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Unraveling and Understanding the Therapeutic Self: A Heuristic Inquiry on Countertransference

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UNRAVELING AND UNDERSTANDING THE THERAPEUTIC SELF: A HEURISTIC
INQUIRY ON COUNTERTRANSFERENCE

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Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

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in

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Department of Creative Arts Therapies

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Abstract

The purpose of this heuristic inquiry was to discover how my countertransference informed my clinical internship experience. My research questions were: How does my countertransference inform my therapeutic relationships while working with survivors of domestic violence? How does my countertransference impact my clinical choices and my development as a dance/movement therapist? Data was collected through semi-structured journal entries that included both writing and art-making; this occurred three times per week during the last five weeks of my internship. I analyzed data sequentially through creative synthesis with a research consultant once per week, which began two weeks after data collection. Findings include increased awareness of my emotional and physical responses during sessions: retreating when my emotional safety was threatened and increased Attention Deficit-Hyperactivity Disorder (ADHD) symptoms when clients were not *grounded* (see Appendix A) within the sessions. My ADHD symptoms made it difficult for me to be in a present relationship with my clients. Additionally, findings indicate that I experienced parallel processing in my *therapeutic relationships* (see Appendix A). This suggests that shared experiences impacted my therapeutic relationships and clinical choices, which enabled me and my clients to grow concurrently. As a result, I became a more informed, knowledgeable therapist.

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Chapter One: Introduction

When I began the master's program in dance/movement therapy and counseling (DMTC) at Columbia College Chicago, I was battling low self-efficacy and wondered how I, a Caucasian woman in her early twenties from a small town in New Jersey, could possibly make an impact with future clients. I questioned my competence and considered quitting, but my desire to help others and my passion for movement are what prevented the success of my inner-negativity. I sought to explore and understand my strengths and professional identity as an emerging dance/movement therapist.

As someone who previously experienced an emotionally abusive relationship, I was interested in how I could utilize my familiarity with the issue with individuals who were going through similar experiences. This interest and connection to the population led to my decision to work with survivors of *domestic violence* (see Appendix A) for my clinical internship during my training as a dance/movement therapist. I anticipated that my relational experience would be prominent during the process of empathizing and intervening with clients, but to my astonishment, its presence felt close to absent. Since my experience did not explicitly present itself in the work between me and my clients, I became curious if and how it was influencing my work. This curiosity sparked the idea that my relational experience was implicitly present through *countertransference* (see Appendix A), the responses or feelings that were elicited in myself as a result of what the clients shared. I was interested in what other aspects of my life may have been impacting my work as a dance/movement therapist through countertransference. I remained open to all of its possible manifestations, which included my *somatic countertransference* (see Appendix A)—the somatic reactions and body sensations that I

experienced in response to my clients at specific moments during the therapeutic process (Dosamantes-Beaudry, 1997).

Countertransference is an essential aspect of therapeutic work. Although there is an abundance of literature on the concept of countertransference, there is little literature regarding the importance of recognizing and utilizing countertransference in a way that will benefit the client. Acknowledging countertransference may cause emotional strain on the therapist, which is what makes it a vulnerable topic of exploration, but growth and transformation within the clinical work are promoted when the therapist is willing to explore these feelings (Little, 1981; Zerbe, 2008). Exploration of countertransference enables the therapist to reflect and provide a thoughtful response or intervention to the client, instead of immediately reacting as a result of the feelings that arose (Hughes & Kerr, 2000).

Not only did my curiosity involve the relationship between countertransference and the therapeutic process, but it honed in on this relationship for the survivor-therapist—a therapist who has endured the same *trauma* (see Appendix A) and/or experiences as his/her clients (Fagnoli, 2014). Literature that incorporates the dimension of survivor-therapists as related to countertransference and the therapeutic process is lacking, which is one reason why this study is imperative for the field of *dance/movement therapy* (see Appendix A). Although my connection to the domestic violence population was recognized before I began my clinical internship, I have discovered my strong compassion towards survivors of domestic violence and my strive to help them in ways that I wish I could have helped myself. Therefore, the examination of my countertransference as a survivor-therapist is important to me because I hope to continue to work with this population throughout my career.

My emerging theoretical approach to my clinical work and my research consists of a combination of both strengths-based therapy and relational-cultural theory. Strengths-based therapy is based on the belief that clients of all different backgrounds are experts of their own lives and, therefore, have insight into what will help them to grow and meet their goals (Oliver, 2014). This study focused on how I could utilize my background and my countertransference to strengthen and support my work as a dance/movement therapist. Although the strengths-based aspect of this study was focused primarily on myself rather than my clients, I maintained the focus on my clients' needs and goals during the clinical work. Relational-cultural theorists (Jordan, 2010; Miller, 1976) suggested that mutually growth-fostering relationships are characterized by "five good things," which include: "a sense of zest; a better understanding of self, other and the relationship (clarity); a sense of worth; an enhanced capacity to act or be productive; and an increased desire for more connection" (Jordan, 2010, p. 25). My goal for this study was to better understand how I could apply my individuality, strengths, and experiences, which were present through moments of countertransference, to promote growth-fostering relationships with my clients. This theoretical approach aligned with my heuristic exploration of my countertransference, as I experienced a growing self-awareness and self-knowledge that was beneficial in creating stronger therapeutic relationships with my clients (Moustakas, 1990). I value this approach, because it supported my goal of remaining focused on my clients' needs while simultaneously learning important information about myself as a therapist, which will enable me to provide more effective therapy in the future.

The purpose of this research was to discover how my countertransference informed my experience during my clinical internship as a survivor-therapist working with survivors of domestic violence. I explored my curiosity about how the mental, physiological, and movement

effects of my past abusive relationship were interrelated and, therefore, influenced my work as a survivor-therapist through countertransference. I sought to understand whether or not that additional connection to my clients' experiences would be beneficial or disadvantageous within the therapeutic process. Lastly, I was curious how my findings would impact my *professional development* (see Appendix A), as therapists form their professional identity through the combination of personal characteristics and professional training (Moss, Gibson, and Dollarhide, 2014). My research questions were: How does my countertransference inform my therapeutic relationships while working with survivors of domestic violence? How does my countertransference impact my clinical choices and my development as a dance/movement therapist?

Chapter Two: Literature Review

This review examines literature related to the mental health and physiological effects of domestic violence, which will provide context to the survivor-therapist experiences of countertransference and somatic countertransference. Additionally, literature related to the value and use of countertransference within the clinical setting is discussed. Although there are various mental health effects of domestic violence, only major depressive disorder and post-traumatic stress disorder will be discussed, as the participant in this study experienced symptoms of those mental health disorders as a result of her past emotionally abusive relationship. There is consistency in the literature regarding the mental health effects of domestic violence, but it is lacking in the possibility that symptoms may be present without qualification for a mental health disorder. Physiological symptoms may also be present or even triggered through unexpected stimuli as a result of the trauma of domestic violence. Various literature supports the use of dance/movement therapy as treatment for survivors of domestic violence. However, the therapeutic movement relationship that occurs during dance/movement therapy may result in the therapist's experiences of countertransference and somatic countertransference. Lastly, literature regarding a survivor-therapist's experience with the domestic violence population is lacking, which resulted in the exploration of literature of survivor-therapists within different mental health populations such as eating disorders.

Domestic Violence

The National Domestic Violence Hotline (n.d.) defines domestic violence as the deliberate intimidation, manipulation, physical assault, sexual assault, emotional abuse, and/or psychological abuse that is perpetrated by one romantic partner against another. Several authors (Ali, Mogren, & Krantz, 2011; Breiding et al. [CDC], 2014; Golding, 1999) utilize the term

“intimate partner violence,” but in order to maintain consistency, domestic violence will be the universal term within this review. It is also noted in the literature that domestic violence is a type of trauma (Bernstein, 1995; Miller & Guidry, 2001; van der Kolk, 2003); this informs the traumatic symptoms that survivors may experience, which will be discussed later in this review. The frequency and brutality of domestic violence may vary, but the main and constant element is one partner’s consistent determination to maintain and exert power and control over the other (National Domestic Violence Hotline, n.d.). Anyone can experience an abusive relationship, regardless of age, gender, background, community, education level, economic level, culture, ethnicity, religion, and lifestyle (Howard, Trevillion, & Agnew-Davies, 2010; National Coalition Against Domestic Violence, n.d.; National Domestic Violence Hotline, n.d.). Approximately 24 people are physically abused, sexually abused, or stalked by a romantic partner in the United States every minute, totaling to more than 12 million men and women per year (CDC, 2014). Approximately 3 in 10 women and 1 in 10 men have experienced physical violence, sexual violence, and/or stalking by a romantic partner and report a related impact on their functioning (CDC, 2014); the related impact that occurs as a result of domestic violence may include an increase in physical, mental, and/or physiological trauma symptoms.

Mental Health Effects of Domestic Violence

Research has shown that domestic violence impacts both mental and physical health (Ali et al., 2011; CDC, 2014; Howard et al., 2010). Specific mental health issues that may occur as a result of domestic violence include depression, suicidal thoughts and behaviors, post-traumatic stress disorder (PTSD), low self-esteem, sleep and eating disorders, and abuse of alcohol and drugs (Ali et al., 2011; Berman, Larsson, Brismar, & Klang, 1989; CDC, 2014; Golding, 1999; Howard et al., 2010; Hughes & Jones, 2000; Humphreys & Lee, 2005; Miller & Guidry, 2001;

Olschen, McVeigh, Wunsch-Hitzig, & Rickert, 2007; van der Kolk, 2015). Each of these authors made specific contributions to these various mental health effects of domestic violence.

Although each of these mental health effects are interrelated, only depression and PTSD will be explored.

Depression and PTSD are significant mental health issues that may occur as a result of domestic violence. Golding (1999) completed a quantitative meta-analysis on the prevalence of mental health problems among women with a history of domestic violence. Her analysis determined that the prevalence of depression and PTSD were much higher among women survivors than the general population of women on a lifetime basis (Golding, 1999). Golding did not specify whether her use of the term depression was intended as a symptom or as a diagnosis of major depressive disorder, which weakens her meta-analysis. The mean prevalence of depression was approximately 47.6% among women survivors; this is much higher than the rate among the general population of women, which ranged from 10.2% to 21.3% (Golding, 1999). Similarly, the mean prevalence of PTSD among women survivors was 63.8%, which was much higher than the range from 1.3% to 12.3% among the general population of women. Although this analysis is valid and provides evidence of the correlation between domestic violence and mental disorders, it lacks an inclusion of the possibility that the symptom presentation may not qualify a survivor for a diagnosis of major depressive disorder or PTSD. Although each survivor of domestic violence may not meet the criteria for a diagnosis of these disorders, they may still experience one or more symptoms.

Ali et al. (2011) performed a cross-sectional study on low and middle-income married women in Karachi, Pakistan, where they found a correlation of domestic violence and mental health issues. Results showed frequent, but varying reports of feelings of worthlessness,

difficulties in decision making, problems performing usual activities, loss of interest in previously enjoyable things, memory and concentration problems, and suicidal thoughts; these are symptoms that signal depression (Ali et al., 2011; American Psychiatric Association, 2013). Due to the varying levels of reports of each symptom, it can be assumed that there were instances when a woman's symptom presentation would not qualify her for a proper diagnosis. Even without a Diagnostic and Statistical Manual (DSM) diagnosis, symptoms still cause an impact on normal functioning. The authors also brought attention to the lack of resources available to women who experienced domestic violence (Ali et al., 2011). The women who may have met the necessary DSM criteria were not diagnosed with major depressive disorder because they did not seek healthcare as a result of social stigma, fear, and/or a lack of supportive resources (Ali et al., 2011).

Similarly, Halket, Gormley, Mello, Rosenthal, and Mirkin (2014) performed two studies on undergraduate students in Massachusetts and found that the students made negative attributions about survivors of domestic violence if they did not leave their abusers. It was predicted that participants may not consider the danger and difficulty of leaving an abusive relationship and instead, see the survivor's decision to stay as a result of her personality (Halket et al., 2014). However, when the participants were given information regarding the risks of leaving an abusive relationship, they made fewer negative attributions (Halket et al., 2014). Therefore, the social stigma that Ali et al. (2011) are referring to may be as a result of a lack of education about domestic violence. Furthermore, the social stigma that blames survivors of domestic violence for their experiences may be preventing them from receiving necessary healthcare.

Hughes and Jones (2000) stated that PTSD is the most common diagnosis by mental health professionals among survivors who were able to seek healthcare. They described the symptoms of PTSD as increased physiological arousal, persistent re-experiencing of the trauma (intrusive thinking), difficulty sleeping, irritability, difficulty concentrating, and feelings of jumpiness, fear, avoidance, hypervigilance, irritability, and dissociation (Hughes & Jones, 2000). Although Hughes and Jones (2000) stated the specific symptoms, their work also does not contribute to the possibility that survivors of domestic violence may be experiencing symptoms of PTSD without meeting the criteria for a DSM diagnosis. In fact, van der Kolk (2003) explained that the symptoms of PTSD may occur without survivors meeting the full criteria for a DSM diagnosis.

