy and vicarious trauma,

> *Somatic* means 'of the body' (Greek soma) and *attunement* means to adjust or accustom something to become receptive or responsive to something else. In the situation of vicarious traumatization, it is important to be clear that we are referring to the therapist's attunement to her own body, as well as to the client's. Somatic attunement (also known as somatic tracking) means the therapist's use of her own bodily experience. It is a state of being and a therapeutic tool. (p. 30)

Rand is illustrating that somatic attunement is the process of tuning in and attending to the body and its processes. One can tune in to ones own body or the body of another. There are a variety of ways somatic attunement can happen, as well as a variety of results from its having happened. This distinct cause and effect is not always clearly outlined in the literature, especially with those authors who do not practice body or movement based therapies. Some authors are focused on empathy as an outcome that somatic attunement may produce, but do not discuss the details of how it is accomplished (Rothschild, 2006; Forrester, 2007, Leijssen, 2006). Other authors are focused more on how to somatically attune, but do not examine its potential results in depth (Sandel, 1993; Tortora, 2006; Fischman, 2009).

The different terms used in the literature that refer to the action or skill of somatic attunement include: mimesis, mimetic synchrony, mirroring, postural mirroring, witnessing, and kinesthetic seeing (Forrester, 2007; Leijssen, 2006; Tortora, 2006; Rothschild, 2006; Fischman, 2009; Sandel, 1993). These terms include varying degrees of visual attendance to the body and/or movement of another and of mimicking various postures, movements and movement qualities of another. It is for this reason I have chosen to use somatic attunement; it can encompass all of these ideas without specifying a particular one.

It is no surprise that dance/movement therapists have developed a varied and detailed vocabulary to talk about movement and the body and how to attend to them (Tortora, 2006; Fischman, 2009; Sandel, 1993; Lewis, 1993). This vocabulary and knowledge about the body is clearly missing from the general psychological field. Psychotherapist Robert Shaw (2003) and psychiatrist Daniel Siegel (1999) provide examples of this.

Robert Shaw and his co-researchers attempt to explore the therapist's body experience, but struggle at times to concisely and explicitly articulate the rich phenomena discovered. They use the terms embodiment, somatisation, and body empathy to generalize a variety of complex phenomena that seem to relate to somatic attunement, empathy, and countertransference. He does admit the limitations of his language by addressing psychology's common pitfall of drawing from the incompatible medical vernacular.

Siegel (1999) on the other hand articulates complex neurobiological concepts and describes attunement and its results, but fails to include the whole body in this consideration. He seems to allude to the nuances of the body's movement and its contribution to the process of empathy without actually saying it directly:

> Both words and the prosodic, nonverbal components of speech contain information that creates representational processes within the mind of the receiver. Other nonverbal signals, including facial expression, tone of voice, gestures, and timing of response, have a direct impact on the socially sensitive value centers of the brain. The expression of these emotional elements of social signals serves to activate the very neuronal circuits that mediate the receiver's emotional response: orienting attention, appraising meaning, and creating arousal. This emotional engagement with another person creates a cascade of elaborated and differentiated appraisal-arousal processes, which serve to direct the flow of energy and information processing within one's own brain. It is in this manner that the emotional state of the sender directly shapes that of the receiver. In complexity terms, such "external constraints" as the signals sent from another person have a powerful and immediate effect on the trajectory or flow of one's own states of mind. (Siegel, 1999, p. 277)

Siegel's explanation supports the idea that relational communication takes place through the dynamic interaction of the body-brain system; as the body-brain system is the vehicle through which all information is experienced and processed. It is frustrating, though, that he too does not seem to possess the language to talk about and include the entire body and its movements in this description, or provide a name for this specific phenomenon. I suggest that somatic attunement is the facilitator of this process. What Siegel is able to provide is an in-depth explanation of what somatic attunement could produce; the development of understanding and empathy.

Somatic Attunement and Empathy

Terms used in the literature that represent the effect that somatic attunement may produce include: kinesthetic empathy, empathic attunement, and empathic reflection (Forrester, 2007; Leijssen, 2006; Tortora, 2006; Rothschild, 2006; Fischman, 2009; Sandel, 1993). It is clear that the humanistic concept of empathy is the focus of the terms that are oriented towards a result or outcome of somatic attunement. It is supported by Siegel's passage that emotional understanding or empathy is a likely result of somatic attunement. Acquiring this empathy through somatic attunement is a significant aspect of DMT. What is unclear in the DMT literature is what empathy truly means, looks like, and achieves. Dance/movement therapist Fischman (2009) attempts to explain what empathy means,

> Empathy is the ability of one person to understand another. It attempts to experience somebody else's inner life and implies knowing what the other one feels, having information about the other's situation and acting accordingly. It arises out of elements that are common in the experience of both individuals who are involved in the empathy process. (p. 33-34)

Fischman fails to explain the extent to which one should understand how another feels in order to achieve empathy. Are there different levels of empathy and understanding? How does one know how much to understand? What if one is not able to truly understand and experience what the other is feeling? There is an assumption that this is possible and positive. There is also an assumption that one would know how to "act accordingly". Where do these assumptions come from? Fischman (2009) credits DMT founder Marian Chace for developing the use of somatic attunement to facilitate empathy and describes her reasons for doing so,

> Marian Chace describes empathic mirroring coming from her own intuitive experience of reflecting her patients in her intent to get into their idiosyncratic worlds. Communication was her goal. She let them know that she was available and interested in their feelings, movements, and thoughts. By making the spontaneous movements of the patients her own, acceptance showed in her body. (2009, p. 43)

Sandel (1993) also wrote about the DMT founder and explained that Chace came to develop this style of working under the influence of the empathy-focused humanistic theory. The humanistic or person-centered orientation is focused solely on the client and does not address the experience of the psychotherapist. Therefore humanism would not encourage an examination of the range of potential outcomes empathy could have for the therapist. This theoretical foundation for DMT may need to be examined and clarified.

What happens when this essential element of DMT is less conscious and more of an automatic process? Rothschild reminds us that somatic attuning or, as she calls it, mimicry and postural mirroring, was not always a developed skill,

> …the human tendency to copy facial expressions, postures, and mannerisms is usually unconscious, though it is a common feature of interaction with others…Mimicry is the basis for many things we learn, including speech, table manners, and tying our shoes…Postural mirroring is the term that has been coined for the mimicry of another's physical posture, including facial expressions, and the communication of emotional and other information that often accompanies such behavior. (p. 59-63)

Rothschild differentiates between unconscious and conscious somatic attunement. This difference is something not explicated in DMT theory. She proposes that unconscious attunement and empathy may be at the crux for therapist's experiencing vicarious trauma. Rand and Forrester join Rothschild in this argument that may call for the serious examination of the use of somatic attunement and empathy in DMT.

Somatic attunement as it relates to vicarious trauma.

Rothschild (2006) makes the biggest contribution to the relationship between somatic attunement and vicarious trauma. She indicates that somatic attunement is the function that fosters what she calls somatic empathy, but that this requires much care and intention as it is what may lead to vicarious trauma,

> Somatic empathy only becomes a danger when the therapist is not aware of it, and therefore not in control of it, unconsciously tuning into the sensations, emotions, images, and thoughts of the clients. Under that circumstance, the therapist will not be able to distinguish client states from her own. Actually, it is this confusion that is usually most problematic. (p. 88)

Rothschild is explaining that when one is unconsciously attuning and empathizing with another, one may be empathizing with a trauma state and thus unable to distinguish where the trauma state originated. Rothschild continues a compelling argument and makes the solution, increased mindfulness, seem so simple. For practitioners who make extensive use of somatic attunement in their work, this would be a significant but challenging skill to master. This validates the ease with which a dance/movement therapy intern could be vicariously traumatized. Rand supports this argument, stating,

> We must not try to be aligned with the client, only attuned to ourselves and the client. Misalignments are very important because they give us valuable information about our differences with the client. We can then, after processing these differences, come to know what we, as therapists, bring to the relationship, factor that into the formula of transference/countertransference and avoid vicarious traumatization. (p. 30)

Rand seems to be talking about staying mindful and mindfully attuned, but also about not fully empathizing with the client to maintain a healthy and distinct psycho-physical boundary.

Forrester also argues that somatic attunement and empathy could trigger an experience of vicarious trauma. Referencing Dosamantes-Beaudry, Forrester explains this phenomenon further,

> Dosamantes-Beaudry (1997) speaks of a '…somatic intersubjective dialogue. Underlying this concept is the notion that bodily experiences and bodily expressions can be viewed as encoded physical aspects of conflicted self and other relationships that are carried on unconsciously.' The failure or inability to address such somatic

> intersubjective dialogue can result in the therapist being blind to crucial aspects of the patient and the clinical relationship, or to "taking on" the patient's material. When the patient's material relates to traumatic experiences and relationships, the clinician may then unconsciously, or more dangerously, dissociatively embody those unformulated, unsymbolized experiences. Here is a direct mechanism for vicarious traumatization, through dissociated kinesthetic empathy. (p.129-130)

Forrester is illustrating that there are parts of a client's past experiences that have not been explicitly expressed or understood by the client, but that through the body may unconsciously influence current experiences and relationships. In many ways she is talking about a very broad view of transference and countertransference. Everything from one's past contributes to the development of the individual and therefore is influencing the present. However, when the past includes implicit trauma and is coupled with unconscious somatic attunement, it creates a double helix of trauma being shared unconsciously between the client and the therapist.

The relationship between somatic attunement and vicarious trauma is well supported by Rothschild, Forrester, and Rand. The literature emphasizes that somatic attunement needs to remain conscious to purposefully support empathy as a therapeutic tool. If unconscious, attuning could lead to empathizing with traumatized states, thus vicariously traumatizing the therapist. It is clear, however, that countertransference is not considered an essential component in the development of vicarious trauma, but if active may create a more potent situation. More discourse about the relationship of somatic attunement, empathy, and countertransference is certainly required. More discourse is also required in the DMT field about how somatic attunement and empathy is discussed, taught, and used, and that

vicarious trauma is a factor to consider in the equation. In the following section the ideas of recovery from and prevention of vicarious trauma will be addressed.

Boundaries in the Therapeutic Relationship

The concept of boundaries is important to many aspects of therapeutic work. Some of the literature regarding the idea of boundaries is in reference to ethics and legal issues and is most often found in resources from the field of social work (Zur, 2007). Other literature addresses boundaries as a skill to develop in work with clients and their relationships (Kornblum, 2002). This paper narrows the focus to the idea of healthy personal boundaries for the therapist in her therapeutic relationships and in relationship to her work.

Much of the work addressing boundaries comes from the literature about therapist self-care, though some is from trauma research. Psychodynamic and pastoral therapists Grosch and Olsen (1994) address the concept of "setting boundaries" in relationships and at work. They explain many situations in which a therapist or client needs to set a boundary with a co-worker or family member. What they are really talking about is the ability to say no when roles or responsibilities become overwhelming or inappropriate. This ability to say no seems to be a significant feature of establishing healthy interpersonal boundaries.

