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LEARNING TO RELATE: A HEURISTIC INQUIRY EXPLORING THE DEVELOPMENT OF THERAPEUTIC RELATIONSHIPS

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in

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Abstract

This heuristic inquiry explored the creation of therapeutic relationships. The intention of this research was to learn how to build therapeutic relationships with clients that I felt uncomfortable around, with whom I did not have much experience and whom I did not want to relate to due my personal prejudices around severe illnesses and extreme developmental and cognitive delays. This study was important not only to expand my knowledge and experiences working with these populations but to also inform my future clinical experiences with new clients as I embark on my professional career. I collected data through reflective journaling and movement responses about the therapeutic relationship after conducting dance/movement therapy sessions. I was able to concretize why I was drawn to certain relationships more than others, the positives and negatives about each relationship, and how to improve my ability to forge therapeutic relationships. I presented my findings and an evolved understanding of the research topic through a public performance. A review of the literature includes the role of nonverbal communication in developing the therapeutic relationship as well as consideration towards external factors, countertransference, and counselor development all contributed my research process. As a result, I have a greater understanding of how to approach therapeutic relationships, individuation, and accept physically and cognitively slower moving clients and relationships that are slow to develop.

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Chapter One: Introduction

Upon beginning my clinical internship at a therapeutic day school working with severely and profoundly disabled children, I was challenged by the population. I had rarely encountered anyone with such extreme developmental and cognitive delays, in addition to physical impairments, in my everyday life, much less in a therapeutic setting. I found that my studies and preliminary research had not equipped me to work with the population at my internship site. Though I had lectures and readings on individuals with cognitive delays, the dance/movement therapy I had been taught to conduct during my graduate school career had been practiced with my "normal" functioning adult peers, who have access to all of their capacities.

The purpose of my research was to explore the development of therapeutic relationships with clients whom I find challenging to relate to or initially made me feel uncomfortable. Due to the questions being about myself as a researcher and clinician it was logical to explore them through a heuristic study. Most of my initial discomfort in working with this population stemmed from my uncertainty as to how to approach the students, much less conduct dance/movement therapy with those who cannot physically move, hear me, or even respond. Every student came with multiple disabilities, however each disability presented differently from the next. For example, two students may be cognitively delayed, vision impaired, and developmentally delayed. However, one student was independently mobile with no verbal communication or vision capabilities, while the other was wheelchair bound and relied on the assistance of others to move their limbs, but could communicate through vocal sounds and subtleties in their affect. These differences are important because it altered the way I approached each therapeutic relationship and the unique manner in which I interacted with each student.

I was tasked with the challenge of adapting the neophyte knowledge I had gained to fit the clinical needs of the population at this adaptive elementary school. I felt uncomfortable, because I had no experience with children, aged four to ten years old, who were functioning at a developmental age of three months to six years. In addition to the developmental delay, almost all students were wheelchair bound with visual, speech, and hearing impairments. Most were completely nonverbal and many had dysfunctional limbs, impairing their ability to move independently. During our dance/movement therapy sessions, the children were lifted out of their wheelchairs and were placed in other assistive devices or on soft mats on the floor. Once removed from their wheelchairs, the children's bodies required support. This dictated much of the movement we were able to do, as they remained laying down, leaned against a foam support or myself. Much of my discomfort stemmed from not knowing how to conduct dance/movement therapy with a child who relied heavily on my physical support as I felt this limited the movement we would be able to do. Facing the challenge of adapting and expanding my knowledge early on, in addition to the added level of intimacy required of me to engage in this way, made me nervous. I frequently found myself hesitating to try new interventions. I did not want to hurt these fragile children and did not know how to communicate with them. The purpose of this study was to gain a wider understanding of how to work, relate, and engage with populations such as these and my hope was that this study would help me to better understand how unique each client's therapy will look.

At my first clinical placement, an adult inpatient psychiatric unit, I was blessed to have a dance/movement therapist as my site supervisor to guide me in times of uncertainty, to process difficult sessions or clients, and with whom I could collaborate. Conversely, I did not have a dance/movement therapist supervisor at my internship site to learn from or share ideas with,

which would have been valuable as I was not used to the functioning level of the students. Little research had been done regarding dance/movement therapy in a therapeutic school setting with the severely and profoundly disabled population with whom I was working. Based on the ability of the population I knew there would be little to no movement occurring during sessions and absolutely no possibility of verbal processing. Not only did this mean I needed to adapt my approach as an emerging dance/movement therapist, but I also needed to change my understanding of what constituted as dance/movement therapy.