Van der Kolk (2015) stated that psychiatric diagnoses have serious consequences, as they inform treatment and often fail to take into consideration the capacities or creative energies that clients developed to survive. He also explained that the DSM does not include a trauma diagnosis for survivors of interpersonal trauma (van der Kolk, 2015). Therefore, a DSM diagnosis does not always address each of the specific symptoms that survivors may be experiencing (van der Kolk, 2015). Additionally, the American Psychiatric Association (2013) addressed the fact that different symptoms may be found among various diagnoses and that individuals may experience disorders differently. Although this does affect the reliability, the adoption of diagnoses leads to extensive scientific studies and the development of effective treatment approaches (American Psychiatric Association, 2013; Seligman & Reichenberg, 2012; van der Kolk, 2015). This suggests that although the symptom presentation of survivors of domestic violence may not qualify them for a psychiatric diagnosis, reliable diagnoses are crucial in guiding effective treatment approaches. Furthermore, knowledge regarding effective treatment

strategies for specific symptoms is beneficial, especially when a reliable diagnosis cannot be made.

The research on depression and PTSD in survivors of domestic violence suggests that there is a lack of supportive resources and that survivors are not seeking out the resources that are available to them due in part to social stigma and fear. Access to mental health care can be a significant means of support for domestic violence survivors, as they may be experiencing symptoms that adversely affect their mental health as a result of their abusive relationships. These symptoms may or may not meet the criteria for a diagnosis of major depressive disorder or PTSD, but often still affect survivors of domestic violence, both mentally and physically. Additionally, diagnoses that do not accurately capture all of the symptoms that are present may lead to less effective treatment approaches.

Physiological and Movement Effects of Domestic Violence

The trauma of abuse has a significant impact not only on emotional and psychological health, but also on the connection to the body (Bernstein, 1995; Chang & Leventhal, 2008; Moore, 2006; Rothschild, 2000; Valentine, 2007; van der Kolk, 2015). Trauma has an influence on this connection because memory occurs mentally and somatically throughout the entire body (Miller & Guidry, 2001; Rothschild, 2000; Valentine, 2007). This physiological impact of trauma on a survivor is evident through “body image, movement style, physical expression, and interactions between her feelings and life actions” (Bernstein, 1995, p. 41).

Physiological effects. The most common physiological effect that occurs during the time of assault is hyper-arousal, or an “excessive emotional reaction that overwhelms rational thought” (Valentine, 2007, p. 193). Hyper-arousal hinders the survivor’s ability to fully process what is occurring, leading to dissociation from the sensory connection to the body (Chang &

Leventhal, 1995; Valentine, 2007). Rothschild (2000) and van der Kolk (2003) stated that while some individuals react to a traumatic event by taking action, otherwise known as the fight or flight response, others respond by dissociating, or freezing. Van der Kolk (2003) explained that survivors are more likely to respond by freezing or with an increased dependence on the abuser if the traumatic event is the result of an attack from a loved one whom survivors depend on for emotional and economic security. He also stated that dissociation during a traumatic event is a significant predictor of PTSD (van der Kolk, 2003). Neurologically, the memory or somatic memory, is located throughout the entire body, as information is transmitted between the brain and all points of the body via the synapses in the nervous system (Miller & Guidry, 2001; Rothschild, 2000). The somatic memory explains how trauma survivors experience heightened physiological responses to simple touches, smells, bodily sensations, movements, and positions (Miller and Guidry, 2001; Rothschild, 2000; Siegel, 2003; van der Kolk, 2003). This pattern of increased arousal as a result of unexpected stimuli is a symptom of PTSD (van der Kolk, 2003). For example, Bernstein (1995) explained that the survival strategy of dissociation often remains after the abusive incident, especially when survivors are exposed to triggering stimuli; symptoms may include numbness, partial amnesia, “out of skin” and “spaced out” states, and sensations of unreality. Van der Kolk (2003) stated that the feelings, sensations, and actions that initially served as survival strategies during the past trauma can create predictable emotional or physical responses that may be irrelevant to present events. Although these responses served as survival strategies during the trauma, they most likely fail to resolve the hurt, pain, terror, or helplessness that survivors are experiencing in the present moment (van der Kolk, 2003). These mental and physiological symptoms are reflected within the movement patterns of survivors of domestic violence.

Movement effects. The trauma of domestic violence may result in the somatization of emotional pain and the different negative feelings that survivors may feel towards their bodies, including distrust, rejection, confusion, shame, and self-hatred (Valentine, 2007). Survivors may even eventually adopt their perpetrators' lens of 'reality' by believing that they, the survivors, are stupid, worthless, ugly, etc. (Chang & Leventhal, 1995). This can lead to rigid movement patterns and limited coping techniques (Chang & Leventhal, 1995). For example, Moore (2006) performed a movement analysis on 16 females in order to discover common movement qualities of survivors of domestic violence. These qualities were divided into five separate categories: *Body*; *Effort*; shape and bipolar shaping, which refers to *shape flow* and *bipolar shape flow* in the *Kestenberg Movement Profile (KMP)*; *Space*; and *tension flow rhythms (TFRs)* (see Appendix A) (Moore, 2006). The observations within the body category, which is an element of *Laban Movement Analysis (LMA)*, included: high *rigidity* in body parts, particularly the breast region, arms, and head; shallow breath; avoidance of eye contact; and *sequential sequencing* (see Appendix A), or moving only one body part at a time (Moore, 2006). The observations made within the Effort category, which is an element of Laban Movement Analysis (LMA), included an initial absence of *directing* and *increasing pressure* (see appendix A) (Moore, 2006). As for shape and bipolar shaping, the women maintained a vertical posture, which refers to the *vertical dimension* and had *convex changes* (see Appendix A) while exploring emotionally difficult topics (Moore, 2006). Additionally, there was *low intensity narrowing* and *hollowing* and they appeared stuck in the *shrinking phase of bipolarity* (see Appendix A) (Moore, 2006). Within the space category, all but one of the clients had *near reach space* (see Appendix A) (Moore, 2006). Lastly, the most visible TFR was the *biting rhythm*, which is a *fighting tension flow rhythm (TFR)* within the hands, head, and face (see Appendix A) (Moore, 2006). It should be noted that

these movement presentations were not compared to the women's pre-trauma movement presentations. While it cannot be concluded that their movement presentations were a result of the trauma, all of the women were survivors of domestic violence and shared similar movement characteristics that may be indicative of the trauma.

Similarly, Bernstein (1995) demonstrated how the trauma of domestic violence can influence movement style and physical expression among survivors. She explained that the dance elements of *rhythm*, *space*, dynamics, body movement, and content can be informative of the effects of trauma (see Appendix A). She went on to say that the survivor's use or avoidance of these elements can be telling of a limited movement range that occurs as a result of posttraumatic stress (Bernstein, 1995). These findings provide examples of how the trauma of domestic violence impacts the connection to the body through movement style and physical expression.

Dance/Movement Therapy for Survivors of Domestic Violence

A horrendous trauma cannot be treated, as the event cannot be undone (van der Kolk, 2015). However, it is possible to treat the impact that the trauma of domestic violence has on the body, mind, and spirit (van der Kolk, 2015). Several authors (Schore, 2003; Siegel, 2003; van der Kolk, 2002) show that trauma affects the areas of the brain stem that are linked to perceptions, emotion, and motivation. As explained above, the memory is located throughout the entire body, which means that trauma is present throughout the entire body as well. Due to the fact that the trauma of domestic violence has so many devastating physical, mental, physiological, and movement effects on the survivor, it is suggested that creative arts therapies can provide a more holistic method of treatment (Bernstein, 1995; Chang & Leventhal, 1995; Valentine, 2007).

Survivors may have difficulty verbalizing their traumatic experiences, therefore hindering the healing process in verbal therapy (Valentine, 2007; van der Kolk & Fisler, 1995). While this may be true, an integration of both verbal therapy and dance/movement therapy may be an effective and all-inclusive treatment approach for survivors (Bernstein, 1995). Successful verbal therapy stresses the improvement of self-esteem and working through traumatic memories, while movement helps to utilize the body as a mechanism for change, so that survivors can feel deeper and more accepting connections to their bodies during the healing process (Bernstein, 1995). Bernstein (1995) stated, “In dance therapy the body becomes at once the vehicle for change and the focus of change, so that the client can begin to reclaim her body as an ally in her struggle toward health” (p. 42). For example, in Moore’s (2006) study, which examined the movement characteristics of survivors of domestic violence, most of the observations gradually changed during the course of the dance/movement therapy treatment; the clients were able to experience deeper breath, movement that reflected qualities of increasing pressure and directing, an increased ability to access movement along the *horizontal axis*, movement in different levels of space, and *indulging tension flow rhythms (TFRs)* (see Appendix A) (Moore, 2006).

Although the movement qualities among the survivors in Moore’s (2006) study did change as a result of dance/movement therapy, it is important to recognize the presence of *body knowledge* and *body prejudice* (see Appendix A). Body knowledge, or the ability to understand, categorize, and generalize movement behavior as a result of personal experiences, can lead to body prejudice—the automatic projection of positive or negative meaning onto a movement behavior (Moore & Yamamoto, 2012). Although a specific movement behavior may be judged based on the therapist’s personal experiences, it does not necessarily mean that the predictions are incorrect (Moore & Yamamoto, 2012). While it is possible that Moore (2006) had

preconceived opinions about the movement qualities of the survivors, there was consistency within the study, which may suggest that the movement qualities occurred as a result of the abuse that each participant experienced. Furthermore, there was consistency regarding the change that occurred among the participants as they received dance/movement therapy treatment. Whether or not the movement changes had positive or negative meanings or effects to their well-being is to be determined by the participants of the study.

Safety and trust are the primary issues when beginning dance/movement therapy with a survivor of domestic violence (Valentine, 2007). Therefore, it is imperative to allow the clients to have control and choice over their participation, to work through issues verbally or through movement, to create boundaries of space and time, and to utilize defense mechanisms when necessary (Valentine, 2007). Some of the general goals that dance/movement therapists have for survivors may include: finding some pleasure and ease in moving; establishing a connection/reconnection with the body; expanding the movement repertoire in order to provide alternative coping mechanisms for the trauma; increasing the sense of control over hyper-arousal; and integrating physical, emotional, and cognitive expression (Valentine, 2007).

Additionally, the therapeutic movement relationship, or the therapist's ability to "kinesthetically perceive, reflect, and react to her patients' emotional expressions through her own body movements and voice tone," is central to the approach of dance/movement therapy, because it supports the therapist in understanding and accepting the client on a deeper and more genuine level (Levy, 1988, p. 25). Chaiklin and Wengrower (2009) supported the importance of the therapeutic movement relationship when they stated that dance therapists understand their clients with their bodies by echoing and reacting to their movements. The kinesthetic attunement that the therapeutic movement relationship creates supports the establishment of client safety and

control on both a verbal and non-verbal level. Mary Whitehouse, a first generation dance movement therapist who worked and taught on the west coast, stressed the significance of the therapeutic relationship (Levy, 1988). Her approach to the therapeutic relationship emphasized the importance for the therapist to “put aside preconceptions of what the client should do, and instead, take the role of not knowing what is correct for a particular individual, letting the individual find his/her own solution” (Levy, 1988, p. 69). This approach is made up of two contradicting, yet complimentary concepts: the therapist’s ability to restrain direction as the client initiates movements and thoughts, which may otherwise be known as “starting where the client is”; and the therapist’s ability to trust her intuition in providing direction for the client when necessary (Levy, 1988, p. 69). Whitehouse’s approach is characterized by the therapist’s sense of security and non-defensiveness, which allows the client to either accept or reject the therapist’s suggestions (Levy, 1988). While this is beneficial because it deepens the therapeutic process, it can also increase the likelihood of countertransference.

Countertransference

The phenomenon of countertransference within the therapeutic relationship was first identified by Freud (1959), who defined it as the unconscious reactions that a therapist experiences while working with a client, which can be influenced by the therapist’s life experiences. Countertransference was found to be one of the first recognized effects of psychotherapy on the clinician (Eckberg, 2000; Figley, 1995; Gentry, 2002; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Previously, Freud (1959) believed that countertransference was a negative product of the therapeutic relationship and that it needed to be prevented or eliminated (Eckberg, 2000; Figley, 1995). As other therapists sought to more deeply understand the relationship between therapist and client, the concept of

countertransference began to be recognized as a natural and normal component of the therapeutic process (Natterson, 1991). The definition shifted and began to include the therapist's conscious and unconscious emotions or attitudes about the client, as well as the therapist's history and lived experiences (Figley, 1995, 1999; Herman, 1992).

It has been argued that through awareness of countertransference, therapists can gain a better understanding of their clients and improve the overall therapeutic process (Eckberg, 2000; Forester, 2007; Figley, 1995, 1999; Gentry 2002; Rothschild, 2000, 2006). Eckberg (2000) expressed the high importance for therapists to acknowledge their personal feelings that are elicited during their work with survivors. For example, therapists working with trauma survivors may experience a variety of intense feelings, including guilt, rage, dread, grief, or shame. Additionally, the therapist may feel overwhelmed, leading to the use of defenses such as numbing, denial, and avoidance. Eckberg went on to argue that if therapists do not have a reaction to their clients then they are unable to become attuned to their clients' experiences, hindering the therapeutic relationship that is essential for survivors of trauma.

While countertransference enables therapists to more deeply understand their clients, it also supports therapists in becoming more aware of themselves (Eckberg, 2000). This increase in self-awareness can be utilized in order to remain grounded and more present for clients, further promoting growth in the therapeutic process (Eckberg, 2000). If therapists do not acknowledge their personal feelings, they may be swept away by a countertransference-related response (Eckberg, 2000). For example, Eckberg recalled when a client was unable to reach her after becoming re-traumatized by a natural disaster. She later received angry phone calls, suicide threats, and refusals to keep appointments; this triggered some of Eckberg's past traumatic memories and influenced her responses to her client. Without acknowledging this

countertransference, Eckberg may not have been able to establish boundaries or remain grounded and empathic with her client. As stated earlier, memories such as those that triggered Eckberg's countertransference are housed within the body, which can also be experienced as somatic countertransference.