Trauma specialist Yassen (1995) discusses boundaries in the context of preventing STSD. She also seems to emphasize the ability to say no within several different types of boundaries, including time of sessions and work schedule, therapeutic/professional boundaries (emotions and involvement), personal boundaries (self-disclosure), roles, and knowing one's limits. Her promotion of boundaries is just one element amongst many that contribute to therapist self-care. She also identifies physical health, spiritual health, seeking support, continuing professional training, and evaluating the workplace environment as

topics to consider. Yassen's concept of boundaries is significant here as it gives the therapist an alternate way to think about how the traumatic nature of the work can challenge boundary setting tendencies and how poor boundaries can allow the traumatized state of the client to reverberate with the therapist. These are all boundary issues that are significant to the focus of this research.

Pearlman and Saakvitne (1995) connect the idea of boundaries to countertransference and the therapist's ability or inability to "set limits" (say no) in the therapeutic relationship. They support developing this skill with establishing a "therapeutic framework" around which the clinician can reference her work and seemingly justify limit setting. What they are really talking about is having well-established therapeutic skills and a firm rational to support what those skills are and why they use them. Their use of the term "therapeutic framework" is a vague way to advise the therapist to reference their chosen orientation to therapeutic practice to figure out how and why to say no.

Norcross and Guy (2007) examine all aspects of boundaries and burn-out prevention, from the interpersonal differentiation between self and other to the differentiation between work-time and home-time. They demonstrate that the concept of boundaries is a way to say "no" to work and "yes" to oneself.

Jocelyn S. Shaw (2009) talks about boundaries in the psycho-physical experience in relation to her work with children as a DMT intern. She correlates the concept of physical boundaries that she is teaching her young clients with her own experience of interpersonal boundaries within the therapeutic relationship, finding an interesting parallel process. The child she works was learning to sense her own body boundary without touch to initiate it. Shaw was learning to "channel (her) own reaction careful not to over-identify or project

(her) own feelings." Shaw provides research that connects with this research, by exploring the relationship of physical and emotional boundaries in dance/movement therapy with children.

Dance/movement therapist, Lewis (1993), gives a metaphor to represent the idea of healthy boundaries in relationship to the patient's issues:

> The therapist can prepare for this experience by emptying the mind in much the same way that someone meditating or engaging in authentic movement would do, and then creating an imaginal inner vessel within, which lies ready to receive and give birth when ready. The walls need to be elastic but also sturdy thus protecting from contamination from either side, i.e., so the therapist's personal countertransference doesn't interfere nor does the patient's material ooze into the therapist's life. (p. 13)

Lewis paints a vivid picture of creating a transitional space to house the patient's material within the therapist's body. This vessel maintains a separate space for her and the patient while holding the patient's material separate as well. This could allow both the therapist and the patient to mindfully observe and work with the material without it having to affect either participant. This is an interesting way to think about mindfulness as a skill to manage somatic attunement and empathy and represent the idea of creating boundaries in the therapeutic relationship.

Lewis's work relates to what Rothschild (2006) proposes as a healthy way to manage somatic attunement and empathy. Rothschild emphasizes that unconscious postural mirroring and somatic empathy are significant to the development of vicarious trauma. She suggests developing a variety of skills to manage this and other related issues. Included in

these boundary setting skills are; increasing awareness of facial and postural movement, increasing awareness of mirroring and empathic tendencies, learning how to "unmirorror" (p. 35), learning how to track personal arousal states and stay mindful, learning how to "apply the brakes" when stressed or hyperaroused (p. 95), strengthen self-observation, manage self-talk, and bolster the internal frameworks that aid in clear thinking. Rothschild does not refer to all of these skills in reference to establishing boundaries, but in one section she does talk about the concept that supports the connection I have made:

> The term boundary is commonly used in psychotherapy jargon to describe several phenomena. Psychotherapists usually think of their professional boundaries as restricted to defining the ethical and sexual limitations of the therapeutic relationship. This section focuses on two additional aspects of boundaries relevant for therapists: those that involve physical distance, or your comfort zone, and those which help you to feel adequately protected inside your own skin, "body armor." (p. 125)

Rothschild focus is clearly on the body. She advocates that the ability to remain aware of and most likely in control of body-based processes like empathy and stress response is at the crux of preventing and recovering from vicarious trauma. This skill is not just essential for dance/movement and body psychotherapists; it is essential for everyone!

This reminder that one is capable of managing the therapeutic material in relation to one's own body is a connecting feature between Lewis and Rothschild. Lewis provides a symbolic representation of this process, while Rothschild maps out its elements. What is different between these two philosophies is Lewis's emphasis on inviting the material into the therapist's body to manage it and Rothschild's emphasis on the ability to say no to

inviting the material in. Is one approach better? I suspect that Lewis's style requires a significant amount of experience and core strength to manage. Rothschild's style of accepting a clearer, albeit stricter body boundary in relation to the patient's material may be more appropriate for the new therapist to learn and use.

Baker (2003) reiterates and provides rational for Rothschild's reminder to stay connected to oneself in her guidebook to therapist personal and professional well-being:

> Boundaries refers to the figurative lines that delineate each of us as separate, unique beings. Good boundaries allow us both to be considerate of ourselves and to connect with others appropriately…The therapeutic and ethical responsibilities of clinical work necessitate both that we practice and model differentiation between our own and our patient's feelings and that we switch back and forth between our emotional connection with the patient and our own intellectual resources to make rational sense of the emotional dynamics we are perceiving. (p. 102)

Baker reminds us that in order to help another, we first must be able to help ourselves; and that this is ethically responsible!

One cannot effectively perform a task without the necessary tools, and the ability to establish healthy interpersonal boundaries are amongst these tools for the psychotherapist. It is clear that within these interpersonal boundaries is the choice to say "yes" or "no" to connection in relationship. These authors demonstrate that working on this skill is key to preventing vicarious trauma.

Recovering from Vicarious Trauma and Burn-Out: Therapist Self-Care

Recovering from vicarious trauma is a process that is not clearly outlined in the literature. Sources that focus on therapist self-care and trauma research suggest similar

strategies (Figley, 1995, 2002; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; Rothschild, 2006; Norcross & Guy, 2007; Baker, 2003; Wicks, 2008). These strategies include a broad range of stress management techniques and points of examination, including: engaging in supervision and therapy; seeking out continued training; eating, sleeping, and exercising well; learning to manage time and workload effectively; connecting with a higher power; assessing one's workspace; maintaining a personal life with personal interests; taking time off from work; and taking an assessment of the client-based interpersonal factors that may lead to vicarious trauma. It seems that there is no straightforward way to recover from vicarious trauma; the strategies are as varied as the therapist's using them. Rothschild addresses recovery in the most simple and concise manner,

> Compassion fatigue and vicarious trauma can be healed and even prevented when the mechanisms leading to them are identified and made conscious. Once vulnerabilities are assessed, strategies for increasing awareness and control can be instituted. Experimentation and evaluation are the keys to helping each therapist discover which interventions are most effective for keeping her in her own chair. (p. 207)

She is talking about somatic attunement and empathy but this statement can be applied to any number of other factors that contribute to vicarious trauma and burn-out. It encompasses the collective view in the literature that recovery from vicarious trauma and burn-out requires mindful assessment of the therapist's individual situation in order to make conscious and purposeful choices to alleviate the issue.

Summary

Much of the literature that the previous topics have addressed has been from the category of therapist self-care. Some of this work is scientific research looking at the existence and definitions of vicarious trauma (Figley, 1995, 2002; Pearlman and Saakvitne, 1995). Some of these works have been manuals or guidebooks to give the therapist some skills and points of discovery (Baker, 2003; Norcross and Guy, 2007; Payne, 2008; Rothschild, 2006; Saakvitne and Pearlman, 1996; Wicks, 2008). What is most significant in this literature is that all of the data point to the therapist prioritizing care for her or himself. This involves learning why, how, and when to do so.

Aside from the unpublished theses of Lengerich (2001) and Agor (2003), there is little in the field of DMT addressing this topic in an in-depth manner. I am curious as to why this is the case. Do dance/movement therapists experience less vicarious trauma than therapists in other fields or do they not know when they are? How is vicarious trauma addressed in the education and supervision of dance/movement therapists? What do dance/movement therapists do to manage work with traumatized clients? Are there different contributions to be had from different styles of DMT? How can DMT contribute to the larger conversation on vicarious trauma? These are many questions that may not be fully addressed in the scope of this paper, but I hope will be fueled because of it. These questions are shared to inspire further thought, discourse, and research on the topic.

As stated previously, the intent of this paper is to contribute to this body of literature by providing an example of how other's theories and ideas have truly played out in a real life and to call for further research and education in the DMT profession. To reiterate, the question of this research is: How does a dance/movement therapist experience, recover

from, and prevent vicarious trauma? In the following chapters I will outline how I conducted this research and then present my findings in narrative form.

Chapter 3: Method

This chapter reviews the method I utilized to conduct the research for this paper and the rationale behind my choice. I chose to use an autoethnographic style of research because it was most compatible with the development of my research question: How does a dance/movement therapist experience and recover from vicarious trauma? I had an experience of vicarious trauma that resulted in many lessons I felt were essential to convey to the dance/movement therapy community. I grappled with utilizing other methods, such as artistic inquiry, to convey my experience but decided that I wanted to share it in a more linear progression and concretize my experience for others to consider. This qualitative method is subjective and based on my personal emotions, thoughts, memories, interpretations and bodily sensations. My hope is to evoke these types of experiences in my reader so that she or he may reflect on how vicarious trauma and self-care can play a part in her or his own life.

Methodology

Autoethnography is a method of research that has evolved from the field of anthropology. Its primary purpose is to examine culture or society by way of the writer's personal experience of it. It has developed out of the method of ethnography, which requires the writer's full immersion in a culture to analyze and understand it. Ethnography does not require, however, an examination of the writer's personal experience. Authoethnography has been readily adopted as a methodology for research in many fields other than anthropology, including sociology and psychology. One of the authorities on the method, Ellis (2008) provides the clearest definition:

Autoethnography…refers to the process as well as the product of writing

about the personal and its relationship to culture. It is an autobiographical genre of writing and research that displays multiple layers of consciousness. Usually written in the first-person voice, autoethnographic texts appear in a variety of forms—short stories, poetry, fiction, novels, photographic essays, scripts, personal essays, journals, fragmented and layered writing, and social science prose. Autoethnographers showcase concrete action, dialogue, emotion, embodiment, spirituality, and self-consciousness. These features appear as relational and institutional stories affected by histories and social structures that are dialectically revealed through actions, feelings, thoughts, and language. (2008,p. 130)

In dialogue with Bochner, Ellis elaborates on the intent of autoethnography:

> On the whole, autoethnographers don't want you to sit back as spectators; they want readers to feel and care and desire. I guess if that's a criticism—that it may affect your life; may even dredge up feelings you're not prepared to deal with now—well, maybe that's a sign it's making a difference. (Ellis & Bochner, p 24, 1996)

Ellis illustrates that the examination of culture is not always best achieved using an objective, pre-prescribed outline. Culture is comprised of a variety of experiences and in order to portray this to the reader, the writer must use whatever creative means he or she feels is accurate. Ellis illustrates that the experience of culture is subjective and that the manner in which the writer shares this and reader experiences it might be subjective as well. Dance/movement Therapist Bonnie Meekums (2008) adds additional insight into the subjective nature of the method:

> The methodological approach of autoethnography offers a relatively

> new and rigorous approach to research. The text of autoethnographic writing does not feature the traditional distanced researcher, but is written in the first person, highlighting stories of relationships and emotions affected by social and cultural frameworks. Researcher subjectivity is seen as a legitimate lens for examination of social and cultural phenomena, rather than a voice to be exorcised. Whilst methods vary considerably, autoethnography as a broad methodological approach is thus consistent with reflective practice in the fields of counselling and psychotherapy, emphasizing as it does self-understanding, creativity and immediacy of communication, whilst maintaining a critically subjective stance. (p. 287)

Meekums provides rational for the use of autoethnography in qualitative psychological research, reminding us that they share similar values. The ability for the reader to have a subjective experience of the autoethnography he or she is reading may depend on the manner in which the writer shares the information. Sparkes (2008) elaborates on the differences between the options of "telling" and "showing" within the autoethnography:

> *Telling* occurs when writers intervene in the narrative and suggest how they and we might feel about characters or interpret events. In contrast, *showing* involves the author's effacement, so that characters act out the story and reveal things about themselves without the author proposing interpretations. (2008, p. 656)

This may or may not be a conscious choice the writer makes, especially in the more creative forms the autoethography can take. For the research of this thesis, I did not consciously choose to "tell" or "show" the reader my experience, but hope that I accomplished both.