Working in relationship with these clients was challenging for me. The relationships did not develop with ease; it felt like our connections were forced in an abnormal manner. I felt that to do the work of a dance/movement therapist I had to engage with the students physically, mentally or emotionally. Without feedback from the students, I felt that I was manipulating their bodies and working with them in a way that was not received well by the students or myself. To feel more comfortable working in this type of relationship, I focused on observing my approach to the *therapeutic relationship*, attending to the client's *nonverbal communication,* and noticing moments of *countertransference* (see Appendix A).

In addition to my initial internship site at the adaptive elementary school, I took on the challenge of adding a second internship on an adult inpatient psychiatric unit. Though the populations at each site were vastly different, I noticed commonalities in my approach towards establishing therapeutic relationships with the clients. I found I was having difficulty relating and creating therapeutic relationships in both settings. On the adult inpatient psychiatric unit, I found myself uncomfortable with patients who were aggressive, had a history of acting out towards female staff, made it a point to acknowledge my neophyte status as a dance/therapist, and were unclean and disheveled. These challenging patients made me nervous when they came

to the dance/movement therapy groups I conducted on the unit, as I was afraid they would derail my process and potentially interfere with how the group was run. I found that grounding myself in the theory and structure of how I conducted groups eased some of my initial discomfort and nervousness.

While initiating these therapeutic relationships I began to notice my theoretical preferences in dance/movement therapy, as well as traditional talk therapy. In my dance/movement therapy work I prefer the Chacian approach (Sandel, Chaiklin, & Lohn, 1993). The structure of a Chacian group consists of the therapist inviting the clients into a circle formation for a body-part warm up. Then, the therapist picks up on movements expressed by the clients and expands on themes or creates more expansive movement ideas, which guide the interventions. Lastly, the therapist will wrap up the session with a cool down and conclude the group through verbal processing (Sandel, Chaiklin, & Lohn, 1993). This structure gives an organization to my sessions; the inpatient psychiatric patients benefitted from the directness and focus that it brings to the groups. In my individual work at the adaptive elementary school I found myself structuring the session in a similar fashion. Despite the limitations of the students, I was able to incorporate a warm up, elaborate on movement moments I picked up from the client, progress into theme development, implement interventions throughout, and close the movement after a theme emerged, although no verbal processing was able to take place.

Additionally, I often found myself working from a cognitive-behavioral theory (CBT) framework. This worked well on the inpatient psychiatric unit, however it was unproductive at the school. I much prefer thinking and talking through situations and obstacles to problem solve, rather than allowing for my body and intuition to lead the session. While working with the students at the school I found that thinking through problems did not advance our work; I had to

tune into my body and theirs. Many of my clients on the inpatient psychiatric unit view the purpose of therapy as changing their thought processes and behaviors, a value that is in line with the CBT framework. This was comforting, but did not challenge me as a dance/movement therapist. It also did not challenge the clients to view their approach to therapy in another manner. This was a growing edge for me as I navigate becoming a dance/movement therapist, due to the body-based nature of our work. I find that often in sessions I remind myself to drop into my body, to notice what is happening on a body level, and allow it guide the session.

Recognizing that I needed to rely exclusively on nonverbal communication in the therapeutic day school forced me to explore entering the therapeutic relationship in ways I had not before. I, too, was curious about how my feelings of countertransference would impact the relationships and how I might be unintentionally nonverbally communicating these feelings. I felt compelled to explore literature on the topics of nonverbal approaches to creating a therapeutic relationship, outside factors that may influence the relationship, countertransference, and other counselor traits that play a role in the therapeutic relationship.

Chapter Two: Literature Review

Introduction

Many can relate to being in a relationship where you disagree on a moral level, which can feel awkward or unsafe, or when someone in the relationship is unsure of what to say. Most people are able to walk away from uncomfortable situations such as these, but what about therapists? It is the job of the therapist to be open and inviting, to withstand relationships that we may never choose to be in outside of the therapeutic setting. There is an abundance of literature available on therapeutic relationships; this review will narrow the scope to look specifically at how to create or mend therapeutic relationships that may not come naturally. This literature review addresses strategies to manage these difficult feelings and navigate these challenging relationships in order to foster effective therapeutic relationships with greater ease and comfort