Somatic countertransference. Dosamantes-Beaudry (1997) used the term “somatic countertransference” to describe the somatic reactions and body sensations that therapists may experience in response to their clients at “particular moment[s] during treatment” (p. 522). Additionally, Forester (2007) defined somatic countertransference as “the effect on the therapist’s body of the patient and the patient’s material” (p. 129). The therapist’s body and mind are equally engaged with the client during the therapeutic process, making somatic countertransference equally as important as countertransference (Forester, 2007). In fact, Lewis (1984) wrote that somatic countertransference “links the deepest core of the patient to the healing container of the therapist” (p. 191). This intersubjectivity is what makes somatic countertransference a major aspect of the therapeutic movement relationship (Young, 2016). Vulcan (2013) wrote that dance/movement therapists view somatic countertransference as a crucial tool for the therapeutic process. Similarly to countertransference, somatic countertransference can be difficult for therapists to recognize (Forester, 2007). Forester (2007) stated that in order to work with somatic countertransference, therapists must increase their *somatic awareness* (see Appendix A) and their ability to reflect on somatic experiences.

Rothschild (1998) stated that somatic countertransference provides therapists with clarity during the therapeutic process. When therapists are aware of their own bodies, they are better able to differentiate their own personal feelings and the feelings that are mirrored from their

clients' experiences (Rothschild, 1998). The lucidity that occurs as a result of somatic awareness is a critical contribution to the field of psychotherapy (Forester, 2007).

Eckberg (2000) shared her experiences working with veterans diagnosed with PTSD. Eckberg (2000) contributed to the idea that remaining attuned to somatic experiences is a "crucial aid" in helping therapists to recognize their somatic countertransference, providing insight into previously inexplicable reactions (p. 71). This important insight enabled Eckberg (2000) to recognize how her own traumatic past influenced her responses to her clients. Through this recognition, Eckberg (2000) implemented strategies to ground herself during moments of somatic countertransference through awareness of her own breath and her feet on the floor. This enabled her to set boundaries with her clients, while remaining focused on the goals of the therapeutic work.

While an awareness of somatic countertransference can improve the therapist's sense of clarity and ability to remain grounded in sessions, this awareness also contributes to stronger therapeutic relationships (Forester, 2007). Forester (2007) wrote, "Relationships themselves are experienced and expressed somatically, as well as affectively and cognitively" (p. 129). Dosamantes-Beaudry (1997) spoke about a "somatic intersubjective dialogue," in which the bodily experiences and expressions are recognized as physical presentations of the "conflicted self and other relationships that are carried on unconsciously" (p. 522). Forester (2007) argued that when therapists fail or are unable to address this dialogue, they may become blind to important parts of their clients and their therapeutic relationships, which may otherwise be utilized to promote therapeutic growth. Forester (2007) went on to say that client material that relates to traumatic experiences and relationships may become unconsciously embodied by therapists who fail to recognize the somatic intersubjective dialogue; this embodiment may also

occur through dissociation. Therefore, failure to recognize somatic countertransference may negatively impact the therapeutic relationship (Forester, 2007).

Somatic countertransference is a normal and expected effect of clinical work on therapists. If recognized and utilized, it can provide therapists with a deeper understanding of themselves, while simultaneously providing greater insight into the important aspects of the therapeutic process. Considering the mental, physiological, and movement effects of domestic violence, the experience of somatic countertransference may be profound for therapists who have experienced similar traumas to their clients.

Survivor-therapists and countertransference. Survivor-therapists can be defined as “Providers who have undergone the same trauma and/or experiences as their clients and have received formal graduate training in counseling or psychology” (Fagnoli, 2014, p. 78). There is a deficiency of literature that links countertransference and survivor-therapists in domestic violence work. However, the idea that countertransference is an important aspect of survivor-therapist work with their clients has been explored and discussed within some research and literature pertaining to eating disorders (Costin & Johnson, 2002; Johnson, Smethurst, & Gowers, 2005; Rance, Moller, & Douglas, 2010; Zerbe, 2008). The information presented in this literature may correspond to countertransference experienced by a domestic violence survivor-therapist, as the constant element is the survivor-therapist role, regardless of the difference in population.

It can be difficult to maintain a therapeutic role while experiencing countertransference, especially if the counselor has an eating disorder history (McEneaney, 2007; Rance et al., 2010; Zerbe, 2008). Johnston, Smethurst, and Gowers (2005) conducted a survey with patients, caretakers, and professionals on the appropriateness of eating disorder survivor-therapists. They

concluded that, “there was a widespread belief that those who had recovered would have therapeutic advantages as a result of their experience” (Johnston et al., 2005, p. 301). These advantages include a stronger therapeutic relationship, more useful therapeutic advice, higher levels of empathic capabilities, an expertise on the disorder, and an ability to be a role model for clients (Johnson et al., 2005). Similarly, Costin and Johnson (2002) shared the advantages and disadvantages of recovering/recovered eating disorder counselors. Costin and Johnson wrote that counselors who overcame an eating disorder have higher levels of empathy and the ability to be a role model for their clients; however, they also wrote that recovered counselors may experience countertransference and become narrow in their treatment approach as a result of their past experiences. Costin and Johnson identified the possibility of a narrow treatment approach as an example of countertransference, but they did not provide any other possibilities of countertransference vulnerabilities.

Additionally, Rance, Moller, and Douglas (2010) contributed to the possible advantages when they explored the lived experience of recovered eating disorder counselors. Their study primarily focused on the correlation between their work as eating disorder counselors and their personal body image, weight, and relationship with food (Rance et al., 2010). Results showed that the counselors felt they had an increased understanding of clients’ experiences and a stronger motivation to help free them from the disorder (Rance et al., 2010). Additionally, the recovered eating disorder counselors maintained an awareness of the increased likelihood and occurrence of countertransference, which is a necessary aspect of their work (Rance et al., 2010). Although there is an expected initial strain, recognizing and understanding the uncomfortable feelings that coincide with countertransference causes a promotion in growth and change (Little, 1981; Zerbe, 2008). Growth and change will occur as a result of these uncomfortable feelings

because the survivor-therapist will gain the ability to understand how his/her experiences can influence the therapeutic relationships with clients who are living similar experiences.

Rance et al. (2010) also discovered that survivor-therapists heavily emphasized normality within their work. This was evidenced by statements that stressed their successful recoveries and chronological distance from their eating disorders (Rance et al., 2010). In addition to the participants' emphasis on normality, results also showed selective attention, which was demonstrated through black and white thinking ("I am recovered or I am not recovered") and determined self-client separation (Rance et al., 2010). The survivor-therapists identified themselves as part of the "non-eating disordered" population as opposed to the "eating disordered population"; this created a contradiction in regard to their understanding of themselves having increased empathy as a result of their shared eating-disorder history (Rance et al., 2010). Although Rance et al. suggested that these findings may indicate a remaining existence of an eating disorder, they may actually demonstrate a desire for normalcy and a fear of revisiting the struggles after fighting to recover.

It is interesting to note that Costin and Johnson (2002) provided different perspectives regarding programs who hire recovering/recovered eating disorder counselors. Costin shared that her program feels strongly about hiring counselors who are "recovered" and have been for a minimum of two years (Costin & Johnson, 2002). This decision to hire counselors who have been recovered for a minimum of two years was determined in order to avoid the potential relapse that may occur for counselors who are still recovering (Costin & Johnson, 2002). On the other hand, Johnson shared that recovery is a lifelong task, as individuals who suffered from eating disorders will need to actively manage their vulnerabilities throughout their lives (Costin & Johnson, 2002). While this pertains to eating disorders, it can correspond with survivor-

therapists within the domestic violence population; although relapse is not a concern in domestic violence, the countertransference that may arise during the therapeutic process may be vulnerable for the survivor-therapist.

Counselor self-disclosure is an important factor to consider, as it should only be utilized for purposes that benefit the client (Edwards & Murdock, 1994). Edwards and Murdock (1994) completed a study amongst 400 doctoral-level psychologists (200 women and 200 men) in order to understand their uses of self-disclosure. Results of the 46% of returned surveys indicated that most of the participants were disclosing at a moderate amount regarding professional issues, such as degrees or experience (Edwards & Murdock, 1994). Participants were clear in rejecting certain reasons for disclosure, such as increasing expertness, attractiveness, trustworthiness, or because the client desires it (Edwards & Murdock, 1994). On the other hand, the participants' highest reasoning for disclosure included modeling appropriate client behaviors and increasing similarities between client and counselor (Edwards & Murdock, 1994). While this may hold true for these participants, disclosing professional issues in order to model appropriate behaviors or increase similarities seems detrimental to the therapeutic relationship; modeling a specific degree or experience level as an "appropriate" behavior seems to be based entirely off of bias. Additionally, utilizing disclosure regarding professional issues would most likely not increase the similarities between the counselor and client (Edwards & Murdock, 1994), especially within the domestic violence setting. Edwards and Murdock (1994) did not incorporate disclosure of similar experiences in order to increase the similarities between counselor and client.

Counselor self-disclosure is an important factor to consider for survivor-therapists, especially since transparency can create a more complex therapeutic relationship. Costin and Johnson (2002) shared the advantages of recovering eating disorder therapists disclosing

recovery history to their clients. Costin and Johnson stated that therapists who successfully recovered serve as a concrete demonstration for their clients that recovery is possible. For example, clients who are drowning in feelings of despair, hopelessness, and self-pity will benefit from knowing that their therapist experienced and overcame the struggle of recovery (Costin & Johnson, 2002). This utilization of self-disclosure can increase the similarities between counselor and client, which can strengthen the therapeutic relationship.

Conclusion

This literature review revealed information regarding the various mental and physiological effects of domestic violence, while considering the possibility that my relational experiences most likely impacted me in similar ways. The literature provided information regarding the presence of these symptoms as a result of unexpected stimuli, which may provide context for my countertransference related to my past relational experiences. Additionally, the literature provided information about the occurrence of countertransference experienced through the therapeutic movement relationship that occurs during dance/movement therapy. Furthermore, an increased awareness and understanding of therapists' experiences of countertransference can contribute to stronger therapeutic relationships through similar experiences.

There was a minimal amount of literature that discussed the advantages and disadvantages of therapist disclosure within the clinical setting; however, survivor-therapists may still utilize their experiences in order to strengthen therapeutic relationships without disclosing information about their past. Lastly, there is a need for literature about survivor-therapists working within the domestic violence population. This needs to be explored in order to help provide more effective therapy for survivors of domestic violence.

This literature review provided me with the hope that this research study will be a valuable asset to domestic violence work and the dance/movement therapy community, as therapists' personal experiences can more deeply serve as catalysts for client growth. As previously stated, the purpose of my study was to explore how my experiences, especially my past relational experiences, impacted my work as a counseling intern with survivors of domestic violence through countertransference. My research answered the following question: How does my countertransference inform my therapeutic relationships, clinical choices, and professional development as a dance/movement therapy and counseling intern with survivors of domestic violence? This question was developed based off of my compassion towards the domestic violence population and my hope that I can utilize my experience to empower other survivors of domestic violence.

Chapter 3: Methods

Methodology

This research is a qualitative, heuristic inquiry using arts-based methods for data analysis. Moustakas (1990) defined heuristic research as an internal search through which the researcher discovers the importance of experience. Through this process, the researcher then cultivates methods and techniques for further exploration (Moustakas, 1990). Moustakas developed this research methodology as a way to more deeply study the self; he believed that the researcher would experience a growing self-awareness and self-knowledge through the process (Moustakas, 1990). Heuristic research can be a vulnerable methodology, as the researcher must have had a direct, intense, and personal encounter with the experience being explored, or at least a comparable experience (Moustakas, 1990). With awareness of this vulnerability, the researcher is willing “to risk the opening of wounds and passionate concerns, and to undergo the personal transformation that exists as a possibility in every heuristic journey” (Moustakas, 1990, p. 14). Therefore, I selected heuristic inquiry in order to complete my own in-depth exploration of my countertransference while working with a population whom I can compare my experiences to: survivors of domestic violence.

Hervey (2004) stated, “When information is felt deeply and known tacitly in the body, it may not always be possible to articulate fully in words...” (p. 185). My countertransference included somatic experiences; therefore, I believed that arts-based methods would provide me with a more holistic articulation of my findings. I analyzed my data through Moustakas’ (1990) creative synthesis—a process in which the researcher “develops an aesthetic rendition of the themes and essential meanings of the phenomenon” (p. 52). This supports the researcher’s passion and knowledge regarding the phenomenon, which is further expressed through a creative

process such as a narrative, story, poem, or work of art. Through the use of creative synthesis, I was able to better explore and understand my experiences by embodying my data through my analysis process.

Participants

I was both the researcher and the participant in this study. I am a 24-year-old Caucasian woman who was raised in a middle class household in New Jersey. My nuclear family is still intact, as my parents are still happily married and living together. I am the youngest of their 4 children, with 3 older brothers with whom I have always sustained close relationships. My household while growing up was always stable, loving, and supportive; my parents and siblings encouraged creativity, passion, and academic, social, and emotional growth. I was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), predominantly inattentive presentation, when I was 12 years old. Although I have medication, I only take it when I have an important exam, paper, or other assignment to complete. I prefer to live everyday life as myself, not medicated, because my medication makes me feel anxious and robotic.