Chang (2008) strictly aligns autoethnography with the anthropological values of culture, affirming that the purpose of self-narratives within this method is for the writer and reader to examine and discuss the overlying concept of culture.

Ethnography is "a research method that utilizes the researchers' autobiographical data to analyze and interpret their cultural assumptions" (Chang, 2008, p. 9).

He points out that there are differing sides of the aisle, those who aim for a more objective style of the method and those who value the subjective and emotional style (Chang 2008). After referencing Ellis and Bochner (2000) and their "insightful triadic model to explain the complexity of the autoethnographic variety." Chang argues

"that autoethnography should be kept ethnographic in its methodological orientation, cultural in its interpretive orientation, and autobiographical in its content orientation" (p. 48).

For this paper, I did not set out with the intention of cultural analysis through the lens of my own experience. One might argue that I reveal much about the culture of dance/movement therapy in my story, but that was not my sole intent. My intent was to share my experience and lessons with my culture of dance/movement therapists, a collection of people to whom this work may apply. In this process I found I examined the culture of my internship and to some extent the institution that trained me as a dance/movement therapist. I also found that the embodied work of DMT has contributed to vicarious trauma. This embodied work is not exclusive to DMT, but it is a significant part of its style and culture and may need to be reexamined to protect the safety and sanctity of the field. My subtle examination of these cultures may not fulfill the standards of an experienced autoethnographer. Nevertheless, I align my method with autoethnography because of its

value of the writer's personal and subjective experience, its expectation that information can be shared through the empathic understanding of the story and its tolerance for the many ways of sharing the experience and eliciting a response from the reader. One could argue that I have pulled from many other styles of research, such as heuristic, transpersonal and phenomenological; and I would agree (see Braud and Anderson, 1998). I have found, however, that autoethnography provides a clearer end-goal toward which I have aimed my research without placing too many restrictions on how I fulfill that goal. I encourage the field of DMT to continue research and discourse on autoethnography and the variety of other methods that utilize narrative, subjective, embodied, and creative approaches.

Participants

I was the primary subject of this study as well as the researcher and writer. Information about other individuals or locations that were involved in this study has been de-identified or modified to protect the privacy of said entities. As this study is focused on my personal experiences during a clinical internship, no consent to release information was required. The data for this inquiry was gathered during the 9 months of this internship. The initial data was gathered at a residential placement facility for children aged 5-15 located in a suburb of a major city in the United States. As suggested earlier, the data includes my personal emotions, thoughts, memories, interpretations, movements, and bodily sensations gathered while interning at this facility.

Procedure

I gathered the information for this study by fully immersing myself in the culture of my master's internship. I took on the responsibilities of a creative arts therapist by adopting a full caseload (for three days a week at least) of groups and individuals, reviewing charts

and writing notes. I took in the sights, smells, and sounds of my internship. I observed and somatically attuned with the emotions, thoughts, and movements of the children and staff I worked with. I compiled personal notes for each session and journal entries about myself each week. These memories, notes, and embodied experiences make up the bulk of my raw data.

Data Analysis

The analysis of my data took me a very long time, about 4 years. I struggled to submerge myself into the deep ocean of raw embodied information I gathered. Analyzing the written data alone would not have sufficed, I knew there was something far more valuable stored in my body and mind, but it was painful and overwhelming to examine. In the year following my internship I attempted to examine my experience to no avail; I was too close to see it clearly. I realized that re-submersion into the data was not the most effective way to look at it. Analyzing the data required a drastically different perspective; I needed to fully dissimilate from the culture of my internship. Obtaining this perspective required time, life experience, professional experience, therapy, supervision, movement, art making, dreaming, and countless conversations. In this transition from one perspective to another I began to look at small pieces of the embodied data I gathered. I found glaring differences between my previous thoughts, feelings, attitudes, observations, movements, and bodily sensations and my current ones. I began to question these differences and slowly learn some valuable lessons about my professional work and myself.

In the following chapter I will share the data I have analyzed; a subjective narrative account of my internship experience. I will inject, when necessary, my questions, thoughts, feelings, attitudes, observations, movements, and bodily sensations I experienced at the time

of the internship and at the time this paper was written. By no means have I been able to analyze all of the embodied data I gathered; this requires much more time than the writing of this thesis allows. I have recorded and analyzed through story telling only what I understood to be pertinent to the research question of this paper. My analysis involved attuning to my responses while writing and reading about my embodied information. I would observe when I had a strong emotional reaction or question to the material I was attending to. When I had an emotional reaction I would fully experience the feeling, let it pass, and then think about what was behind it. When I had a question I would examine what I was really unsure of and reference literature, other people, or myself; most often I would ask myself and trust my own expertise. This process of analyzing my data subsequently shaped the story that has been shared; my emotions and questions in response to the data helped me stay true to the research question. What I hope I have accomplished is a distillation of the lessons I have gathered from this internship so that others in the field may consider how a dance/movement therapist can experience and recover from vicarious trauma.

Chapter 4: The Story of my Internship

The Site

As stated earlier in this paper my internship took place at a residential treatment facility for behaviorally challenged children aged 5 to 15. Many of these children were wards of the state; some were adopted after a time in the Department of Child and Family Services; some children were put there by biological families, parents if they were lucky, or by other family members like grandparents and aunts who had custody. This facility was in a nearby suburb of a major U.S. city. It housed five small units in two wings that were categorized by age, types of behavior issues, and sometimes gender, though there were mostly boys. The total capacity for this facility was around 50 children. There was a wing that housed education, where most of the children went to school, and a wing that housed administrative offices, which included the creative arts therapy rooms. We had an office and two art rooms that were solely ours. We also had use of two family therapy rooms with two-way mirrors and a spacious conference room that could be arranged to support a dance/movement therapy group.

The Creative Arts Therapy (CAT from here) Department consisted of one art therapist and her several interns from the disciplines of art therapy and dance/movement therapy. The dynamics between the CAT department and the rest of the facility were a bit strained at times. There were reasons for this, many of which I am sure were well outside my realm of awareness. I will only share here the dynamics that I observed and have found contributed in some way to my experience of vicarious trauma. The primary issue surrounding the system in which I interned was isolation. There was isolation on many levels. Our small department was physically isolated from the rest of the facility. Only two

other non-CAT staff shared our floor irregularly. We were separated from the children, the unit staff, and even office staff by locked doors. We did not even have to leave our area to file notes, as they were all submitted through the computer. We were theoretically isolated as well. The CAT department operated primarily from a psychodynamic standpoint with a general and irregular usage of other theories as needed. The rest of the facility was rooted in cognitive-behavioral management. CAT sessions did not participate in the behavioral-management program that was in place to help the children chart their progress. Finally, there was a cultural divide between the CAT department and other staff. A majority of the facility staff were minorities, mostly African American, who hailed from more urban regions. The highest level of education acquired from most of the staff was a bachelor's degree. This excluded supervisors, who required a master's level education. The CAT supervisor and her interns, including myself, were Caucasian and from more suburban and rural regions. Our CAT supervisor possessed her master's degree and the interns were all pursuing master's degrees. We all had extensive backgrounds in the fine arts. There were times when it was difficult for these groups to relate to one another. I am not sure if this was acknowledged in the rest of the facility, but it was certainly complained about in the CAT department behind closed doors. These discussions would usually arise in the office after some disagreement about the treatment of a child or staff participation in group sessions. It would then evolve into how the staff were not well trained in "clinical technique" or possessed little motivation to understand the goals of CAT. These factors helped fuel an "us vs. them" mentality within our own department and I believe on the units. There was a poor sense of team collaboration, support, or understanding at times. Staff members were then unavailable as role models, teachers, confidants, or feedback providers

to my fellow interns or me. This contributed to my own isolation within my internship experience. Isolation from a potential community of support was something I grew up, worked, and learned in, so it was a way of being that was too familiar. I knew no other environment. This was unfortunate because isolation is a tendency towards which introverts like me gravitate.

This isolation around me was one element that reinforced my less-than-healthy tendencies towards independence and capability. It triggered in me a sense that I needed to prove myself as more than capable and independent. I was not sure how to go about doing that however. I was unsure of whom I was as a therapist and it did not feel acceptable to figure that out openly in my internship. This need to prove myself has been a topic of many anxious dreams over the years, as it is an ever-evolving issue for me. Since high school or college this topic has been represented by dance. Often I appear in a dream where I am expected to be dancing, except that I do not know the dance. My response in these types of dreams has shifted over the years. Earlier in my college career (I was a dance major) my dream self fumbled and was overwhelmed and embarrassed. Later in my college years I was often able to follow along and manage to get by, but still felt under-prepared and overwhelmed. In graduate school I would get angry, wondering who expected me to know this dance and for what purpose!

During this time at my internship I took a secretly defensive stance against this feeling that I had to prove myself; I probably would not have admitted it or even been aware of it. I certainly learned the tools for good therapeutic work, and had a general idea of how to use them. I was just building the muscle and coordination to wield my craft, so I was not wielding my craft with much power, authority, or artistry yet. These self-inflicted

expectations to master something right away have kept me from asking for help or support, and my internship behavior was no exception. I harbored feelings of shame around asking for and accepting support, which kept me isolated and paralyzed. I justified this by telling myself that I would expose myself as incapable of handling the work and that these were not issues to work on with my supervisors; this was work for my own therapy. I did not seek out my own therapy until the middle of my internship. These internship circumstances coupled with my less-than-healthy independent tendencies supported my experience of vicarious trauma.

At my internship site there were enough interns each school year to provide individual and group work for every child in the facility. I was assigned four to five children to work with individually and two units in which I co-led groups. I began working by myself with individuals and groups during my first week. I watched maybe a handful of art therapy sessions conducted by my site-supervisor or another intern and I never did see how a usual day on the unit went. There was an expectation for me to jump right into the work and start swimming! I did not feel comfortable or confident doing this but with my aforementioned beliefs I did not feel like I could do anything about it either, so I decided to go along with it and be as accommodating as possible. Little did I know that it is possible to be too open and accommodating and that these factors can set the stage for vicarious trauma.