Naidu and Behari (2010) found the therapeutic relationship to be a central element and key strategy to success in therapy. Psychotherapy research (Bowlby, 2005; Farber, 2006; Naidu & Behari, 2010; Prasko et al., 2010; Ray, 2007; Reese, 2011; Reidbord, 2010; Roaten, 2011; Siegel, 2012; Sultanoff, 2013; Tortora, 2006; Tortora, 2010; Wylie & Turner, 2010) highlights three common themes regarding influences on therapeutic relationships: non-verbal communication, varying approaches to building relationships, and the importance of outside factors on relationships. Baker (2009) stated, “Early struggles [in a therapeutic relationship] could be a bad prognostication, but therapists could also turn these struggles into transformative experiences for their patients, depending on how they negotiate them". This literature review closely examines how one can improve a difficult therapeutic relationship and transform it into a valuable experience that can be therapeutic for both the client and therapist. It begins with a

description of nonverbal communication, highlighting specific strategies for creating therapeutic relationships; followed by a discussion of external factors that affect these relationships, such as support systems and counselor traits; countertransference and somatic countertransference; and finally, the role of the therapist's development and somatic identity in creating a therapeutic relationship.

Nonverbal Communication in Therapeutic Relationships

The therapeutic relationship can be defined as an expressive, communicative, and adaptive way in which to connect with others that serves to focus on movement as the relationship emerges (American Dance Therapy Association, 2016). Therapeutic relationships can be improved through creating a secure attachment with the client. Bowlby (2005) defined secure attachment as an emotional bond one individual forms with another, be it child to caregiver or client to therapist. This bond is largely formed through nonverbal communication in psychotherapy (Tortora, 2006).

Nonverbal communication is comprised of postures, gestures and facial expressions, and may also include nonverbal aspects of speech (accent, tone of voice, speed, etc.) (Nonverbal-communication, n.d.). Gestures can be defined generally as the movement of a body part or combination of parts with an emphasis on expressivity (Bartenieff & Lewis, 1980). Gestural body actions can be exemplified by the flinging of one's hands, nodding one's head, or shrugging one's shoulders to communicate uncertainty (Tortora, 2006). Postures, where the whole body is used for expression, can be portrayed through the body by stepping backwards, shifting the torso from one side to the other, or leaning forward to communicate uncertainty or

one's inner feelings (Tortora, 2006). While these forms are another way for many us to communicate, for some it is their only way to communicate.

It is important to take into consideration that, as humans, we are always communicating non-verbally; the premise of dance/movement therapy (DMT) is based upon and values the use of non-verbal communication. Dance/movement therapists utilize nonverbal communication by attuning kinesthetically to the client, thus helping the client feel seen, supporting the client's emotional regulation, creating a safe space in which to connect with one another, and understanding individual differences (Betty, 2013; Ramseyer & Tschacher, 2011; Roaten, 2011; Tortora, 2011).

Meaning making from nonverbal communication is a large component of dance/movement therapy. While attending to the nonverbal communications from the client and the nonverbal aspects of the relationship, it is crucial to be cognizant of one's personal body knowledge and body prejudice to extract personal meaning and reality test or validate its meaning with the client. Moore and Yamamoto (2012) defined body knowledge as developing an understanding of our personal movement behavior through processes of categorizing, abstracting and generalizing based on our own experiences in the world. Body prejudice was differentiated from body knowledge when Moore and Yamamoto (2012) described body prejudice as attaching a positive or negative meaning to a certain type of movement based on our experiences in the world.

Charles Darwin (1872) examined nonverbal movement behavior from a biological and evolutionary standpoint. Darwin viewed deciphering movement to be something that is an innate quality, established from the time of birth (Darwin, 1872). Examples of these innate qualities are

blushing from shame as our skin fills with blood or our heart rate increases with anger; these are actions that are not learned, but innate and biological (Darwin, 1872). Similarly, he believed that facial expressions were universal - something one does not need to think about, reflect on, or decipher – humans innately know how to express them and what they imply (Darwin, 1872). Initially, anthropologist Ray Birdwhistell (1970) agreed with Darwin. Birdwhistell's initial studies led him to the creation of Kinesics – the process of how one interprets bodily movements such as facial expressions, gesture, and nonverbal behaviors as they relate to movement; however, his views shifted when he began studying smiling and culture-specific movement (Birdwhistell, 1970). Birdwhistell believed the meaning of movement is culture-specific. Thus, actions that mean one thing in the United States could have an entirely different meaning in Italy or China (Birdwhistell, 1970). Moore and Yamamoto (2012) wrote that the same holds true for preferences for personal space. It is imperative to note that Americans tend to prefer a larger area of space around them; while in Middle Eastern and Asian cultures personal space is much smaller (Moore & Yamamoto, 2012). It is evident that, because it is significant in finding meaning in movement, therapists take culture into account while in relationship with others (Moore & Yamamoto, 2012). Caldwell (2013) noted similarities in human universality of movement; she found that movement empathy makes it easy for clinicians to make meaning out of movement from others. However, movement clinicians must constantly be aware of their own (and of those they are observing) biases, culture, race, gender identity, orientation, ability, and power dynamics (Caldwell, 2013).