Although I was the sole participant in this study, I collected data based on my subjective experiences during my internship with survivors of domestic violence. I worked with individuals of various ages, genders, sexualities, backgrounds, communities, education levels, economic levels, cultures, ethnicities, religions, and lifestyles. I facilitated individual, group, and family counseling sessions, which were all considered throughout the data collection process. I had different feelings and relationships with each of my clients, as our similarities and differences shaped our relationships.

My background and experiences growing up varied significantly from many of the clients that I worked with at my internship site. I was aware that my exploration of countertransference,

which was based on my subjective experience of the therapeutic relationships with my clients, might have included learned prejudicial biases that were previously out of my awareness.

Therefore, I was mindful and sought the assistance of a research consultant in order to maintain the validity and authenticity of my findings without enabling biases to deter the goal of answering my research question.

Methods and Procedure

I followed Moustakas' (1990) six phases of heuristic research, which included initial engagement, immersion, incubation, illumination, explication, and creative synthesis. My research began during my clinical internship at a counseling center for survivors of domestic violence. I anticipated that my relational experience would be prominent during the process of empathizing and intervening with clients, but to my astonishment, its presence felt close to absent. Since my experience of an emotionally abusive relationship was not explicit in my work as a dance/movement therapy intern, I became curious about how it was present and how it was impacting my work. This marked the initial engagement phase of my research, as the population and research questions were of "intense interest" and "passionate concern" (Moustakas, 1990, p. 27). Moustakas (1990) wrote, "During this process one encounters the self, one's autobiography, and significant relationships within a social context" (p. 27). I immersed myself in the discovery of how my autobiography and my significant relationships related to my work with my clients. Due to timing, I had to adjust the order of Moustakas' phases, which resulted in the incubation phase occurring before the immersion phase. I experienced the incubation phase during spring break in March 2016, as I had an opportunity to visit my family in New Jersey and completely detach from my involvement with the population and my research question (Moustakas, 1990). During this phase, the question has an opportunity to incubate while the researcher is involved

with something else. This process of incubation allows for clarity and expansion on the topic outside of the researcher's immediate awareness (Moustakas, 1990). While this process of incubation enabled me to more deeply understand various aspects of my study, such as the data collection and analysis methods, it would likely have been beneficial to incubate in-between data collection and data analysis. This may have significantly deepened my findings, because rather than collecting and analyzing data concurrently, I would have had time to deeply reflect on the data before analyzing it with my research consultant. Additionally, the concurrent process may have impacted my approach to data collection in the later weeks, as my research consultant and I were already discovering themes. However, I also believe that by simultaneously completing data collection and data analysis, the experiences that I journaled about during data collection remained vivid in my mind.

Data collection. I spent five weeks during April 2016-May 2016 in the immersion phase of my research. According to Moustakas (1990), "The immersion process enables the researcher to come to be on intimate terms with the question - to live it and grow in knowledge and understanding of it" (p. 28). I began this process by considering all of the ways that countertransference might manifest itself. I delved into the possibilities through data collection, which occurred three times per week for five weeks. Throughout this process I recognized any sensations, movement responses, images, feelings, and thoughts (SMIFT) that arose during my sessions with my clients. At the end of each internship day, I engaged in semi-structured journaling, which consisted of both writing and art-making; the art was done on a body outline in order to display my experiences (see Appendix B), while journaling occurred to describe the experiences in further detail. The semi-structured journal was guided and structured by my experiences of each SMIFT category. Data collection occurred in two different locations as a

result of my client scheduling. On Mondays, I was able to designate 30-60 minutes at the end of the internship day for data collection at my desk in the intern area. On Tuesdays and Wednesdays, my last client(s) left only 15 minutes before the office closed; this resulted in data collection occurring immediately upon arriving home in my bedroom.

Data analysis. The illumination phase occurred during data analysis in my research consultant's office, which began two weeks after data collection. It is important to note that I audio-recorded the data analysis sessions in order to revisit them while organizing my results. As I collected data over the course of five weeks, I recognized qualities within my journal entries. Moustakas (1990) described the illumination phase as “a breakthrough into conscious awareness of qualities and a clustering of qualities into themes inherent in the question” (p. 29). I made my own meaning of these qualities, which were then discussed with my research consultant—a board certified dance/movement therapist (BC-DMT) and a licensed clinical professional counselor (LCPC). It was through this process that I recognized any distortions within my own previous assumptions about my journal entries. According to Moustakas (1990), the illumination phase “may involve corrections of distorted understandings or disclosure of hidden meanings” (p. 29).

The explication and creative synthesis phases also occurred during data analysis. Through the explication phase, the researcher fully investigates “what has awakened into consciousness, in order to understand its various layers of meaning” (Moustakas, 1990, p. 31). After discussing specific journal entries, my research consultant and I explored these various layers of meaning through creative synthesis. During this process, I illuminated material through authentic movement—a process in which the individual relinquishes control and choice and allows the body to move freely, inviting the expression of underlying emotions and thoughts (Levy, 1988).

During this process, I allowed myself to act on my bodily impulses in response to my journal entries rather than consciously and judgmentally choreographing a movement phrase. This authenticity provided my research consultant and me with a deeper understanding of my findings. After completing each authentic movement session, my research consultant shared her experiences as the witness and the two of us further discussed the journal entries and the movement experiences. These discussions helped us to recognize patterns and themes throughout the 5 weeks, which were then determined as the results of this study. As described earlier, “Once the researcher has mastered knowledge of the material that illuminates and explicates the question, the researcher is challenged to put the components and core themes into a creative synthesis” (Moustakas, 1990, p. 31-32). I concluded my creative synthesis phase with a choreographed solo, *I Can Almost See You*, which I performed on July 28th 2016 in the student/faculty concert at Columbia College Chicago (see Appendix C).

Validation Strategies

Research consultant. I hired a research consultant as a source of validity for this study. She and I both signed a contract (see Appendix D). Two weeks after data collection began, this individual and I met five times over five weeks and analyzed data sequentially through creative synthesis. After arriving at my results and taking the time to process and revise them, I checked in with my research consultant one more time in order to maintain validity.

Resonance panel. I sought the assistance of a resonance panel for my other source of validity for this study. My resonance panel consisted of two classmates (MA candidates) and a professor (LCPC, BC-DMT, GL-CMA) with whom I have trusting and supporting relationships. I initially asked each individual in person and then followed up with a formal email that explained the objectives of our session together (see Appendix E). I met with these individuals in

the professor's dance/movement therapy office once after my fourth data analysis session in May 2016. I decided to schedule our meeting before I was finished with data analysis because I wanted to gain the perspective of my resonance panel before concluding the data analysis process. Due to our various scheduling needs, the most convenient time for us to meet was after the fourth data analysis session. During our meeting, my resonance panel asked questions regarding my findings and challenged me to look at them from different perspectives.

Chapter 4: Results

Through self-exploration of my countertransference and a thorough analysis of my data, prominent themes were revealed. This chapter explores how I discovered these themes through my heuristic inquiry and how each connected to my process of further understanding myself as an emerging dance/movement therapist. I sought to answer the following research questions: How does my countertransference inform my therapeutic relationships while working with survivors of domestic violence? How does my countertransference impact my clinical choices and my development as a dance/movement therapist? The findings will, in turn, help me to understand how I can utilize my countertransference as a therapeutic tool in the future.

Body Findings

In reviewing my journal entries, I recognized recurring patterns within my body. Through this increased body awareness, I learned that different emotions within myself were reflected in my sensations and movement responses. Therefore, my body sensations and movement responses served as primary indicators of the presence of somatic countertransference.

Heart. In reading my journal entries, I frequently reported sensations related to my heart. These sensations included an increase in heartbeat, which was so powerful that I felt as though my heart was going to beat out of my chest, and a sinking sensation, which felt as though my heart was being pulled down into my stomach by the strong emotions that I was feeling. The most prominent theme of the two was the sinking sensation, which occurred concurrently with my own feelings of sadness, rejection, and incompetence within sessions with my clients. I frequently felt these feelings when clients suggested that our work together was not helping, when they questioned my competence as their counselor, and when they shared their own feelings of rejection within their romantic relationships; each of these scenarios connected to my

own past and present feelings of sadness, rejection, and incompetence. Figure 1 is a sample from the journal that displays the drawing of the sinking heart sensation on the body outline. It is accompanied by a sample from the written entry that further describes that sensation.



Figure 1. A pictorial representation of the sinking heart sensation. “She shared feelings of hopelessness and powerlessness. Memories of past break-ups came to mind. I remembered that I felt very similarly when I was heartbroken - I felt like I could never possibly get through it or survive on my own. I felt my heart sink into my stomach as she spoke. I wanted to find someone to hold me. I wanted to hold her so she didn’t have to feel so alone.”

Breath. Another pattern that I recognized was the impact that my memories and emotions had on my breath. When memories of my codependent tendencies during my past abusive relationship arose, I experienced sensations of my breathing being blocked. When I tried to take deep breaths, it felt as though someone had placed a wall in my lungs, preventing me from getting air. These memories and sensations were accompanied by feelings of sadness, frustration, and being stuck. Figure 2 is a sample from the journal that displays the drawing of

the blocked breath sensation on the body outline. It is accompanied by a sample from the written entry that further describes that sensation.

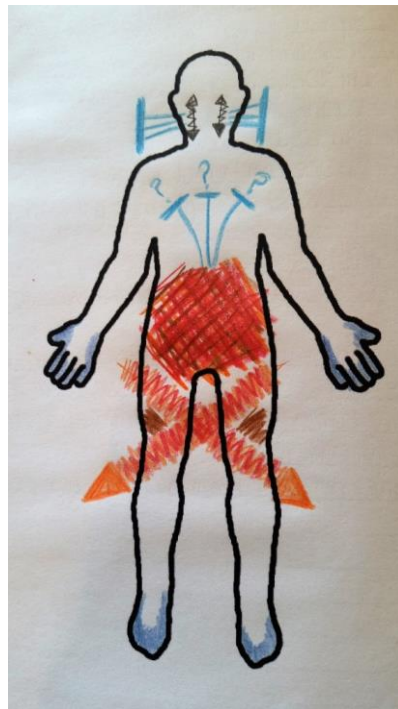


Figure 2. A pictorial representation of the blocked breath sensation. “I felt as though I couldn’t breathe. At other moments I felt like I was forgetting to breathe...like the signals weren’t going from my brain to my lungs. When I did manage to get/remember to get a breath out, it felt like it was being blocked by a wall...As she spoke of her experiences, images and memories of codependency came up. I felt sad. Deeply sad...I feel frustrated that she won’t allow herself to be alone. She needs to be-in order to heal. I want to be up front and direct with her, but I don’t want to hurt her feelings. That’s probably my own codependency presenting itself. I want to help her but I don’t know how. I’m stuck.”

Tension. Feelings of tension were present in almost all of my journal entries. Tension was identified in multiple areas of my body, including my jaw, throat, neck, shoulders, back, gut, and legs. The fact that tension was present in almost every journal entry made it difficult to

determine one specific emotion that it correlated with. However, as I read through my journal entries, I noticed that I concurrently identified tension with emotions such as sadness, anger, confusion, fear, and embarrassment. Figure 3 is a sample from the journal that displays the drawing of the tension sensation the body outline. It is accompanied by a sample from the written entry that further describes that sensation.



Figure 3. A pictorial representation of the tension sensation. “In the second session, the mom started intensely yelling at her daughter and I felt my throat tighten, my heartbeat increase, and my jaw clench. I felt my eyes widening and my body retreating. Images of my ex-boyfriend screaming at me came to mind. I always felt terrified and embarrassed when he yelled at me. I felt angry at the mom. I wanted to tell her to just love and support her daughter instead of making her feel afraid and unheard.”

Floating. I reported feeling a floating sensation during multiple sessions. This sensation felt as though I had a cloud surrounding my head, causing reality to feel like a dream and

hindering my ability to be completely mentally present with my clients. This feeling of floating occurred as a result of multiple different factors, including a lack of structure and organization in the sessions; protecting myself from feelings of rejection, sadness, and incompetence; and avoidance of empathy due to my fear of revisiting my past. Figure 4 is a sample from the journal that displays the drawing of the floating sensation on the body outline. It is accompanied by a sample from the written entry that further describes that sensation.



Figure 4. A pictorial representation of the floating sensation on the body outline. “They [mother/daughter family session] say they understand how the other feels but then the next week they come back in with the same stuff. My ex-boyfriend apologized and said he understood how I was feeling and then still criticized me for the same thing a week later. It’s frustrating to watch! **JUST LISTEN!** I felt floaty again. I kept shifting in the chair but it was noisy. Sit still. But I need to shift, I’m uncomfortable. Sit still. Shift. Too noisy! I picked at my fingers and I couldn’t stop. Why am I picking? Listen to what they are sharing with you! **JUST LISTEN!**”

Flooding. Although it only occurred during one session, this experience was powerful and informative. I did not write in my journal after this session, as I felt so overwhelmed by my

bodily sensations that I did not know how to put it into words. Additionally, I was afraid to revisit the “negative” emotions that I experienced and wanted to just go home and recuperate instead. During this session, my body sensations completely took over. I felt as though I was floating, was stuck in a very tight space, and couldn’t breathe. My head was in a cloud. My hands and feet were tingly and my brain was jumping back and forth. I could not stop picking at my fingers and I could not sit still. I tried to utilize deep breathing in order to bring myself back into the present, but I felt as though I had no control over my mind. I felt extremely angry with my client and incredibly sad for her son. I felt angry with her for allowing her husband to abuse her son. I felt angry that she could not understand the reasoning for her son’s behavior. Figure 5 is a sample from the journal that displays the drawing of the flooding sensation on the body outline.