The Client

During my nine-month placement at my internship site I saw all of my individual clients for a maximum of four and one half months, with one exception. An art therapy intern and I "traded" clients with whom we struggled to connect or effect change after four and one half months. For a few of my other clients their time in residential treatment ended

two to four months into my placement. Only one child had all of her individual CAT sessions with me. This was for several reasons; we both enjoyed our sessions and there was change occurring in the sessions that my peers did not want to disrupt. My supervisor failed to acknowledge either of these facts, but also did not encourage a trade. For the sake of confidentiality this child will be called Bernadette, a fitting name (as will soon be clear) that means "strong, brave bear". My site-supervisor thought that she and I would be a good match. Bernadette was a creative and playful child who enjoyed stories and animals, and I had a creative dance background that seemed fitting.

Upon reviewing her chart and history I found that she had led a sad and tragic little life that made my heart ache to read. Bernadette was abused and neglected from infancy until early school age when she was removed from her home. She had a mother who suffered from a chronic and severe mental illness and was unable to care for her effectively or protect her from an abusive and equally neglectful father. These factors severely affected Bernadette's development, though she may have had some genetic predisposition towards emotional instability as well. Her more significant diagnoses included post traumatic stress disorder (severe), reactive attachment disorder of infancy (this one alarmed me), mild mental retardation (I.Q. of 56), and receptive-expressive language disorder.

When Bernadette was removed from the home she was eventually placed with and adopted by an older relative I will refer to as Aunt Emily. Aunt Emily tried her best to help Bernadette adjust and recover from such a difficult start to life but there was too much for a single older woman to manage. Bernadette was going to require long-term energy and resources, so was placed in residential care.

When I came to work with Bernadette she had been at this residential site for a couple of years. Children are admitted with the intention to keep them up to six months, but many stay much longer due to the severity of their behaviors. This most certainly included Bernadette. She struggled with violent anger outbursts, defiance, and a lack of verbal expression that exacerbated everything. Bernadette was practically non-verbal when she began her stay in residential treatment, and attempted most of the time to pretend to be an animal, such as a dog. It was thought among staff that she was locked in a room with the family dog to "watch" her when she lived with her parents. She was like a modern day version of the girl raised by wolves. Bernadette was slightly more verbal when I came to work with her, composing basic phrases and sentences only when she felt it was necessary to communicate with language. She was also more stabilized, no longer becoming violent and unsafe when emotionally challenged. She was about 11 when we met but functioned at the level of a 4 or 5 year old at best.

Before my placement at this site there were other Dance/Movement Therapy Interns who worked with Bernadette. I reviewed the session notes and found that the previous DMT Intern had attempted to conduct more structured developmental movement sessions that were met with much resistance. Developmental movement seemed to be a very necessary task for this child. She had missed many developmental milestones and was reportedly an awkward mover with poor muscle tone, coordination and physical boundaries. I was concerned and disappointed by her resistance to prescriptive movement but was curious about her desire to play instead. I was excited but nervous about the challenge to figure out how to incorporate developmental movement based on Bartenieff Fundamentals

with play, stories, and animals. I was more concerned, however, with establishing a solid therapeutic relationship, and that became my initial and primary therapeutic goal.

My neurotic (and narcissistic) insecurities started to take root and grow. This child struggled to find appropriate, healthy attachment figures and I felt pressure to be that for her. Pressure seeped its way into and colored my experience. As a student my job was to begin *practicing* my craft, figuring out and experimenting with the nuances of it. I was unsure how much experimenting I could "get away with" as I felt like I had to facilitate great change right away. My initiation into the work was by way of the proverbial fire. I jumped right in, overly eager to figure it all out, not mindful of what I was jumping into or how I might come out. This was my first step onto the path of vicarious trauma.

Setting Sail

For my first session with Bernadette I went to the unit with my supervisor to confirm the regular meeting time with the unit staff. She was in the windowed quiet room, playing by herself (as she always did), with the radio on. While we talked outside of the room, Bernadette looked through the window at me and smiled with curiosity and excitement. She knew she was going to have CAT sessions and seemed to realize that I was there for that reason. After being introduced and informed of her schedule I noticed Bernadette blushing and appearing embarrassed and shy. Looking back I saw in her a response I had experienced myself, then and since. For me it was an embarrassed, being put on the spot feeling, mixed with the urge to run or hide from the immediacy of a one-to-one relationship that was unknown, scary, and very intimate for a first meeting. It is a strange situation, meeting with a complete stranger for the sole purpose of conducting therapy, whether one is the patient or the new therapy practitioner. In the moment I felt not unlike a child myself,

being introduced to a new playmate and told to go off and play. I was conscious of being seen and of seeing and found it a little overwhelming. I was trying so hard to ground myself as a professional adult, trying to figure out in the moment what was the most therapeutic way to behave and still assert my authority. I think I ended up assuring myself to *just be myself* and the situation would figure itself out. Bernadette's and my discomfort faded once we moved past that moment. We were stepping into unknown territory together and this simple idea alone forged the small bond from which our relationship grew.

During this first session Bernadette engaged very quickly through symbolic play. She brought with her a small stuffed dog, her transitional object. This stuffed dog became the transitional object for both of us. It gave us something through which to interact and connect, a safe way to "test each other out," a conversation starter of sorts even though we spoke very little. I struggled with the idea of allowing her to bring her own toy. I struggled with the thought that I should not allow her to manipulate the session with her desire to "just play," and that I should rely on my "DMT skills" to guide our actions. At the same time I struggled with the understanding that the transitional object was healthy and necessary in order to connect interpersonally and that children learn about themselves and their world through playful activities. Non-consciously I made the choice to play in order to gain Bernadette's trust. Allowing something she wanted to do, rather than pushing for something she was not interested in probably won me many brownie points with Bernadette. I allowed the stuffed dog during this session and for all of them after.

Bernadette played with the dog by herself, enacting a story, but soon included me in the activity. At the time I struggled to remember how to play in this manner. I was not the most social of children and had few regular playmates when I was at the age of Bernadette's

functioning (four to five). Later in the internship, when I began some of my own therapeutic work, I realized this was an issue that probably contributed to vicarious trauma. A "lonely child" part of me was awakened and invited into the room by Bernadette. This part of me wanted to play, but was not sure how. At the time, of course, I was entirely unaware of this. I only knew that I was grappling with how to respond and interact on a therapeutic level. I *did* have a very active imagination in my youth, and I tried to access that. I narrated my observations of what Bernadette did (a conscious therapeutic choice), asked questions about what was going on in the story (not always answered), and made suggestions as to what could happen next (not often taken). I was very clearly game for this way of working and Bernadette knew it. I think she was willing as well. The play morphed into complicated forms of tag (with our feet) and hide-and-seek with a stretch sack. I was amazed and impressed that this apparently low functioning child could figure out how to navigate the complicated terrain of our developing relationship through such enthusiastic symbolic play. I was confused if this was in any way a conscious choice on her part. I struggled to assess her intelligence enough to deduce what she was capable of. How much of an 11 year old was she really? At the time I struggled to verbalize this quandary during supervision.

The symbolic play of our first session continued to shift until there was a turn of events in the story line. Bernadette decided to turn the stretch sack into a symbolic monster, and we took turns being eaten by the monster. Then *I* was assigned the role of monster, and it was *my* turn to try to eat her and the dog. I found myself confused in this moment. I felt like I was suddenly being reprimanded for something without knowing why. I was not sure I wanted to be the monster. I wanted to be the good guy. I wanted to be liked. My inner

lonely child was distressed. On an intellectual level I was fascinated and understood that this was interesting work for building trust in our relationship as well as working out some complexities in her emotional trauma. "I should not take it personally, it's not about me", was what I was telling myself. My confusion and ambivalence were still there, though, and I disregarded them. I could have made many different decisions about how to handle this within the therapeutic relationship, but I made a choice on some level that my discomfort was my own "stuff" that I should work on later. I did not, however, work on this until much later.

After I took on the role of monster, Bernadette "protected" the stuffed dog while acting like a dog. She positioned her self strongly in front of me on her hands and knees, while I sat on the floor frozen, and she barked and growled inches from my face. I was amazed by the symbolism but still did not want to be the bad guy. However my shock at the moment was far stronger; I was a little embarrassed for her and a little freaked out for myself. The barking was loud and there were other sessions across the hall; I knew she was easily heard. She was also too close for comfort. I again disregarded my own feelings about this through intellectual curiosity and added therapeutic justification. I decided she needed to experience taking a defensive stance against the monster more than I needed my personal bubble of comfort space. This tendency towards self-sacrificing behaviors in the therapeutic relationship is not healthy. I realize this now. Would she have benefited more from being told to back it up because I needed my space? In my mind at the time I was afraid to disrupt the story by interjecting my blunt reality. I stepped right into the position of objectification. I was no longer Ellie, DMT Intern with her own feelings and needs. I was almost a living-breathing doll or character Bernadette could direct to act out the stories

she needed to work out. In some therapeutic traditions there is a way to make this work. In these traditions, however there are methods to process this work in the session with the client, process this work in supervision with a supervisor, and establish healthy boundaries for therapist and client. I had no context for any of this in my professional exposure. I did not even have a great context in my personal life for asserting my own needs and being direct about what was happening in a relationship. This harkens back to my childhood of limited playmates. When I would play with other kids I often followed their lead. I had a favorite cousin who I could collaboratively play with, but for the most part I let the other kids figure out what we were doing. I thought a lot of kids were bossy, but I did not want to lose a playmate. I had so few available to me and I could not risk having none. Flash forward twenty years and I still did not want to lose a "playmate". In this case I did not want to lose the enthusiasm Bernadette had for including me in her world of play, so I sacrificed some of my own comfort for that.

Bernadette stopped barking as soon as she started, though, and decided my character was acceptable and that I could be a male dog partner to her female role. I was again unsure that I wanted to take on this role. Bernadette enacted marriage, birthing the stuffed dog as our puppy and problem solving together to repair our puppy's broken leg. At this point our time was up and my head was swimming. This was so much symbolic material for one hour! What was I supposed to do with all this information? What had happened, what had I "tried on"? What could I have done differently? I had no idea. This is not what we had practiced or even talked about in our course-work. As stated before, I had no context for this type of work. My body was abuzz with unfamiliar and unexplained reverberating energy that I did not know what to do with and did not know how to bring up with my

supervisor. My heart was racing, I felt a little shaky, and my mind was spinning. My site supervisor was not a body-based practitioner and I had decided early in the internship that she was not going to help me process my body-based quandaries or triggers, so I kept this information to myself. She was able to look at the symbolic ideas the story portrayed and how they related to Bernadette's own life issues and struggles. This was helpful to provide story context and insight for me, but we never seemed to discuss how or if I could process this material with Bernadette. Was she intellectually or emotionally capable of addressing the symbolic themes explicitly? If so, how would I go about doing that? I had so many questions for this young soul that I did not know what to do with. I had so much of my own non-conscious "stuff" that was activated that I did not know what to do with. I found supervision unsatisfying. I conducted and understood my work in a different language than my supervisor. I did not know how to translate my experience and ask for what I needed. I was not sure what I needed. I felt angry that I felt all of this. I left that day reverberating with excitement, fear, annoyance, loneliness, and a host of other emotions I could not identify or explain. This was only my second day of my internship.