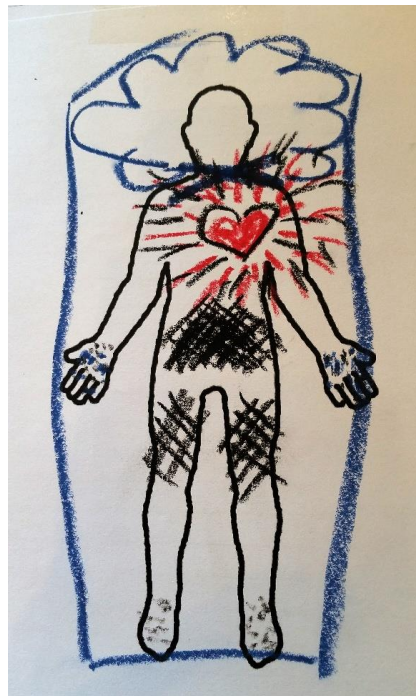


Figure 5. A pictorial representation of the flooding sensation.

Mind Findings

While these next findings are not specific to body sensations or movements, they are directly represented through the body findings listed above. Through a deeper analysis of the body sensations and movements, I discovered what my countertransference was showing me.

Attention-deficit/hyperactivity disorder. I was diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD), predominantly inattentive presentation, when I was 12 years old. Although I have medication, I only choose to take it when I have an important exam, paper, or other assignment to work on. I prefer to live life as myself, not medicated, as I do not enjoy how anxious and robotic my medication makes me feel. I did not initially consider the idea that my ADHD symptoms could be present during my sessions with my clients or in my data; however, to my astonishment, they made it more difficult to be in relationship and were clearly represented in my journal. My ADHD symptoms were most frequently represented through the floating sensation that I experienced, which occurred when sessions felt unstructured and disorganized. Clients often came in with a lot to share, so they jumped between various topics rather than discussing and exploring one at a time. This made it difficult for me to remain focused and attentive to my clients, as I felt like my brain got lost in the midst of all of the various topics. Additionally, my difficulty remaining focused correlated with sloppier writing in my journal. One of the first observations that my research consultant and resonance panel made was the neatness and organization of my journal. This pattern of orderliness is important for me, as I tend to lose focus when things are sloppy or disorganized. During the process of data analysis, I learned that my pattern of extreme neatness and organization serves as a compensation for my disorder.

Sample from written journal. “My next client came in, the one who I barely ever see.

She kept talking and talking and talking. I wanted to interrupt her and go deeper into something but I couldn't find the right opportunity. I finally cut in and did my movement intervention with her. It helped her understand what was going on at a deeper level. Before that, I kept getting lost in her story and couldn't re-ground myself."

Avoidance of past abusive relationship. Although it was not explicitly stated in my journal, my research consultant, resonance panel, and I recognized an avoidance of revisiting my past abusive relationship while in sessions with my clients. During the data analysis process, I spoke to my research consultant about how I had worked so hard to heal after breaking up with my abusive ex-boyfriend. It was a long and difficult journey to reclaim my independence and control over myself. I was fearful of giving up that control by revisiting the similarly difficult emotions and experiences of my clients. I put up an emotional barrier, which was demonstrated in my floating sensation, tension, and difficulty breathing. While attempting to revisit and explore these feelings with my research consultant, I experienced the same sensations and emotional barriers.

Sample from written journal. "I felt stuck with my clients today. The daughter expressed anger toward her mom. My face felt a little warm and I felt like there was a bubble around my head...kind of like a helmet that protected me from all of the yelling. I felt intimidated- anger is intimidating. I tried to say something but they argued over me. "You're stupid," she yelled to her mom. They didn't hear me. They don't want to hear me when they are angry. I wanted to bang on the table and tell them to stop yelling and to listen, but I couldn't. I wondered, "Maybe if I just sit here it will stop." I remembered how my ex-boyfriend always yelled over me when we fought. I floated in my helmet until the yelling stopped. I'm safe."

Parallel processing. Although I was fearful of revisiting my past abusive relationship while in sessions with my clients, I noticed moments of parallel processing during times that I did not close myself off. Even though I have already come a long way in my healing journey, I still found that I was dealing with some of the same issues that my clients were experiencing, such as struggling with low self-efficacy and fearing the unknown. Parallel processing was somatically experienced through my sinking heart sensation.

Sample from written journal. “She cried the entire session and I felt myself wanting to move next to her and hold her in my arms. I wanted to support her and help take her pain away. I wanted to know how he could do that to her. Why did my ex do that to me? I thought she was so strong but I also wondered how she could possibly stay with someone who was so awful to her. How could I stay with someone who was so awful to me? Did she feel that she deserved that treatment? Did I feel that I deserved that treatment?”

Conclusion

Several themes emerged throughout my journaling and my creative synthesis processes. Through recognizing and further exploring my moments of countertransference and somatic countertransference, I gained awareness of the body findings (heart, breath, tension, floating, and flooding) and the mind findings (attention deficit-hyperactivity disorder, avoidance of past abusive relationship, and parallel processing). These findings culminated in a dance performance at the student/faculty concert on July 28th 2016 at Columbia College Chicago (see Appendix C). Before the data collection process began, I was almost certain that my past abusive relationship was not present within my work with my clients because I was “healed, healthy, and over it.” However, I was proven wrong through the process of this exploration, as my past was a major aspect of my countertransference. In addition to my past abusive relationship, my ADHD was

also present within my findings. This was evident within my choreography and my performance experience (see Appendix C), as I recognized the avoidance of themes in order to maintain my appearance of normalcy.

Gaining awareness of these themes assisted me in answering my research questions: How does my countertransference inform my therapeutic relationships while working with survivors of domestic violence? How does my countertransference impact my clinical choices and my development as a dance/movement therapist? My countertransference taught me a lot about myself and helped me to understand how I reacted to different information that clients shared. This increase in self-awareness helped me to maintain grounding in sessions with clients, rather than immediately reacting to my clients as a result of the feelings that arose. With this ability to remain grounded, I was able to reflect on how I felt in order to better empathize with my clients; this improved my therapeutic relationships. My ability to remain grounded and reflect on my countertransference also correlated with my clinical choices, as I was able to make logical decisions while simultaneously allowing myself to experience the strong feelings that I felt. Lastly, this use of my countertransference as a tool to better understand myself as a therapist is necessary for my continued professional development. Countertransference is especially important to recognize and work with in the role of survivor-therapist, and as such, it will continue to challenge me to grow as a person and therapist.

Chapter 5: Discussion

During my dance/movement therapy internship at a counseling center for survivors of domestic violence, I sought to understand how my relational history influenced my work with my clients. Although I felt empathy and a deep connection to my clients, the influence of my past experience seemed absent in my work. Through personal therapy and supervision, I became aware of moments of countertransference during the therapeutic process. With this awareness came a new curiosity surrounding the idea that my relational history could be influencing my clinical work through countertransference. I became hyper-aware of feelings and thoughts that arose during my sessions, which led to my insistence that each must be connected to my relational history. This need to cognitively link my feelings and thoughts to my past emotionally abusive relationship, even if there was no clear association, encouraged me to explore this curiosity not only cognitively, but creatively as well. Additionally, I sought the assistance of a research consultant and a resonance panel in order to maintain validity in my understandings of my countertransference. I engaged in a heuristic inquiry to better understand how my countertransference informed my therapeutic relationships, my clinical choices, and my professional development as a dance/movement therapy and counseling intern with survivors of domestic violence. I expected that my past emotionally abusive relationship would be the most prominent and influential theme in this research.

While engaging in the data collection process, I experienced an increase in body-awareness, which helped me to explore my topic on a deeper physiological level. Through the exploration of my sensations, movement responses, images, feelings, and thoughts that arose during my sessions with my clients, I gained many insights in regard to how not only my past relationship, but aspects of who I am as an individual influenced my work as a dance/movement

therapy intern with survivors of domestic violence. Through data analysis with my research consultant and encouragement from my resonance panel, I gained much more insight than I initially anticipated. During this process, I was challenged to think more deeply and to consider all possibilities. With these insights, I expanded my understanding of my personal and professional development as a future dance/movement therapist. Furthermore, I learned the importance of utilizing countertransference as a tool for strengthening therapeutic relationships, creating effective therapeutic interventions, and more deeply understanding my professional identity.

Performance of Findings

On July 28, 2016 I performed my solo, *I Can Almost See You*, at the Dance Center of Columbia College Chicago (see Appendix C). This performance consisted of a choreographed solo in which I embodied and presented each of my findings through movement. The main themes that I explored included, *heart, breath, tension, floating, flooding*, and *ADHD*. It is interesting to note that I did not explicitly incorporate the themes of *avoidance of past abusive relationship* and *parallel processing* into my choreography because they were outside of my awareness while choreographing. During dress rehearsal, I performed my solo and felt overwhelmingly exhausted afterwards. My emotions and connection to the material felt numb, as if I had a wall up that was protecting me from possible vulnerability. A member of my resonance panel approached me when I was finished and asked me why I did not consider taking a moment to slow down and pause. He shared that he felt as if I was embodying *flooding* for the majority of the solo and suggested pausing at different moments. I felt confused, but after contemplating his insight, I decided to give his suggestions a try. The next night, I performed my solo during the concert with newly added moments of stillness. I felt myself on the verge of tears as my need for

organized choreography dissipated. I improvised each of my findings in a way that felt much more authentic than the original organized and calculated choreography; this authenticity felt sloppy and exposed. My movement felt more connected to my findings than ever, especially *avoidance of past abusive relationship*, which I had initially forgotten to include in the choreography. As Eckberg (2000) shared, therapists who work with trauma survivors may experience intense feelings, which will lead to defenses such as numbing, denial, and avoidance. It is interesting to note that my forgetting to include themes in my choreography speaks to avoidance and my fear of not being in control. Moreover, through the embodiment of my findings, I re-experienced different emotions and memories that connected to my past relational experience; these emotions and memories initiated my desire to protect myself from the emotions and vulnerability that coincide with revisiting my past abusive relationship. I was met with a round of applause at the end of my solo. I bowed and exited the stage with a flood of emotions: anger, sadness, relief, and happiness.

By opening my heart and experiences to an audience, most of whom I did not know, I felt as if I was sharing my deepest and darkest secrets and insecurities. I felt vulnerable and apprehensive about what they thought of me. Did they think I was broken? If so, am I unfit to be a therapist? How can I help others to grow and heal if I am still growing and healing? I felt anger regarding my past experience and sadness concerning my need to appear normal to others. Rance et al. (2010) mentioned the emphasis of normality for survivor-therapists within their work. This performance brought to light my need to appear “normal” and “healed,” especially as a future therapist. Rance et al. went on to say that the results of their study showed selective attention regarding recovery, or black-and-white thinking. This finding was evident in my pre-performance belief that I was completely healed from my past emotionally abusive relationship

and in my avoidance of two vulnerable themes in my original choreography. During and immediately after my performance, the vulnerability and flood of emotions resulted in my concern that I was still broken. What I learned was that my normalcy, which I initially viewed through the black-and-white lens, is actually occurring through continuous growth and perseverance. As Johnson argued, recovery is a lifelong task and I will need to actively manage my vulnerabilities throughout my life (Costin & Johnson, 2002). It was through my own growth and perseverance that I was able to connect to my clients on a deeper level; this deeper connection enabled me to help my clients in their process of growth and healing. As several authors (Dosamantes-Beaudry, 1997; Eckberg, 2000; Forester, 2007; Little, 1981; Rothschild, 1998; Zerbe, 2008) suggested, exploring countertransference enabled me to develop a deeper understanding of myself, which strengthened the therapeutic process with my clients because I had higher levels of empathy and an ability to be a role model for my clients. After hearing wonderful feedback from my advisor, my resonance panel, my research consultant, and friends, I was reminded of my last finding: *parallel processing*.

Although this performance initially opened the door for feelings of vulnerability, self-doubt, and a variety of other emotions, I am grateful for the opportunity. While I had already analyzed my data, I believe that the one missing piece was my understanding of my position as a survivor-therapist. This performance connected my experience to Rance et al.'s (2010) finding of survivor-therapists' need for normalcy and their use of selective attention concerning the healing process. Prior to this performance, I thought that I believed that recovery did not occur on a "healed" or "not healed" basis. I read Rance et al.'s study and felt that the survivor-therapists who participated were lacking self-compassion. However, this performance brought my attention to my hypocrisy, as I still placed myself in those "healed" or "not healed" categories rather than

granting myself the same compassion towards gradual healing. This performance increased my awareness of my personal healing process and how it related to my work as a survivor-therapist with survivors of domestic violence.