The Beginning Continues

For many sessions following, Bernadette and I continued with similar symbolic themes but shifted characters from monsters and dogs to dog owners, ghosts, hunters, burglars, and vampires. Similar issues continued, of embodying roles I was not sure I wanted to take on, fear of disrupting the flow of the story, and disregarding my personal boundaries. Bernadette had come to enjoy our sessions, though, and began to struggle with ending each of them and separating. She would first try to continue with whatever story we were playing when I would tell her it was time to end. She then tried to stall our ending by

taking my shoes and giving me hers (maybe it would be more fun to be Ellie for the rest of the day…). She then attempted to acquire other objects to take with her, transitional objects from our session and our relationship. She had become attached and I struggled to find a way to detach at the end of each session. This became literal when she tried to cling to my out-stretched legs while I sat on the floor. I struggled to actually *be* the "bad guy" with a stern voice and a stern "NO." I struggled to insist it was time to go and that I was no longer open for business. I struggled in our/my timeless state to bring in the staccato rhythm of weight and time I felt was needed to bring the story and session to a close. There were rarely endings to the stories we enacted already. I had lost part of my identity in the sessions, so of course the sudden assertion of "time to end" was not easily enacted or received.

Bringing this dilemma to my site-supervisor was an uncomfortable experience. She suggested implementing a behavior plan. I was resistant to the behavior plan. It involved a timer, a sticker reward for ending on time, and a bigger reward after several successful endings. This was a straightforward behavior-modification plan that utilized positive reinforcement as a means to illicit change. It was not my cup of tea. It was not something my supervisor or the other interns did, or had to do. It felt unnatural, like a worn pair of someone else's jeans. It did not mesh well with my approach or me. I felt disempowered and incapable. I felt like I was incapable of getting my client to listen to me and of figuring out what to do about it. I felt discouraged, misunderstood and annoyed that there was not a more collaborative discussion on how to find a solution that was more true to my approach. I was unable to initiate the discussion I felt I needed. I tried the behavior plan. It felt forced, but I put up with it. We used the behavior plan half-heartedly for a couple of

months. It eventually fizzled out as I became better versed at saying we were done for the day or manipulating our ending transition to better involve the unit staff instead of my site-supervisor. This experience turned me off further to bringing many issues to my site-supervisor. I struggled to find ways to work collaboratively with her to best fulfill my needs. I also struggled to realize what my needs *were* at times. I know I had a role in my struggle. I felt too needy and intense for my site-supervisor and figured that we both would be better off if I just left the issue alone. My isolation and discomfort continued.

As I moved deeper into my internship I became more curious about Bernadette's capacity for insight. Her stories were nuanced and quietly charged with emotions from her past. I wanted to know what she understood in relation to her life experiences. I wanted to process what was going on in our sessions. I never did have a thorough discussion with my site-supervisor about this. I did discuss the idea of processing with children in my course-based group supervision and with my academic supervisor. I decided to give it a shot and see what would happen. Very little happened. As stated earlier, Bernadette was mostly non-verbal until she came to residential treatment. She said very little during our sessions together and continued this during my attempts to recap the session and relate her story themes to real life. I asked all sorts of questions, about feelings and thoughts, but kept them very basic. I might as well have been talking by myself in that room. Bernadette seemed bored and impatient with my attempts to talk. She tried to get me to continue with the story enactment at first, but then just sat looking at me with a "what are you trying to do? I just want to play!" look. I tried different ways of processing a few more times before giving up. I was either not finding the right way to go about verbalizing the process or she really was

incapable of verbal processing. I will never entirely know. That still bothers me. I still have so many unanswered questions.

Into the Thick of Things

In the hour before my session with Bernadette I typically co-led a group session with the art therapy interns. Bernadette would come to the session directly from school. Bernadette's and my arrival to the session would usually coincide. If she was late I often picked her up from the office and we would walk together to drop off her belongings before beginning our session. This felt motherly and a bit beyond my accepted responsibilities, but I liked the opportunity to ask her about the day (to which she responded with very little) and interact with her in a different context, more like "regular life." The "regular life" activities felt more comfortable to me in some way as they harkened back to my years of babysitting in high school and college. Much later I came to realize that this was a dangerous blurring of boundaries for me. One day I was very late. I had been a bit late once before and Bernadette expressed concern, fearful of being forgotten. The day I was very late I entered the play-room and found Bernadette curled up in a ball in tears. She was truly fearful that I had forgotten her. I was struck by the impact I made. She admitted that she had a rough day as well, and I believe that primed her for the moment of fear and disappointment after looking forward to our session. I realized this was an example of transference. My actions triggered her neglect and abandonment issues in a very real and profound way, and yet she expressed her feelings around them in a healthy and appropriate way. She did not lash out and become aggressive like she might have in her past, and she did not attempt to cling to me like a koala to a tree. A regular staff-person indicated that she looked forward to our sessions, something I was not fully aware of. I was deeply moved by this moment in many

ways. I felt deep sadness for her past; pride that she valued our time and that she could be open with me; confused and worried about how to best handle the moment; remorseful that I was late; protective and reassuring; and the ever present pressure that I had to be the new healthy attachment figure that could not let her down. I reassured her that I would not forget her, but that occasionally I would be late due to the group I saw before her. If there was ever a time I could not make it I would make sure she knew. I would not leave her waiting. She seemed reassured by this and we continued to the therapy room.

In the session following, Bernadette directed a complicated story line in which I played a werewolf/vampire/owner to her mother dog role. My character was a source of fear and caution as well as comfort and reassurance. I realized I was probably representing the real life role of her unstable mother. A part of me was confident that I was *not* like her mother; clearly I was never psychotic, we saw each other only once a week, we were "playing" out her emotional work, and I conducted no traditional care-taking tasks. I started to become a little suspicious, though. This was pretend, right? Had she begun to see me like her mother? A part of me felt a strong urge to process this information with Bernadette, to make sure she really understood that I was not purposely stirring up these issues in her. Did she know this? Could she understand the idea of transference? Her next move reassured me that she was working this information out in a strangely more sophisticated way than I imagined. Children are surprising that way. She acted out and stated that she (her mother dog character/Bernadette) realized my character was "dangerous" and she needed to maintain a defensive and protective stance, but that at the same time she deeply cared for my character. It was a sad and confusing situation, but she accepted it. She demonstrated a level of compassion and forgiveness I had not seen in any of the other

children at this site. This was compassion I had rarely seen in many adults! I was floored. How had she come to realize this? Had she been working this out on some level since our work together, or before? Had she seen this demonstrated somewhere? I found Bernadette to be an enigma, an idiot savant in emotional processing. In some ways I felt she was an old soul, crafting complex stories to share life lessons but unable to share the inspiration from which they came. This was frustrating and inspiring. Part of my work with my academic supervisor was just coming to accept this enigma. The work Bernadette needed to do was getting done in a fascinating and beautiful way and conscious processing seemed unnecessary for her at the time. Later in our work (I don't remember when) I was able to ask her if she remembered that our stories were pretend and that I was not a monster in some shape. She gave me a sheepish look and sort of rolled her eyes as if to say: "Well, duh, we are just pretending. You have to ask?" as she really said "Yea". I guess *I* really needed the reassurance.

Despite the mild acceptance that there would be no insightful processing, something still bothered me, but I was not sure what it was at the time. I realize now that I was waist deep in the murky waters of countertransference. I was struggling to hold on to a sense of myself when I was taking on these characters, which were becoming more complex and emotionally real for me. I very easily attune to the emotional states of others and characters by "trying them on," feeling the emotions in my own body. This is where *I* tend to get a little lost. I will either forget that these feelings do not fully belong to me or they will get mixed up with some of my own issues, stirring up my own stuff in a complicated and confusing way. Generally attunement is an acceptable and ideal way of working as a dance/movement therapist, as long as one is mindful of oneself and one's issues and is

taking the time to work on those issues. I was doing neither just yet. I would have benefited from a witness at this time; someone who knew me enough and who could tune in and notice that something was off and could help me notice it too. Of course in my isolated, introverted, private, and shameful state I did not have someone to do this. I was supposed to be able to do that by myself, or so I believed. Had I more practice in regulating attunement work or if our sessions were more simple and straightforward I might have managed better. As it was I struggled to manage this type of work and these sessions were emotionally complicated. It was getting to me. My "stuff" was getting stirred up, but I was not clear of what *my* "stuff" was anymore. I was not sure what to do about it anyway. I was functioning as best I could in the middle of a very busy semester, but the emotional load was starting to weigh on me.

Roles and Responsibilities

After I had been working for about two months at my internship, a group-therapy session was organized for Bernadette and the other girls on her unit. I reminded Bernadette during our individual session that this was happening in two days. She seemed uninterested. The group session arrived and it became very clear that Bernadette was nowhere near an average 11-year old. Though the other girls on her unit were close in chronological age and also not functioning where they should, they still were clearly more mature than Bernadette. Bernadette had very little interest in the structured group activity and attempted to play at first and then pretended to sleep. She maintained an air of disinterest and boredom. I attempted to coax her into the activity. She was not having it. I decided that I needed to focus my attention to the needs of the group and let her pretend to sleep. The waters of countertransference were rising. I had come to feel that our sessions were "special" and that

we had a bond that could coax more motivation from her. I felt embarrassed and remorseful that Bernadette was non-compliant. I narcissistically believed our relationship should have been enough to motivate her to participate! How could I fail! I was disappointed; I had hoped to see a different side of her that I could not see in our individual sessions. How frustrating! In many ways I took this personally. I felt like I had failed in some way, even though the supervising unit staff-person indicated that this was not surprising or unexpected. She did not understand the other girls and they did not understand her. I was unsure of what my role was at this point. What was I supposed to do when I had an individual client unmotivated to work in a group? What were my goals? Should I push her to engage and risk our individual relationship as a result? What was a reasonable expectation? Did she behave this way because of me, was it attention seeking, or was this standard behavior? I checked in with Bernadette at our next individual session. After several questions she only agreed that she did not like group work but was unable to articulate a reason. I could guess several reasons why she did not like our group work. One reason *I* was not enthralled with our group work was that is was very prescribed and structured. I value organization and structure, but the therapy Bernadette and I did together was "special;" creative, organic and free form, it had no context within this group form. This type of group was just not a good fit for her. Bernadette seemed accepting of this; it was how her world was. I eventually learned to do the same.