Survivor-Therapist and Countertransference

Through the results of this study, I learned that my past emotionally abusive relational experience was present within my work as an intern with survivors of domestic violence through countertransference. The symptoms that I was still coping with as a result of my past relationship served as the foundation for my moments of countertransference. The impact that my past relationship had on me was present in my data, as I experienced low self-esteem, memory and concentration problems, feelings of worthlessness, and difficulties in decision making while working with my clients; these are symptoms that Ali et al. (2001) described as signaling depression. In agreement with van der Kolk's (2015) statement concerning the possibility for survivors of interpersonal trauma to present varying symptomology without meeting a DSM diagnosis, I also experienced symptoms of PTSD; as Hughes and Jones (2000) described these symptoms, I experienced an increased physiological arousal, difficulty concentrating, fear, avoidance, dissociation, and hypervigilance while working with my clients. My symptoms did not meet the criteria for a DSM diagnosis of Major Depressive Disorder or PTSD. These mental health symptoms were simultaneously present within my body.

Rothschild (2000) stated that trauma occurs psychophysically, as it impacts both the mind and the body regardless of whether or not the event itself causes physical harm. This was evident in the presence of my past emotionally abusive relational experience within my somatic countertransference. My finding *avoidance of past abusive relationship* was somatically present through my body tension, breathing difficulties, and floating sensations that occurred during

moments of vulnerability and memories of my ex-boyfriend. These feelings, sensations, and actions initially served as survival strategies during my past trauma, as they protected me during moments of suffering; however, they have since become predictable emotional and physical responses that are now irrelevant to present events (van der Kolk, 2003). The predictability of these responses was demonstrated through the recurring themes within my journal entries. For example, feelings of sadness were accompanied by a sinking heart sensation, breathing difficulties, tension within my body, floating, and flooding. Feelings of rejection also coincided with a sinking heart sensation and floating. The combination of feelings of anger and sadness resulted in the theme of *flooding*, where I felt as though I had no control over myself. Although *flooding* only occurred during one session, the feelings and sensations of the theme persisted throughout the remainder of my evening. Bernstein (1995) stated that the survival strategy of dissociation often remains after the incident. Although my experience of *flooding* is not identical to dissociation, I experienced an uncontrollable state of “spacing out” and partial amnesia, as I struggled to remember what my clients told me during the flooding experience (Bernstein, 1995).

My *parallel processing* finding was somatically present through my sinking heart sensation, which coincided with feelings of sadness, rejection, and incompetence. Most of my feelings regarding my past emotionally abusive relationship consist of sadness, as it saddens me to know that someone whom I deeply loved emotionally abused me. Additionally, my past emotionally abusive relationship resulted in the mental and physiological symptoms that I continue to experience. Chang and Leventhal (1995) stated that survivors might eventually adopt their perpetrators’ lens of ‘reality.’ This adopted lens of reality was evident in my feelings of incompetence while working with my clients. While my personal relationship with these symptoms was stressful, it provided me with an advantage within my therapeutic relationships,

as I had higher levels of empathic capabilities, an expertise on the survivor role, and an ability to be a role model for my clients (Costin & Johnson, 2002; Johnson et al., 2005). Supervision served as an effective form of self-care throughout this process, as I was able to address my past abusive relationship and my moments of countertransference in a way that did not interfere, and instead, benefitted the therapeutic process with my clients. Furthermore, the fact that I still experienced mental and physiological symptoms from my past relationship resulted in moments of parallel processing. These moments of parallel processing facilitated growth and change for both my clients and myself, as I was able to utilize my own experiences within the therapeutic process. Finally, this increase in self-awareness and ability to utilize my past experiences in my clinical work will positively contribute to my professional development.

Therapeutic Relationships

As argued by several authors (Eckberg, 2000; Forester, 2007; Figley, 1999; Gentry, 2002; Rothschild, 2000, 2006), awareness of countertransference provides therapists with a better understanding of themselves and their clients, which improves the overall therapeutic process. Through my exploration of my countertransference, this argument proved to be true in my therapeutic relationships with my clients. Prior to this study, I found that I felt frustrated, angry, or sad towards clients, but could not understand why. I worried that something was wrong, especially since I always thought that therapists were not supposed to feel any specific emotions towards their clients. I learned that through my reactions, whether “positive” or “negative,” I could become attuned to my clients’ experiences, which strengthened our therapeutic relationships (Eckberg, 2000). For example, my own feelings of sadness, rejection, and incompetence demonstrated an attunement to my clients’ feelings, as they simultaneously experienced similar emotions. This demonstrates our moments of parallel processing. However,

when my own feelings did not parallel those of my clients, I had the ability to recognize how my past traumatic experiences influenced my reactions to my clients. Through this increased awareness and understanding, I implemented strategies to ground myself, which enabled me to remain focused on the goals of the therapeutic work with my clients (Eckberg, 2000). These strategies included focusing on my breath, gradually deepening each inhale and exhale, and firmly planting my feet on the floor. I also consciously focused on what my clients were sharing with me and repeated what I heard in different words. Not only did this help in re-grounding myself, but also in validating my clients' feelings and encouraging them to delve even deeper into the topic.

Clinical Choices

While my past relational experience did contribute to stronger therapeutic relationships, higher levels of empathic capabilities, an expertise on domestic violence, and an ability to be a role model for my clients (Johnson et al., 2005), it also helped me to make more effective clinical choices. For example, I only utilized self-disclosure for purposes that benefitted my clients (Edwards & Murdock, 1994). I did not utilize self-disclosure in order to increase expertness, trustworthiness, or because the clients desired it (Edwards & Murdock, 1994). However, when I rarely decided to self-disclose my past emotionally abusive relationship to my clients, I chose to do so in order to increase our similarities and to provide a concrete demonstration that independence and healing was possible (Costin & Johnson, 2002; Edwards & Murdock, 1994).

The awareness of my countertransference helped me to understand when self-disclosure would be beneficial and when it would be detrimental to the therapeutic process. As I became aware of my own feelings regarding what my clients shared, I was able to think rationally about whether or not disclosure would benefit my clients or me. For example, when the mother yelled

at her daughter in our family session, I felt afraid and angry. I recognized that I felt that way because my ex-boyfriend made me feel afraid and embarrassed when he yelled at me. As I thought about my countertransference in that moment, I knew that disclosing my feelings and my history would not benefit this family because it would instead shift the focus toward myself. Rather than utilizing self-disclosure in that moment, I recognized my personal feelings and then asked the daughter how she felt. She shared her feelings of fear and sadness. I then shifted the focus toward the mother, who felt empathy regarding her daughter's feelings. The three of us explored new and effective approaches towards communicating strong emotions.

Costin and Johnson (2002) wrote that survivor-therapists might become narrow-minded in determining effective treatment approaches for their clients. This may occur because survivor-therapists know what specific strategies were effective for them. While this may be true, the exploration of my countertransference and the therapeutic movement relationship helped me to “put aside preconceptions of what the client should do, and instead, take the role of not knowing what is correct for a particular individual, letting the individual find his/her own solution” (Levy, 1988, p. 69). For example, there were many moments when I felt the urge to tell my clients to leave their abusers or to avoid jumping into new relationships. I knew that those strategies helped me to heal from my past emotionally abusive relationship; however, it was important for me to support my clients in finding their own solutions rather than telling them what to do.

Professional Development

The impact of my countertransference on my therapeutic relationships and clinical choices with my clients helped me to understand how I can continue to utilize my countertransference in the future. Epstein, Siegel, and Silberman (2008) described an informed clinical practice as “involving consciousness and intentionality to a present situation – including

the raw sensations, thoughts, and emotions as well as the interpretations, judgments, and heuristics that one applies to a particular situation” (p. 9). In other words and as demonstrated in the findings of this study, the awareness and understanding of my countertransference improved my therapeutic relationships and my clinical choices during the therapeutic process. Therefore, I can continue to provide effective therapy to my clients in the future by utilizing my sensations, feelings, thoughts, and emotions that are present through countertransference. This contributes to my development as a successful dance/movement therapist.

Limitations and the Unexpected

While this study provided evidence that my past emotionally abusive relationship was present within my work as an intern with survivors of domestic violence, it also came with some limitations and an unexpected finding. These limitations include data collection inconsistency and a lack of evidence of countertransference. As a suggestion for future studies, I would recommend incorporating clients in order to differentiate between countertransference and transference. Lastly, I did not expect that my Attention Deficit-Hyperactivity Disorder symptoms would be present within my findings.

Data collection inconsistency. Due to different client scheduling, I collected data at my internship site on Mondays and in my own home on Tuesdays and Wednesdays. This lack of uniformity was difficult for me, as I preferred to only collect data at my internship site. As a method of self-care, I strived to leave everything internship-related at my internship; by collecting data in my home, I felt forced to bring my internship into my personal and recuperative space. Additionally, I attended both class and internship on Tuesdays, which contributed to higher levels of exhaustion at the end of the day. During the first two weeks of the data collection process, I collected data at my desk in my bedroom immediately upon returning

home at 9:00 p.m. My roommate interrupted and checked in on me, as it was unusual for her to witness me immediately locking myself in my bedroom for an extended period of time upon returning home after a long day. When the third week came, I felt resentment towards data collection, as I was exhausted and wanted to recuperate. I took time to cook dinner and to watch television with my roommate in hopes that I would later feel refreshed enough to collect data. This proved more difficult and I noticed that I started collecting data in my living room while watching television. By week four, I collected Tuesday and Wednesday's data one day late, and by week five, I collected data two days late. Although I feel that my data still maintained validity, it would have been more beneficial and less stressful to complete it at my internship site each day.

Lack of evidence of countertransference. Although this was a self-study and I received validation from my research consultant and my resonance panel, I was unable to differentiate between moments of countertransference and transference. Rothschild (1998) explained that when therapists are aware of their own bodies, they are better able to differentiate their own personal feelings and the feelings that are mirrored from their clients' experiences. While this held true in my study, I remain curious as to whether or not some of my findings were actually moments of transference. I believe that if I had incorporated some of my clients as participants in this study, I would have been able to discern which data was related to my own personal experiences and which was mirrored from my clients' experiences.

Attention deficit-hyperactivity disorder: The unexpected. When I created this study, I never anticipated that my ADHD, predominantly inattentive presentation, would be among my findings. I was diagnosed at 12 years old and have since spent my life attempting to compensate for and hide my disorder through intense organization and clarity. This connects to my heavy

emphasis on normality within my work, as I tried to hide my disorder and appear ‘normal.’ (Rance et al., 2010). I discovered that my ADHD was presenting itself through somatic countertransference. Dosamantes-Beaudry (1997) explained that therapists might experience different somatic reactions and body sensations in response to their clients at “particular moment[s] during treatment” (p. 522). While maintaining organization and clarity helps to keep my ADHD symptoms under control, I found that I experienced the floating sensation whenever sessions felt unstructured or disorganized. Through working with my research consultant and my resonance panel, I learned that this floating sensation was an ADHD symptom. I often fail to recognize when my ADHD symptoms are present, as I am not fully present myself. By increasing my somatic awareness and my ability to reflect on somatic experiences, I have a stronger ability to recognize when my ADHD symptoms are present (Forester, 2007). Through this recognition, I have developed strategies in order to ground myself during the session, such as increasing my awareness of my own breath and my feet on the floor (Eckberg, 2000).

Summary

The purpose of this study was to discover how my countertransference influenced my therapeutic relationships, clinical choices, and professional development as a dance/movement therapy intern with survivors of domestic violence. During my research, significant insights were revealed in regard to how my past experiences and who I am as an individual influence my work as an emerging dance/movement therapist. I discovered how my countertransference was manifesting itself through my sensations, movement responses, images, feelings, and thoughts during my sessions. My increased awareness of these manifestations promoted stronger therapeutic relationships and clinical choices, because I remained attuned to my clients’ experiences, recognized moments of parallel processing, remained grounded when my feelings

did not match those of my clients, recognized the appropriate use of self-disclosure, and supported my clients in finding their own solutions. This knowledge of how my countertransference impacted my therapeutic relationships and clinical choices contributes to my professional development, as I now have an increased ability to utilize my countertransference in ways that will benefit the therapeutic process.

Although this study was unique to my individuality and my experiences as a survivor-therapist, I believe that my findings can be taken into consideration by other dance/movement therapists regardless of survivor-therapist identity or population. This study can be generalized and applied to the work of other dance/movement therapists because identifying factors such as gender, sexuality, age, religion, culture, ethnicity, education level, economic level, community, past experiences, and lifestyle all contribute to the various ways that therapists are able to relate and be in relationship to their clients. These similarities and/or differences that they may share with their clients are what elicit moments of countertransference. By utilizing this study as an opportunity for self-exploration, dance/movement therapists can increase their self-awareness, which can then promote stronger therapeutic relationships and more intentional clinical choices.

The insights that I gained from this study will be particularly useful in any future work I may have with survivors of domestic violence, as I learned how to utilize my survivor-therapist identity to strengthen my therapeutic relationships and the overall therapeutic process. However, these insights will also positively influence my work with any population, as my increased body awareness and self-reflection will enable me to more effectively work with my clients (Eckberg, 2000; Forester, 2007, Rothschild, 1998). New research questions that have emerged from this study for future inquiry include: What movement qualities are common for survivor-therapists of domestic violence and how can an increased awareness of these qualities promote the therapeutic

process? What movement qualities and/or patterns trigger survivor-therapists of domestic violence when engaging in the therapeutic movement relationship or the therapeutic process? What are the vicarious trauma symptoms of working with trauma survivors as a survivor-therapist? What movement qualities and/or movement patterns trigger ADHD symptoms when engaging in the therapeutic movement relationship or therapeutic process? How does the impact of ADHD symptoms inform the therapeutic process when the clinician is medicated?