Several weeks later, after Thanksgiving, the facility had a holiday party for the children. This party was sponsored and hosted by a local corporation and was held off-site at a hotel banquet room. My site-supervisor, two fellow interns, and I accompanied all the children and their staff. There was a lunch and holiday gifts. I was again confused as to

what my role was. I was not given any specific task by anyone but I did not feel it was acceptable to just socialize with the other interns. I wanted a "job", a goal to be working towards. I milled around and attempted to "supervise" some of the children, but I did not know what was expected of them; what was the norm when opening presents with children like this? I decided to just watch and reflect whatever excitement I witnessed. After opening her gifts, Bernadette decided she needed to use the restroom and since I was the nearest and "dearest" adult, I should take her. "Oh good, something to do", I thought. We notified a staff-person and headed down the hall in search of a restroom. This simple trip to use the restroom illuminated how sheltered Bernadette and her peers were. She struggled to figure out how to close the stall door and use the fancy toilet seat cover and automatic sink. Then there was the issue of manners. In the restroom there was a woman wearing a fur coat, though I could not say if it was real or not. It did not matter. I could tell by her expression that Bernadette thought that coat was real. She stared at the stranger in such a way that I knew it was a horrified glare, but that the stranger probably did not perceive. Bernadette's affect was limited for an 11 year old, but I had learned to understand her repertoire of facial expressions. I found this moment a bit embarrassing, as I knew from her love of animals that she was intending to glare. I muttered something out loud about it being a nice coat and how soft it must feel so that the stranger wouldn't be offended before I bustled Bernadette out. She shot *me* a protesting glare as if to say: "That is not what I was thinking," to which I verbally responded with an agreement that fur is wrong but we should be polite and not glare at strangers. What was I supposed to do? I struggled between honoring Bernadette's convictions and teaching the finer points of social graces. This was a task for a parent, how

did a residential counselor, let alone me, work on basic manners in public? I was again confused about my role.

The day of the holiday party happened to be the same day Bernadette and I met for our individual session. All the other children who I typically met with decided to forgo their session so they could play with their new toys when we got back to the facility. When I gave Bernadette the option to forgo our session she made a counter-offer. She wanted me to stay on the unit and play with her and her new toys. I thought about it, and decided that might be blurring boundaries a little too much. I countered and gave her the option of playing with me on the unit for only ten minutes with her new toys or having a regular hour-long session as usual. Looking back I realize I felt pressured to maintain "appropriate boundaries" around session activities. I felt like my site-supervisor disapproved of the playful enactments we conducted during our sessions and that she would likely disapprove of my staying on the unit to just "play." I did not like the sense of disapproval I perceived so I tried to prevent feeling that way in whatever way I could. Bernadette thought about her options a little bit, looking at each of her new toys as if to ponder their worth and decided to take the full hour-long session. I was surprised. She had brand-new toys and an opportunity to play with them but she would rather do therapy? I suppose to her it was not really therapy. I concluded that she valued our interpersonal interaction much more than "stuff". I was impressed that she knew what she really needed; time with a person to work out her issues in the playful way only a child can do. I was also honored that I got to be that person included in the process, but I was concerned as well. The idea that she did not really do this kind of work with other people was beginning to wander into my consciousness. Was I doing this therapy-thing "right"? What was going to happen when our work ended and we

went our separate ways? Was I letting her get too attached? Was I getting too attached? I needed some feedback and fortunately my academic supervisor was coming for a visit the next week.

Witness to the Work

When my academic supervisor came the following week to see a session with Bernadette I was very nervous. I had been observed before with different clients, individuals and groups, but with Bernadette I was particularly anxious. I already perceived a sense of disapproval from my site-supervisor. I was not conducting traditional DMT work and I was fearful of being reprimanded in some way for that. I was also unsure of what my goals were anymore. My predetermined therapeutic goals were no longer on the agenda. Bernadette seemed to have her own goals, though they were difficult to translate into a therapeutic language. What was I doing, exactly?

When the session began with the three of us, Bernadette had no qualms about diving right into her usual playful enacting. She hid under some chairs and portrayed hesitance about this new person joining the session. I was embarrassed and unsure if I should also dive into the symbolic enacting or try to conduct an introduction or something else. I think I asked Bernadette if she wanted our guest to join us or just observe (I had warned her previously that we would have a guest). I don't think she responded. My supervisor decided to observe and reflectively narrate. Bernadette decided she wanted to then continue our session as usual and ignore my supervisor. We enacted a story of a wolf and vampire. I suddenly felt very silly. How odd was it that I was crawling on the floor pretending to be a vampire with an 11-year old while being observed by my professor? The room felt very small. We continued on with our story as usual, though. At some point during this session

Bernadette decided she wanted to portray her affection for me. The manner in which she did this was unusual. As my supervisor described it she got very close to me and appeared as if she wanted to either crawl into my body or swallow me whole, but tried to "restrain herself" instead and attempt to lick/kiss my face instead. I held Bernadette back in some way and told her that we don't express our affection in that manner and gave her some sort of alternative. It was a strange, hilarious, scary, and cute moment, all in one. Many people would probably just be freaked out, and I was on some level, but I understood where it came from. She loved our time to play and act and make stories together. I fulfilled a role in her life that she needed filling. This was her way of saying "thank you" and making sure someone else knew it. This evoked in me a strange sense of pride, despite its inappropriate nature.

After the session I processed with my supervisor. She agreed that it was symbolically rich work but that traditional verbal processing might not be possible or necessary. We discussed what the goal was for my therapy with Bernadette and determined that she just needed affirmation, support, and verbal reflection. She appeared to be doing the emotional processing a young child typically does, but that she had a lot more of it to do considering her developmental trauma and delay. What we were doing was just fine as long as I was okay with it. Part of me was okay with it. I deeply respected the conviction and passion Bernadette had for her play and I wanted to support it. Most of the other children seemed more interested in engaging in constant power struggles. They seemed so hurt and frustrated with themselves and their lives; their scars were fresher, nightmares more vivid. Bernadette represented hope and resilience. She had come through to the other side of her terror and begun to flourish as much as she was able. I desperately needed to see that. That

was why I entered into the work of therapy, and I needed to know it was really there. Part of me was not okay with the work we were doing. I was emotionally exhausted and confused. I did not realize I was doing anything "wrong" at the time, though. I thought that this state was normal and I would learn to tolerate it over time.

Shifts in the Current

During the weeks following the visit from my academic supervisor and into the New Year the themes, characters, and effort-life in Bernadette's stories began to shift. Her characters transitioned into Jesus, his friend the rainbow bull, Jesus' mother Mary, and God. She became stronger in her movement and more physically active. She required of me a less physically active role and a more verbally attentive role. She wanted me to watch carefully and narrate all she did. I am unsure if this shift of my function in our sessions was entirely for her needs. I'd like to think that she began to sense that my embodying her characters was wearing on me.

During this time Bernadette and I both began to experience changes in our lives that paralleled and at some point met. Aunt Emily was beginning to look for Bernadette's next placement. Unbeknownst to Bernadette, Aunt Emily had been grappling in the fall with the choice to take her back into her home or place her somewhere else, potentially giving up guardianship. The two were only getting older and Bernadette was a child with special needs who would always require some level of care. I am unsure of how much information Bernadette ever had about her future. My site-supervisor was never clear and Bernadette never mentioned regular life issues with me. I know at some point she asked why she couldn't live with me; why I couldn't be her mom. It broke my heart. I so desperately wanted her to have the happy, peaceful, and loving home she deserved. I wanted it bad

enough for her that I almost wanted to give that to her myself. I cry to think about it to this day. When I responded I told her the truth. I was not able to provide for her what she needed. I was just beginning my own life. I had no job and no home of my own. I was still too young for a child; not quite able to settle down and provide a good home. No, I could not take Bernadette as my own child. In truth, if I were in a different place in my life, I might have tried. If I were in a different place in my life, though, we might not have bonded as we did. I might have maintained a healthier/different boundary. At this point in the development of my clinical philosophy, I was grounded very much in the psychodynamic theories of attachment and object-relations. I thought that part of my role was pseudo-parental-replacement. I had taken this a little too far. I had taken on a full desire to mother when clearly I was in no place to do so. I did not know how to keep my maternal instinct in check. I did not even know I needed to keep it in check.

Bernadette seemed to accept that I could not take her. I think she understood that I wanted the best for her but could not give that to her from my own life. Some time later she wanted to know when we would see each other again after our time at this facility ended. This struck me through to the heart. The life change I was going through at this time was the slow death of my grandmother. She had been battling cancer for a long time and was reaching her end. This loss was intense for me and Bernadette hit it on the nerve. This was a pounding wave of countertransference. I told Bernadette that we would never meet again in this world but, knowing she believed in heaven, I said we would meet again there. This was something *I* needed to hear for my grieving; Bernadette brought it out for us to share and grieve our losses together. In my supervision sessions during school and after, I have often heard that sometimes our clients bring us our own issues to work on; that sometimes

what attracts a client to us is that we have the same part of the soul that needs work, and therefore understands. Bernadette brought my work to me. She saw in me a lonely child and brought her lonely child to play. She saw in me the need for reassurance at a time of sadness and asked for reassurance. She may not have really *seen* these things in me, but they were ways in which we connected on a deep level. This type of work gets scary, intense, beautiful, and very real. Around this time I finally broke down and sought out my own therapy. I had so much stirred up and going on, I struggled to keep it together.

As winter transitioned into spring, Bernadette brought themes of transition, grieving, and loss into her stories. We were beginning termination work months before we expected to actually terminate; though we were not aware when termination would happen. Aunt Emily decided to put Bernadette with a foster family and the process started to progress quickly. A foster family was found. My site-supervisor claimed that she could not have possibly dreamed up a more perfect place for Bernadette. This family had a large piece of property far from the city with horses and dogs. They had other kids who were old enough to understand and accept that Bernadette would not be an average (now) 12-year old. She began to visit them on the weekends while the legal details were worked out. Bernadette did not bring this information to me herself. I heard from my site-supervisor and I asked. Bernadette was not forthcoming. I portrayed enthusiasm for this new placement but did not see it reflected back. I asked about the animals, she responded with a comment about chores. I was concerned but I knew on some level this was a good place for her, regardless of her initial struggle to transition. It seemed like she was going to have to face the reality of life while at her new home. Real dogs and horses do not talk or have dramatic stories of betrayal or love. They require work. They need to be fed, exercised, and cleaned up after. I

had mixed feelings about this. On one hand it was good for her to figure out the real world and how to live in it without pretending to be an animal or character. She was beginning to grow into a young woman, a teenager, and was going to have to leave behind some parts of her child-ness. On the other hand I felt sad that she would no longer have our story world to be in. She was able to connect with me through our stories wondered if she would ever be able to connect again on that level? What had I done to prepare her for this change? I feared that all the work we had done together would only hold her back.

The beginning of April saw my grandmother's death. The end of April saw Bernadette's sudden and unannounced departure. Both were highly anticipated but anti-climatic. I was unable to actually say goodbye to either. For me the two losses were engrained together deeply in my experience. For both, I had experiences of anger and frustration surrounding the circumstances. For both my grandmother and Bernadette I wanted more peaceful and fulfilling places and can only have faith that they moved on there. After Bernadette left, I felt alone and unimportant. My other clients were not as excited to work with me; they would work with any therapist or intern just the same. I felt alone in my experience of loss. No one else seemed to be missing her clients in quite the same way. I felt ashamed and I kept this experience to myself.

The Open Seas

I struggled to shake off my internship when I finally finished. My sleep was restless and unsatisfying. I struggled to focus and think clearly. I struggled to look for and find any job prospects. I dwelled on my now former clients, especially Bernadette. I began to have doubts about the work I had done. How could I explain creative embodied play to a potential job placement? Wasn't I a *dance/movement* therapist? If I did not feel like I had

proven myself a skilled therapist at my internship, how was I going to get hired elsewhere? I felt lost at sea. I had determined early on in my work with Bernadette that something about what we did would be my thesis topic; I just did not know what. My thesis work stalled out and I could not get it started again for a very long time. That summer I finished my remaining course work and realized I needed some means to support myself. I could no longer afford therapy, even though I was clearly depressed. I needed to find a way to keep myself afloat while I figured out what to do with my life.