This study proved to be an incredibly vulnerable and exposing experience; however, it provided tremendous insight into how I can utilize my past experiences to strengthen my work with my clients. This study also encouraged me to find more self-compassion in my survivor identity and curiosity in how I can utilize my uniqueness as an emerging dance/movement therapist.

References

- Ali, T. S., Mogren, I., & Krantz, G. (2011). Intimate partner violence and mental health effects: A population-based study among married women in Karachi, Pakistan. *International Journal of Behavioral Medicine, 20*(1), 131-139. doi:10.1007/s12529-011-9201-6
- American Dance Therapy Association (ADTA) (2009). What is dance/movement therapy? Retrieved from <http://www.adta.org/>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Amighi, J. K., Loman, S., Lewis, P., & Sossin, K. M. (1999). *The meaning of movement: Developmental and clinical perspectives of the kestenberg movement profile*. New York, NY: Routledge.
- Bartenieff, I. & Lewis, D. (1980). *Body movement: Coping with the environment*. New York, NY: Gordon and Breach Science Publishers
- Bernstein, B. (1995). Dancing beyond trauma: Women survivors of sexual abuse. In F. J. Levy, J. P. Fried & F. Leventhal (Eds.), *Dance and other expressive art therapies: When words are not enough* (pp. 41-58). New York, NY: Routledge.
- Breiding, M.J., Smith, S.G., Basile, K.C., Walters, M.L., Chen, J., & Merrick, M.T. (2014). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2014 Summary Report*. Atlanta GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Chaiklin, S. & Wengrower, H. (Eds.). (2009). *The art and science of dance/movement therapy: Life is dance*. New York, NY: Routledge.
- Chang, M.H. & Leventhal, F. (2008). Dance/movement therapy interventions in domestic

- violence: Still a paradigm in action. In S. Brooke (Ed.), *The creative therapies and domestic violence* (pp. 158-175). New York, NY: Charles Thomas.
- Costin, C. & Johnson, C.L. (2002). Been there, done that: Clinicians' use of personal recovery in the treatment of eating disorders. *Eating Disorders, 10*(4), 293-303.
doi:10.1080/10640260290081722
- Dosamantes-Beaudry, I. (1997). Somatic experience in psychoanalysis. *Psychoanalytic Psychology, 14*(4), 517-530.
- Dosamantes-Beaudry, I. (2007). Somatic transference and countertransference in psychoanalytic intersubjective dance/movement therapy. *American Journal of Dance Therapy, 29*(2), 73-89.
- Eckberg, M. (2000). *Victims of cruelty: Somatic psychotherapy in the treatment of PTSD*. Berkeley, CA: North Atlantic Books.
- Edwards, C. E., & Murdock, N. L. (1994). Characteristics of therapist self-disclosure in the counseling process. *Journal of Counseling & Development, 72*(4), 384-389.
doi:10.1002/j.1556-6676.1994.tb00954.x
- Epstein, R.M., Siegel, D.J., & Silberman J. (2008). Self-monitoring in clinical practice: a challenge for medical educators. *Journal of Continuing Education in the Health Profession, 28*(1), 5-13.
- Fargnoli, A. (2014). *Maintaining stability in the face of adversity: Self care practices of human trafficking survivor-trainers in India* (Master's thesis). Retrieved from http://digitalcommons.colum.edu/cgi/viewcontent.cgi?article=1046&context=theses_dmt
- Figley, C. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C.

- Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York, NY: Brunner/Mazel, Publishers.
- Figley, C. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B.H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3-28). Lutherville, MD: Sidran Press.
- Forester, C. (2007). Your own body of wisdom: Recognizing and working with somatic countertransference with dissociative and traumatized patients. *Body, Movement & Dance In Psychotherapy*, 2(2), 123. doi:10.1080/17432970701374510
- Freud, S. (1959). Future prospects of psychoanalytic psychotherapy. In J. Strachey (Ed., Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 139-151). London: Hogarth Press. (Original work published 1910).
- Gelso, C. (2013). A tripartite model of the therapeutic relationship: Theory, research, and practice. *Psychotherapy Research*, 24(2), 117-131. doi:10.1080/10503307.2013.845920
- Gelso, C. J., & Carter, J. A. (1985). The real relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist*, 13, 155–244. doi:10.1177/0011000085132001
- Gentry, J. (2002). Compassion fatigue. *Journal of Trauma Practice*, 1(3-4), 37-61. Retrieved from <http://ehis.ebscohost.com.emils.lib.colum.edu>
- Golding, J.M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*, 14(2), 99-132. doi:10.1023/A:1022079418229
- Hackney, P. (2002). *Making connections: Total body integration through bartenieff fundamentals*. Routledge, New York, NY.
- Halket, M. M., Gormley, K., Mello, N., Rosenthal, L., & Mirkin, M. P. (2014). Stay with or

- leave the abuser? The effects of domestic violence victim's decision on attributions made by young adults. *Journal of Family Violence*, 29(1), 35-49. doi:10.1007/s10896-013-9555-4
- Herman, J. L. (1992). *Trauma and recovery*. New York, NY: HarperCollins.
- Hervey, L. (2004). Artistic inquiry in dance/movement therapy. In R. Cruz & C. Berrol (Eds.), *Dance/movement therapists in action* (pp. 181-205). Springfield, IL: Charles C. Thomas.
- Howard, L. M., Trevillion, K., & Agnew-Davies, R. (2010, October). Domestic violence and mental health. *International Review of Psychiatry*, 22(5), 525-534.
doi:10.3109/09540261.2010.512283
- Hughes, M.J., & Jones, L. (2000). Women, domestic violence, and posttraumatic stress disorder (PTSD). *Family Therapy*, 27(3), 125-139.
- Hughes, P., & Kerr, I. (2000). Transference and countertransference in communication between doctor and patient. *Advances in Psychiatric Treatment*, 6(1), 57-64.
doi:10.1192/apt.6.1.57
- Humphreys, J., & Lee, K. (2005). Sleep disturbance in battered women living in transitional housing. *Issues in Mental health Nursing*, 26(7), 771-780.
doi:10.1080/01612840591008401
- Johnston, C., Smethurst, N., & Gowers, S. (2005). Should people with a history of an eating disorder work as eating disorder therapists? *European Eating Disorders Review*, 13, 301-310.
- Jordan, J. V. (2010). *Relational-cultural therapy*. Washington, DC: American Psychological Association
- Levy, F.J. (1988). *Dance movement therapy: A healing art*. Reston, VA: American Alliance for

Health, Physical Education, Recreation and Dance.

- Lewis, P. (1984). The somatic countertransference: The inner pas de deux. In P. Lewis (Ed.), *Theoretical approaches in dance-movement therapy* (Vol. II) (pp. 181-192). Dubuque, IA: Kendall/Hunt.
- Little, M. I. (1981). *Transference neurosis and transference psychosis*. New York, NY: J. Aronson.
- McCann, L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*. 3(1), 131-149.
- McEaney, A. (2007). Envy in body transference and counter-transference: Female treatment, patients with eating disorders. In L. Navaro & S. L. Schwartzberg (Eds.), *Envy, competition and gender—Theory, clinical applications and group work* (pp. 155–182). London, UK: Routledge.
- Miller, J. B. (1976). *Toward a new psychology of women*. Boston, MA: Beacon Press.
- Miller, D., & Guidry, L. (2001). *Addictions and trauma recovery: Healing the mind, body, and spirit*. New York, NY: W.W. Norton.
- Moore, C.A. (2006). Dance movement therapy in the light of trauma. Research findings of a multidisciplinary project. In S. C. Koch & I. Brauninger (Ed.) *Advances in dance/movement therapy. Theoretical perspectives and empirical findings*. (pp. 104-115). Berlin, Germany: Logos Verlag Berlin.
- Moore, C., & Yamamoto, K. (2012). *Beyond words: Movement observation and analysis*. New York, NY: Routledge.
- Moore, C.L. (2014). *Meaning in motion: Introducing laban movement analysis*. Denver, CO:

MoveScape Center

Moss, J. M., Gibson, D. M., & Dollarhide, C. T. (2014). Professional identity development: A grounded theory of transformational tasks of counselors. *Journal of Counseling & Development, 92*, 3-12. Doi: 10.1002/j.1556-6676.2014.00124.x

Moustakas, C. E., (1990). *Heuristic Research: Design, methodology, and applications*. Sage Publications, Inc. Newberry Park, CA.

National Coalition Against Domestic Violence. (n.d.). *Statistics*. Retrieved from <http://www.ncadv.org/learn/statistics>

National Domestic Violence Hotline. (n.d.). *Abuse Defined*. Retrieved from <http://www.thehotline.org/is-this-abuse/abuse-defined/>

Natterson, J. M. (1991). *Beyond countertransference: The therapist's subjectivity in the therapeutic process*. Northvale, New Jersey: J. Aronson.

Oliver, C. (2014). The fundamentals of strengths-based practice. *Child & Youth Care Practice, 27*(3), 46-50.

Pearlman, L.A., & Saakvitne, K.W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York, NY: Norton.

Rance, N. M., Moller, N. P., & Douglas, B. A. (2010). Eating disorder counselors with eating disorder histories: A story of being 'normal'. *Eating Disorders, 18*(5), 377-392.
doi:10.1080/10640266.2010.511901

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: W. W. Norton.

Schore, A. N. (2003). *Affect regulation and the repair of the self*. New York, NY: W. W. Norton.

- Seligman, L., & Reichenberg, L. (2012). *Selecting effective treatments: A comprehensive, systematic guide to treating mental disorders*. Hoboken, NJ: John Wiley & Sons.
- Siegel, D.J. (2003). An interpersonal neurobiology of psychotherapy: The developing mind and the resolution of trauma. In M.F. Solomon & D.J. Siegel (Eds.), *Healing trauma: Attachment, mind, body, and brain* (pp. 1-56). New York, NY: W.W. Norton.
- Valentine, G. (2007). Dance/movement therapy with women survivors of sexual abuse. In S.L. Brooke (Ed.) *The use of creative therapies with sexual abuse survivors*. (pp.181-195). Springfield, IL: Charles C. Thomas
- van der Kolk, B.A. (2002). Beyond the talking cure: Somatic experience and subcortical imprints in the treatment of trauma. In F. Shapiro (Ed.), *EDMR: Promises for a paradigm shift* (pp. 57-83). New York, NY: APA Press.
- van der Kolk, B.A. (2003). Posttraumatic stress disorder and the nature of trauma. In M.F. Solomon & D.J. Siegel (Eds.), *Healing trauma: Attachment, mind, body, and brain* (pp. 168-195). New York, NY: W.W. Norton.
- van der Kolk, B.A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Penguin Books.
- van der Kolk, B.A., & Fisler, R. E. (1995). Dissociation and the fragmentary nature of traumatic memories. Overview and exploratory study. *Journal of Traumatic Stress*, 8, 505-525
- Vulcan, M (2013). Crossing the somatic-semiotic divide: The troubled question of dance/movement therapists (DMTs) professional identity: *The Arts in Psychotherapy*, 40, 6-9
- Young, J. (2016). *The therapeutic movement relationship in dance/movement therapy: A*

phenomenological study (in progress). Department of Creative Arts Therapy, Columbia College Chicago, IL.

Zerbe, K. (2008). *Integrated treatment of eating disorders- Beyond the body betrayed*. New York, NY: W. W. Norton & Company.

Appendix A

Definition of Terms

Bipolar Shape Flow

Bipolar shape flow “refers specifically to symmetrical expansions and contractions [of the body]... because the changes are symmetrical, bipolar shape flow encourages stability and an internal sense of balance” (Amighi et al., 1999, p. 111).

Biting Rhythm

The biting rhythm occurs during the second half of the first year of life. This rhythm is characterized by tapping while shortly holding before transitioning; this rhythm is used in chewing and grinding food. The biting rhythm encourages self-definition, body boundaries, and differentiation between self and other (Amighi et al., 1999).

Body

The Body is one of the four elements of Laban Movement Analysis (LMA). Hackney (2002) stated that understanding within the Body category is informed by these questions: “How is the whole body organized/connected?” “What is consistently maintained in the body?” “Which body parts are moving?” “Where in the body does movement initiate?” “How does movement spread through the body?” (p. 218).

Body Knowledge

Body knowledge is “an understanding of movement behavior” (Moore & Yamamoto, 2012, p. 50). Body knowledge describes how our physical experiences enable us to discern and understand the movements we witness. (Moore & Yamamoto, 2012).

Body Prejudice

Similar to body knowledge, body prejudice originates from our ability to discern and understand the movements we observe. As a result of our personal experiences, we are able to categorize and generalize different movements. Over time, we begin to associate certain types of movements with positive or negative meanings (Moore & Yamamoto, 2012).

Convex Changes

A convex change means that the movement is being carved with an outward curve. Amighi et al. (1999) wrote that the “three-dimensional concave and convex shapes which our movements sculpt in space serve our rapport and manner of connecting and relating to others, whom we represent internally in multidimensional ways” (p. 283).

Countertransference

Countertransference is the therapist’s conscious and unconscious emotions or attitudes about the client that may occur as a result of the therapist’s history and lived experiences (Figley, 1995, 1999; Herman, 1992).

Dance/Movement Therapy (DMT)

Dance/Movement Therapy (DMT) is “the psychotherapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual” (ADTA, 2009).