The only work I could justify for myself was working in a coffee shop. Strangely enough I learned something valuable making coffee for crowds of people in the wee hours of the morning. That fall I learned how to move fast and be direct. This was not my tendency. My internship allowed me to indulge in a timeless space where I was way too comfortable and not present. I had very little practice at finding direct accelerating movement until I had 10 caffeine-deprived customers at 7 a.m. waiting for *me* to make their lattes. My outlook began to change. I was so proud that I was able to eek out a small living just by making coffee. I felt like a survivor. This did much for my sense of self-efficacy. I was connecting and communicating with co-workers and customers. I began to realize how capable I really was. I began to realize I had my life together more than I previously thought.

By the end of December I applied for and acquired a therapy job in a bustling hospital. That coffee shop job prepped me well for the fast paced world of short-term care. Using my new skills of moving quick and direct, I learned a different way of being with my clients. I realized I did not need to and probably should not somatically attune and empathize with my clients. I was leading large groups only and I realized I needed to be the

"expert"; I was indeed the healthiest person in the room and the clients were there to learn from me. What a drastically different outlook! Being the "expert" I found I was able to be directive and challenge my clients, but figure out *with* them what they really needed to learn. I also learned how to say "no" in relationship, how to disconnect. I discovered the nuances of the "power struggle" and learned how to remind the client (and myself) that treatment was in *their* hands, not mine. My emotional boundaries became much clearer. I discovered that I had a tendency to put a lot of my self-worth in my career. I did not need to let the events of work influence if I was happy with myself. If I made a mistake it was something to learn from, not be ashamed of.

I learned how to find support and guidance. I observed the therapeutic style of many skilled therapists and "tried them on," finding out what made their work appealing or effective. I became part of the treatment team and collaborated with other staff in the treatment of the clients. After a couple months of working in the hospital I realized I needed supervision to address questions and concerns that were not easy to address. I sought out a supervisor and a supervision group who I felt comfortable with and I learned how to talk about my experiences. It is with that group that these lessons emerged. It was through these lessons that I recuperated. Gradually, I learned to look at and unravel what had happened with Bernadette that left me so shaken and burnt-out. I was vicariously traumatized. There was no wonder why I struggled to work on my thesis; my very topic was charged with trauma and I needed to wade in and sort it out. How terrifying! I felt so ashamed that this had held me back so long, but I knew I needed to face it. I knew there was something valuable to share. Gradually, I learned to have compassion for myself and realize that this was all my learning process; albeit a long, roundabout way of learning. It has taken me four

years of difficult work to be able to tell this story of how I experienced vicarious trauma. In the next chapter I will correlate what I found in the literature with my results to support the research question of this paper: How does a dance/movement therapist experience and recover from vicarious trauma and burn-out?

Postscript

More recently, while writing this paper, I had another "anxious" dream where I needed to perform a dance I did not know. This time I improvised it on the spot. I still felt a bit annoyed and a little under-prepared, but I knew I had the tools and artistry to create something to share from my heart, and I did. In my dream I decided that was good enough for me for now, so it would have to be good enough for everyone else.

Chapter 5: Discussion

In this chapter I will correlate what I found in the literature with the results in the story chapter to answer the research question of this paper: How does a dance/movement therapist experience and recover from vicarious trauma and burn-out? First I will discuss how I knew my experience was vicariously traumatizing. Next, I will review how countertransference and somatic attunement contributed to my vicarious traumatization. Finally, I will review how my struggle to establish therapeutic boundaries and engage in therapist self-care strategies contributed to my experience of vicarious trauma and how I could have possibly prevented vicarious trauma.

It is important to clarify that the support for this paper is based on the research of Rothschild, Forrester, and Rand. The work of these body-based therapists aligns with the unique qualities of DMT more than the traditional psychotherapeutic research is able to. I purposely sought out research that discussed the body and its relationship to vicarious trauma. My subjective investigation of the literature may have left out research that could have challenged my conclusion. I remain confident, though, that any challenge would have helped the focus of this paper. This strong subjective influence may present another potential issue. The reader at times may be unable to relate to parts of this paper and fully grasp the nature of my experience. In choosing an autoethnographic method, I understood that my research would not be easily generalized. I hope that in sharing my personal truth that I might encourage others to consider their own truth, and that this might provoke questions and invite discourse about this topic in the field of psychology and DMT.

What I Experienced Was Vicarious Trauma and Burn-Out

It is supported by the research of Rothschild (2006) that what I experienced was vicarious trauma and burn-out. She explains that the term vicarious trauma is used "with regard to psychotherapists impacted by working with traumatized individuals in their workplaces…Even when a therapist was not actually involved in the client's trauma, she can still vicariously experience it in her nervous system." (p. 15). Burn-out "describes anyone whose health is suffering or whose outlook on life has turned negative because of the impact or overload of their work" (p. 14). From my first session with Bernadette I presented with a trauma response during and after our sessions. This is evident in the story chapter, "She positioned her self strongly in front of me on her hands and knees, while I sat on the floor frozen, and she barked and growled inches from my face." Following the session, "My body was abuzz with unfamiliar reverberating energy that I did not know what to do with and did not know how to bring up with my supervisor. My heart was racing, I felt a little shaky, and my mind was spinning. … I left that day reverberating with excitement, fear, annoyance, and loneliness." Rothschild supports that these physiological responses are evidence of an activated sympathetic nervous system; I was ready for fight or flight and was not sure why.

I was somatically attuning with Bernadette and her stories without being mindful of her traumatic origins and the impact it could have on my nervous system. As a result I responded to invasive barking by atypically freezing, a trauma response that Rothschild explains, "During freezing there is an altered sense of time and space, reduced registration of pain, and dampened emotion. Those who have frozen under threat report a kind of dissociative experience: Time slows down and they are no longer afraid" (p. 102).

Over time these experiences became emotionally trying and overwhelming. I eventually became burnt-out. I displayed symptoms of depression, including disrupted sleep and difficulty focusing. This affected all aspects of my life, including my ability to seek employment and write this thesis. This is as Rothschild (2006) explains, "The result [of] what I identify as the hallmarks of post-traumatic stress disorder (PTSD): Persistent symptoms of hyperarousal in the ANS. These include hyperstartle response, hypervigilance, difficulty staying asleep, and others listed for PTSD in the DSM-IV" (p. 101).

One might argue that these symptoms were a result of my academic workload or other factors in my personal life. I would agree that these added to my stress, but they did not trigger a torrent of unexplained emotions like my sessions with Bernadette. One might question the alignment of my experience with vicarious trauma, and I agree it is difficult to provide concrete evidence for, my data is somatic and subjective. My experience of burn-out is difficult to challenge, as there is clear evidence in my struggle to find employment as a dance/movement therapist as well as write this thesis following the end of my internship.

Countertransference Played a Part in My Becoming Vicariously Traumatized

When the trauma response was activated in my neurological system, I was unable to manage it effectively in part because it related to and challenged many of my own unresolved issues. This activation of countertransference is well supported by the literature. Gelso and Hayes (2007) explain countertransference in this way:

> The relational theorists…emphasize co-construction; that is, whatever happens in the hour is jointly constructed by therapist and patient. Both shape the nature of transference and both shape the nature of countertransference, as well. Countertransference then is a product of the inevitable interaction of the patient's

> dynamics (his or her transference, realistic expression, personality, et.) and the therapist's dynamics (unresolved conflicts, personality, needs, realistic expression, etc.). (p. 12)

This countertransferential experience was activated in the first session and continuously reactivated through my time working with Bernadette. This was first illustrated in my fear of saying no to her or of making requests for personal space due to my discomfort with rejection. As illustrated in chapter 4, "I was not sure I wanted to be the monster. I wanted to be the good guy. I wanted to be liked." The countertransference activated by my internship-site exacerbated this situation. I was uncomfortable asking for help and I did not feel like I could share my issues with others. The parallel process of loss also illustrated my experience of countertransference. Bernadette's loss of Aunt Emily as her caretaker paralleled the death of my grandmother. Our termination intersected this parallel process and our loss of each other became an additional transferential experience.

The conclusion that I experienced countertransference could be questioned based on the definition and qualifications for the term. I agree that this area of therapeutic understanding varies greatly and I would encourage more research and discourse on countertransference specific to the field of dance/movement therapy and body-based experience.

How Somatic Attunement Played a Part in My Becoming Vicariously Traumatized

As discussed in the literature, the act of somatic attunement communicates a complex array of information that facilitates empathy. Rothschild (2006) explains this using different language, "Postural mirroring is the term that has been coined for the mimicry of

another's physical posture, including facial expressions, and the communication of emotional and other information that often accompanies such behavior" (p. 62).

This use of somatic attunement to achieve empathic understanding is a cornerstone in DMT training and philosophy, and was the foundation for my sessions with Bernadette. I attuned to her with my movement and with my visual attendance. I had become proficient at mirroring others, and at times did so unconsciously. Rothschild (2006) indicates that unconscious somatic attunement, which fosters empathy, may be an issue,

> When unchecked, somatic empathy can be problematic. As discussed earlier, unconscious somatic empathy may be a major factor underlying your risk for compassion fatigue, vicarious traumatization, and burnout. However, managing that risk is fairly easy and mainly requires common sense. Somatic empathy only becomes a danger when the therapist is not aware of it, and therefore not in control of it, unconsciously tuning into the sensations, emotions, images, and thoughts of the clients. Under that circumstance, the therapist will not be able to distinguish client states from her own. Actually, it is this confusion that is usually most problematic. (p. 88)

This unconscious somatic attunement and empathy facilitated my neurological resonance with Bernadette's. Like a radio on auto-search trying to find a station, I had tuned in to the traumatized broadcast of Bernadette. My use of somatic attunement and its effect on me is illustrated in the story,

> I was struggling to hold on to a sense of myself when I was taking on these characters, which were becoming more complex and emotionally real for me. I very easily attune to the emotional states of others and characters by "trying it on", feeling

> the emotions in my own body. This is where *I* tend to get a little lost. I will either forget that these feelings do not fully belong to me or parts will get mixed up with some of my own issues, stirring up my own stuff in a complicated and confusing way… My "stuff" was getting stirred up, but I was not clear of what *my* "stuff" was anymore.

As discussed in chapter 2, Forrester (2007) explains that there are parts of a client's past experiences that have not been explicitly expressed or understood by the client, but that through the body may unconsciously influence current experiences and relationships. Everything from one's past contributes to the development of the individual and therefore is influencing the present. However, when the past includes implicit trauma and is coupled with unconscious somatic attunement, it creates a double helix of trauma being shared unconsciously between the client and the therapist. This was clearly in play here. Bernadette's trauma was implicit and unconscious and I was unconsciously attuning to it.