Directing

Directing is the fighting quality of the space factor within the Effort element of Laban Movement Analysis. Directing is described as straight-forward, single-focused, and pinpointing (Moore, 2014).

Domestic Violence

Domestic violence is the deliberate intimidation, manipulation, physical assault, sexual assault, emotional abuse, and/or psychological abuse that is perpetrated by one romantic partner

against another. The main and constant element is one partner's consistent determination to maintain and exert power and control over the other (National Domestic Violence Hotline, n.d.).

Effort

Effort is one of the four elements of the Laban Movement Analysis (LMA) taxonomy, which consists of four basic motion factors: Flow, Weight, Time, and Space. These four factors are defined by two polar elements. For example, Flow can be Free or Bound, Weight can be Light or Strong, Time can be Sustained or Sudden, and Space can be Indirect or Direct (Hackney, 2002).

Fighting Tension Flow Rhythm (TFR)

Fighting TFRs are “based on rhythms which are more aggressive and differentiating” (Amighi et al., 1999, p. 26). Fighting TFRs include snapping/biting, strain/release, starting/stopping, surging/birthing, and spurting/ramming.

Grounded

According to Hackney (2002), “to say a person is ‘grounded’ implies that that person has a stable sense of him/herself. This presence of self requires an embodied relationship to the earth” (p. 41). This embodied relationship occurs through yielding weight into the earth while simultaneously feeling a sense of support from the earth (Hackney, 2002).

Horizontal Axis/Horizontal Dimension

Movement within the horizontal dimension changes as a result of widening and narrowing through the body. Movements that occur in the horizontal dimension are associated with attention, exploration, and communication (Amighi et al., 1999).

Increasing Pressure

Increasing pressure is the fighting quality of the weight factor in the Effort element of Laban Movement Analysis. Increasing pressure is described as strong, firm, and forceful (Moore, 2014).

Indulging Tension Flow Rhythm (TFR)

Indulging TFRs have an “indulging, accommodating, mobilizing quality” (Amighi et al., 1999, p. 26). The indulging TFRs include sucking, twisting, running/drifted, swaying, and jumping.

Kestenberg Movement Profile (KMP)

The Kestenberg Movement Profile (KMP) is a comprehensive movement analysis system for identifying psychological, developmental, emotional, and cognitive patterns through movement observation, notation, and interpretation (Amighi et al., 1999). Amighi et al. (1999) wrote, KMP “amended Laban’s description of efforts into four distinct movement clusters: tension flow rhythms (which reflect unconscious needs), tension flow attributes (which reflect temperament and affects), pre-efforts (which reflect immature ways of coping, often used in learning and defensive behaviors), and efforts (used in coping with space, weight, and time elements)” (Amighi et al., 1999, p. 3). KMP is organized through diagrams of system 1 and system 2. System 1 is organized to reflect the developmental progression of space, weight, and time during the first three years of life; the diagram contains tension flow attributes (feelings), pre-efforts, and efforts. System 2 is organized to reflect the movement of the body in space and the shapes that the body creates. These movement qualities reflect the “relationship of the mover to self and to others” (Amighi et al., 1999, p. 110); the diagram contains bipolar shape flow (self-feelings), unipolar shape flow (attraction-repulsion), shaping in directions, and shaping in planes.

Laban Movement Analysis (LMA)

LMA is a method and language for describing and analyzing human movement, according to the elements of: Body, Effort, Shape, and Space (Hackney, 2002). It is in the phrasing of these elements, or how they are combined and patterned, that individuals are able to express themselves and form relationships.

Low Intensity Narrowing & Hollowing

Low intensity narrowing and hollowing is a combination of low intensity tension flow and narrowing and hollowing within the bipolar shape flow category of the Kestenberg Movement Profile. Low intensity is characterized by a gentleness/lightness (Amighi et al., 1999). This approach may represent the defensive element of caution (fear of getting into something too deeply or bringing up deep feelings) (Amighi et al., 1999). Shrinking movements, such as narrowing and hollowing, “tend to create closed shapes which reduce exposure of the body to outside contact” (Amighi et al., 1999, p. 113).

Near-reach space

Near-reach space is the area that is closest to the mover’s body. Moore (2014) explained that “Actions in near reach space can involve self-touch and other gestures performed with flexed limbs” (p. 96).

Professional Development

Professional development is the idea that counselors are continuously growing and developing throughout their entire careers. It is “the integration of the professional self and personal self (including values, theories, and techniques). Personal attributes combine with professional training as a counselor forms his or her own professional identity” (Moss, Gibson, & Dollarhide, 2014, p. 3).

Rhythm

“Rhythm can be perceived in many ways. It can be visible and/or audible, and can be observed in the accents of changing body tensions – all of which are interrelated” (Bartenieff & Lewis, 1980, p. 71). Laban considered rhythms to be based on exertion and recuperation, as changes within movement produce different rhythmic patterns (Bartenieff & Lewis, 1980).

Rigidity

Rigidity is stiffness within the body or body parts while moving.

Sequential Sequencing

Sequential sequencing can be described as “a sequence of movement of non-adjacent body parts within one phrase: head, leg, and arm move-one immediately after the other” (Hackney, 2002, p. 219).

Shape Flow

Shape flow demonstrates how breath underlies the movement patterns (Amighi et al., 1999, p. 110). For example, growing in shape flow, or inhalation, creates open shapes that may coincide with feelings of comfort. On the contrary, shrinking in shape flow, or exhalation, creates closed shapes that may be linked to feelings of discomfort (Amighi et al., 1999).

Shrinking Phase of Bipolarity

Shrinking creates closed shapes that may be associated with discomfort. Bipolar shape flow relates to self-feelings; therefore, the shrinking phase of bipolarity can be correlated with discomfort with the self (Amighi et al., 1999).

Somatic Awareness/Body Awareness

Somatic awareness can be thought of as “occurring on a continuum, from pure sensation (breath, heart-rate, tension/relaxation, hunger, pain, movement, posture, temperature, tingles, numbness, sleepiness, alertness, and so forth), to sensory experiences that are affectively or

cognitively involved such as a melting sensation around the heart with emotional warmth, an urge to kick with anger, a sense of protective strength in the arms, a sense of tenderly holding a patient, or of holding them at bay, or of being spat out” (Forester, 2007, p. 127).

Somatic Countertransference

Somatic countertransference consists of the somatic reactions and body sensations that the therapist experiences in response to the client at specific moments during the therapeutic process (Dosamantes-Beaudry, 1997).

Space

Space is one of the four elements of Laban Movement Analysis (LMA). An individual’s use of Space provides information about his or her personal movement sphere (Kinesphere). Some questions that Hackney (2002) provided regarding Space are: “How large is the mover’s Kinesphere and how is it approached/revealed? Where is the movement going?” (Hackney, 2002, p. 223).

Tension Flow Rhythms (TFRs)

Tension Flow Rhythms (TFRs) are discernible movement patterns that occur as a result of alterations in muscle tension (Amighi et al., 1999). Specific TFRs originate from discrete biological zones and are “adaptively associated with specific biological functions” (Amighi et al., 1999, p. 24). Although the TFRs reflect different stages of development, they remain present in all children and adults (Amighi et al., 1999).

Therapeutic Relationship

The therapeutic relationship consists of the feelings and attitudes that the therapist and client have toward each other and how they are expressed (Gelso & Carter, 1985). Although

therapists are taught different theories and roles, they are constantly interacting with the relational aspect of a counseling practice (Gelso, 2013).

Trauma

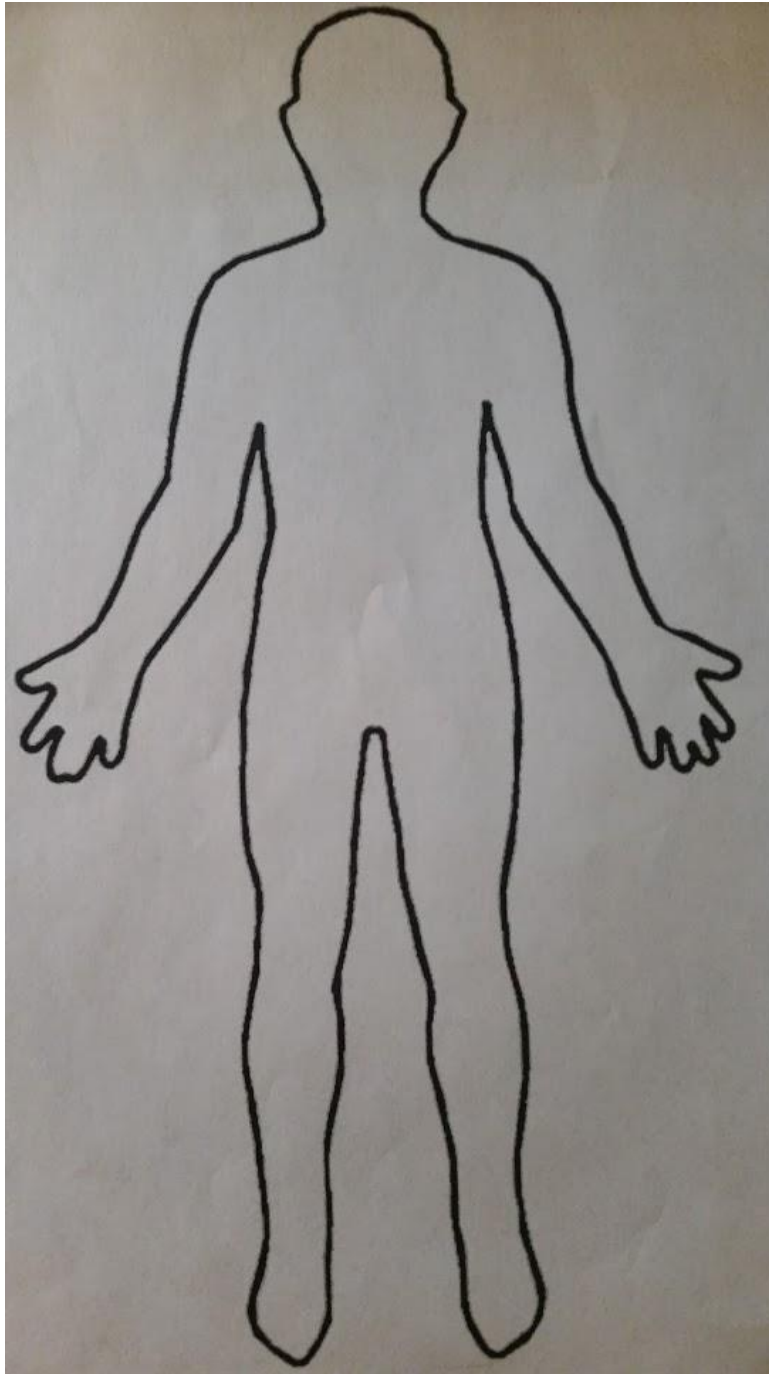
Trauma occurs when a person experiences or witnesses a traumatic event, which may involve actual or threatened death, intense fear, horror, or helplessness (Herman, 1992; Rothschild, 2000). Trauma is a psychophysical experience, as it impacts both the body and the mind (Rothschild, 2000).

Vertical Dimension/Posture

The vertical dimension changes as a result of lengthening and shortening along the spine. Movements that occur within the vertical dimension are associated with intentionality, presentation, evaluation, and confrontation (Amighi et al., 1999).

Appendix B

Data Collection Tool



Appendix C

Performance of Findings

https://youtu.be/uXaz94y5_Ug

Appendix D

Contract Agreement with Research Consultant

RESEARCH CONSULTANT AGREEMENT

This agreement is made between researcher, Donna DeCotiis, and research consultant, _____, for the following services beginning on Effective Date.

Services. Beginning on Effective Date, and remaining in effect for the duration of this Agreement, the research consultant shall provide DeCotiis with the following services, without limitation.

Research consultant will facilitate 5 weeks of authentic movement sessions for the researcher while considering a theme that was present in the data collected over the previous week. Specific mutually agreed upon session dates will be determined. Research consultant will be responsible for viewing and discussing each journal entry from the previous week, facilitating authentic movement sessions while considering a prominent theme within the data, and participating in a discussion with the researcher regarding observations made. Researcher will audio record the sessions. Researcher will later share the results chapter of her thesis for feedback from the research consultant in order to maintain validity after the sessions have concluded.

Compensation. The work performed by the research consultant shall be performed at a flat rate fee that is a mutually agreed upon amount.

Signature of Researcher

Date.....

Signature of Research Consultant

Date

Appendix E

Resonance Panel Letter Adapted from Moustakas (1990)

Date_____

Dear_____,

Thank you for your interest in my research on the impact of my countertransference on my work as a dance/movement therapy and counseling intern. I value the unique contribution that you can make to my study and am excited about the possibility of your participation in it. The purpose of this letter is to reiterate the objectives for our consultation together.

We will meet on Friday, April 29th at 7:00pm at resonance panel member's dance/movement therapy office address. The research methodology that I am using is a heuristic inquiry and I am including a resonance panel as one of my validation strategies. Through interacting with members on my resonance panel, I hope to illuminate or more fully answer my question: How does my countertransference influence my therapeutic relationships, clinical choices, and professional development as a dance/movement therapy and counseling intern with survivors of domestic violence?

Through your participation as a resonance panel member, I hope to clarify and validate my preliminary findings. I value your participation and thank you for your commitment of time, energy, and effort. If you have any further questions or if there is a problem with the date and time of our meeting, I can be reached at email address (phone number).

Sincerely,
Donna M. DeCotiis