In addition, I was unfamiliar with the experience of trauma. I struggled to recognize or understand it in more obvious and explicit situations, let alone the unconscious and implicit situations. This is evident in my confusion after the first session, "What was I supposed to do with all this information? What had happened, what had I 'tried on'? What could I have done differently? I had no idea." This realm of therapeutic work must require an extensive amount of experience, awareness, and support to navigate without drowning. To work with a client and her implicit and unconscious trauma experience and its manifestation in the present needs to be a slow and purposeful process. To do this with a non-verbal child would be doubly challenging. It is understandable why as an intern I struggled to manage this process. This is illustrated by my strong desire for and frustration

around verbally processing with Bernadette. There was so much I wanted to explicitly know and understand that was just not possible. After a prolonged period of attuning to Bernadette's implicit traumatic material *I* struggled to explicitly express myself. I struggled to justify my desires to not take on her characters or enact in her stories. I struggled with the "no"; I did not know what I wanted to say "no" to.

Somatic attunement and the development of empathy as a result of it can easily be brought into question. The literature is inconsistent and vague about the topic of somatic attunement and it is difficult to assess in my data if I was always somatically attuning or developing empathy because of it. More discourse about the topic and its risks is certainly required, especially between the greater psychology field and the DMT field. There is a great deal DMT can add to the current research about somatic attunement and empathy.

Inadequate Boundaries and Therapist Self-Care

My experience of countertransference, traumatizing somatic attunement and empathy was enabled and complicated by unclear interpersonal boundaries. As discussed in the literature, the term "boundary" is very broad and used to discuss many concepts in psychotherapy. One distinguishing feature within most uses of the term is the emphasis on the choice between disconnecting or saying "no" in relationship and staying connected or saying "yes" in relationship. This can be executed in many ways. Rothschild advocates for the increased awareness and control of body-based processes like empathy and stress response. If the practitioner is aware of what is happening in her body as well as her client's body, then she can decide the nature of her actions, including her somatic attunement and empathy. She can make sure she is not attuning to the client's stress response and triggering stress response in her own body. Rand supports this argument, stating,

> We must not try to be aligned with the client, only attuned to ourselves and the client. Misalignments are very important because they give us valuable information about our differences with the client. We can then, after processing these differences, come to know what we, as therapists, bring to the relationship, factor that into the formula of transference/countertransference and avoid vicarious traumatization. (p. 30)

This misalignment or, as Rothschild calls it, unmirroring, is maintaining the physical and emotional boundary between "my body and your body." As stated before, I struggle to remain connected with my own experience when trying to attune to and empathize with another person's experience. I struggle to maintain that boundary between myself and "other."

This breach in boundary maintenance was evident in my emotional investment in Bernadette and my sessions with her. A healthy amount of fondness is expected within a therapeutic relationship, however I had come to invest my pride, self-confidence, and approval in it. This was evident in my frustration and disappointment when Bernadette was not motivated to engage in group therapy. This is also evident in my tendencies to place Bernadette's "needs" far ahead of my own.

> I decided she needed to experience taking a defensive stance against the monster more than I needed my personal bubble of comfort space. This tendency towards self-sacrificing behaviors in the therapeutic relationship is not healthy. I realize this now. She would have benefited from being told to back it up because I needed my space. In my mind at the time I was afraid to disrupt the story by interjecting my blunt reality.

I struggled to say "no" to Bernadette and what I thought were her needs and say "yes" to my own. This is also evident in my role confusion; I struggled to figure out and typically overestimated what my responsibilities were. This was found in my picking her up from the office after school and dropping off her belongings as well as my uncertainty with teaching manners in public. This is most evident in the following example,

> I so desperately wanted her to have the happy, peaceful, and loving home she deserved. I wanted it bad enough for her that I almost wanted to give that to her myself…I thought that part of my role was pseudo-parental-replacement. I had taken this a little too far. I had taken on a full desire to mother when clearly I was in no place to do so. I did not know how to keep my maternal instinct in check. I did not even know I needed to keep it in check.

My emotional investment in Bernadette was too great, and I did not know how to manage it. In contrast, my interpersonal boundaries with my fellow interns, site-supervisor, and academic support system were too rigid. I struggled to connect with others to receive or give interpersonal support. Fueled by my issues around asking for help, I was unable to identify and seek out the social support I needed. I was not disciplined about my self-care and making sure I was happy and taken care of by others or myself. I did not ensure that I had a consistent outlet for my own emotional experiences. I was not mindful of my own emotional state and how it interacted with my clients or co-workers. I put my needs last until it was absolutely intolerable.

One could question how experience as a dance/movement therapist played a role in my struggle with boundaries. I lacked experience as a therapist. The skill and artistry to establish and maintain healthy interpersonal boundaries is acquired along with that

experience. I would say my lack of experience played a significant role in my difficulty with boundaries. This may call for a re-examination of how interpersonal boundaries are examined and worked on with new dance/movement therapists.

Recovery from Vicarious Trauma and Burn-Out: Therapist Self-Care

The literature does not provide a clear outline for the recovery of vicarious trauma and burn-out. What is emphasized is the therapist mindfully assessing her or his situation. Rothschild explains most simply,

> Compassion fatigue and vicarious trauma can be healed and even prevented when the mechanisms leading to them are identified and made conscious. Once vulnerabilities are assessed, strategies for increasing awareness and control can be instituted. Experimentation and evaluation are the keys to helping each therapist discover which interventions are most effective for keeping her in her own chair. (p. 207)

Although Rothschild is talking about the identification and awareness of somatic attunement and empathy, this applies to many other factors that lead to vicarious trauma and burn-out as well. This task can be achieved through a variety of strategies, including: engaging in supervision and therapy; seeking out continued training; eating, sleeping, and exercising well; learning to manage time and workload effectively; connecting with a higher power; assessing one's workspace; maintaining a personal life with personal interests; taking time off from work; and taking an assessment of the client-based interpersonal factors that may lead to vicarious trauma. My recovery from vicarious trauma and burn-out fulfilled this task by utilizing many of these strategies.

As stated in the story, my process of recovery began when I started to work in a coffee shop. This loosely aligns with two strategies outlined in chapter 2; seeking out continued training and taking time off. I was no longer in the role of therapist, which reduced a significant amount of pressure and, although I was not continuing my training as a therapist, I acquired new skills. When I began working at the hospital I acquired more skills related directly to therapy, such as disconnecting from a power struggle and taking charge in my role as a therapist. During this time I was starting to assess my use of somatic attunement and empathy and I realized it was not always necessary or advised. I also began to assess my emotional investment in my career and I realized that the events of my job did not need to dictate my happiness.

Most importantly, my recovery process was facilitated by interpersonal support and guidance. I would not have made these discoveries without fellow staff at the hospital or without the members of my supervision group. I discovered with these people that I had recovered from vicarious trauma and burn-out. I began to look at my experience of vicarious trauma and burn-out more closely and connect how I was traumatized with how I recovered.

Summary

To summarize, the research question for this paper is: how does a dance/movement therapist experience and recover from vicarious trauma and burn-out? The literature supports the conclusion that I did indeed experience vicarious trauma and that this process was facilitated in part by my use of the DMT technique of somatic attunement. Through this somatic attunement I unconsciously developed empathy with the traumatized state of my client and subsequently experienced trauma vicariously. Additionally, my own

unresolved issues were triggered through the phenomena of countertransference. Because this empathy was unconscious, I was unable to maintain healthy emotional boundaries between my client and myself. Had I been more consciously mindful of my use of somatic attunement and empathy or been able to address my experience regularly in supervision I might have prevented or had a more mild experience of vicarious trauma. In investigating this process I began to practice mindfulness around somatic attunement and empathy and more consciously examined my emotional boundaries. This process allowed me to recover from vicarious trauma.

I do not recommend following this extended, four-year process of investigation as a means of recovering. I do not advise experiencing trauma vicariously for an extended period of time. Nor do I advise not addressing personal issues that are provoked as countertransference. My intent in sharing my experience is to instigate contemplation and conversation about somatic attunement and therapist self-care in the field of DMT and psychology. A few questions for further research and conversation include: What does the DMT student learn about somatic attunement? How do they learn to use it? How do experienced DMT practitioners use it? How is it understood and practiced in conjunction with other psychotherapeutic methods? How is it thought and talked about in conjunction with movement concepts like Laban Movement Analysis? How do dance/movement therapists relate somatic attunement and empathy to therapist self-care? How is the DMT community addressing therapist self-care as a larger topic? What can the DMT community learn from other fields and other realms of therapeutic practice and study to enrich the conversation about somatic attunement and empathy and therapist self-care? How can DMT add to the conversation about somatic attunement and empathy in the larger psychological

field? As the research continues to support the significance of interpersonal connection and body-based treatment of trauma, these questions and conversations are pertinent to the growth and development of dance/movement therapy and dance/movement therapists.

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Appendix A

Definition of Terms

Acute secondary stress

Equivalent to *STSD*

Compassion fatigue

"Identical to secondary traumatic stress disorder and is the equivalent of PTSD." (Figley, 1995, p. xv)

"A general term applied to anyone who suffers as a result of serving in a helping capacity." (Rothschild, 2006, p. 14)

Countertransference

"The relational theorists…emphasize co-construction; that is, whatever happens in the hour is jointly constructed by therapist and patient. Both shape the nature of transference and both shape the nature of countertransference, as well. Countertransference then is a product of the inevitable interaction of the patient's dynamics (his or her transference, realistic expression, personality, et.) and the therapist's dynamics (unresolved conflicts, personality, needs, realistic expression, etc.)" (Gelso & Hayes, 2007, p. 12)

Post traumatic stress disorder (PTSD)

"The impact of a traumatic incident on the obvious victim of that incident." (Rothschild, 2006, p. 14)

"The patient has experienced or witnessed or was confronted with an unusually traumatic event that has both of these elements: the event involved actual or threatened death or serious physical injury to the patient or to others, and; the patient felt intense fear, horror, or

helplessness. The patient repeatedly relives the event…The patient repeatedly avoids the trauma-related stimuli and has numbing of general responsiveness (absent before traumatic event)…The patient has at least two symptoms of hyperarousal that were not present before the traumatic event…The symptoms above have lasted longer than one month…These symptoms cause clinically important distress or impair work, social, or personal functioning." (Morrison, 2001, p. 269-270)

Secondary traumatic stress disorder (STSD)

"The natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person." (Figley1995, p. 7)

Somatic countertransference

"Somatic countertransference is the effect on the therapist's body of the patient and the patient's material…somatic countertransference can be thought of as occurring on a continuum, from pure sensation to sensory experiences that are affectively or cognitively involved. The experiences may appear to embody something that "belongs" to the patient through a form of communication by impact…or may be a somatic reaction to something about the patient and their material that evokes the therapist's material." (Forrester, 2007, p. 129)

Transitional object

"Psychoanalytic concept referring to any material object having a special value that serves an anxiety-reducing function. Such attachment is a normal phenomenon during transition from one phase to another in separation-individuation." (PsychInfo online, 2010)

Vicarious post traumatic stress disorder

Equivalent to *STSD*

Vicarious traumatization or trauma

"Psychotherapists impacted by working with traumatized individuals in their workplaces…even when a therapist was not actually involved in the client's trauma, she can still vicariously experience it in her nervous system." (Rothschild, 2006, p. 15)

"The transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material." (Pearlman & Saakvitne, 1995, p. 31)