Though therapists may gather movement data based around their own personal and cultural beliefs, it is imperative to have a conversation about their movement observations with the client to ensure its validity. Gathering data in this way will not only help to ensure accuracy,

but allow for open discussions with the client which may lead to a deepening of the therapeutic relationship. Nonverbal communication can take many forms, but includes mirroring and kinesthetic attunement. Tortora, (2009) differentiates mirroring from kinesthetic attunement. She described mirroring as creating a mirror image of the client or mover (Tortora, 2009). It is embodied by creating the clients' exact shape or by the therapist taking on their movement qualities (Tortora, 2009). Attunement is regarded as matching to one's particular movement quality rather than to their exact shape or embodying them simultaneously (Tortora, 2009).

Suzi Tortora is a recognized dance/movement therapist, nonverbal movement analyst, and authority in the field of infancy mental health and development, who stated that kinesthetic attunement occurs when the client is able to feel seen or acknowledged through mirroring by the therapist (Tortora, 2009). One of the main principles of Tortora's work is the concept of the client's need to feel seen (Tortora, 2006). Tortora (2006) described the need to be seen as an individual's need to be acknowledged, understood, and cherished for their unique qualities and truth. This concept is encompassed through techniques in dance/movement therapy such as mirroring, kinesthetic attunement, and a more subliminal intrinsic state involving mirror neurons in the brain. A study on nonverbal synchrony conducted by Ramseyer and Tschacher (2011) concluded:

> The visual perception of another's motor actions leads to neuronal changes in the perceiver (neuronal resonance), which can in turn influence the perceiver's actions. Nonverbal synchrony may thus play its role as a subtle and an evolutionary-based signal that embodies important information about the compatibility of a social interaction partner. (p. 22)

It can be concluded that in a therapeutic relationship feeling seen on a neuronal level may be a significant source of information for the therapist.

From a neurobiology perspective, mirroring takes place through the work of the mirror neurons. Mirror neurons are cells in the brain that contain both motor and perceptual capacities that fire when the mover and the observer perform and perceive an action or movement done with intention or purpose (Siegel, 2012). This process occurs and is learned from experience as well as repeated movements; due to the spontaneous effect, the process of mirror neurons does not require intentional thought to initiate, similar to a reflex (Siegel, 2012). This movement performed by one individual can then be automatically mirrored back by the other individual. Berrol (2006) noted that what underlies the capacity for an individual's ability to empathically relate socially, cognitively, emotionally, or kinesthetically is due to mirror neurons firing. This process occurs continuously in dance/movement therapy, as there is a constant interplay of attunement to one another.

Nonverbal communication can support emotion regulation and can assist in creating a safe space to form a therapeutic relationship (Betty, 2013). Betty (2013), a dance/movement therapist studying the development of emotion regulation in maltreated children, found that if the therapist attunes to another's internal states and creates opportunities for learning and reflection through emotional events, the clients can become more successful in implementing this into other relationships. Another understanding of attunement is that attuning not only refers to matching one's quality of movement and body language or emotional state, it also includes attuning to one's mental state (O'Connell, 2010). This can be done through mental state resonance in which the therapist's and the client's mental states both influence and are influenced by that of each other (Siegel, 2012). Through mental state resonance the therapist's

ability to hold and regulate with the client becomes a skill gained. This alignment, or attunement, allows the mind of the client to regulate him or herself in the moment and continue to regulate in future relationships (Siegel, 2012). Cueing into the therapist's organized mental state can aid the client's stability, thus creating cohesion and a place of mutual understanding from which a successful therapeutic relationship can grow (Siegel, 2012).

Thus, the literature suggests that it is possible to gain great knowledge about clients through attuning to and mirroring through nonverbal communication to their movement, body language, gestures, and emotional states. In addition, it is important as therapists to be a blank canvas for our clients (Wylie & Turner, 2010). Being a blank canvas can help the therapist to maintain a clear mental state and focused attention in order to accurately attune to the client, while setting aside uneasy feelings and distracted thoughts (Wylie & Turner, 2010).

Nonverbal communication also plays a large role in creating a safe space to connect with the client. Creating a safe space is another way to develop a therapeutic relationship (Tortora, 2011). The client must trust the therapist and feel safe before the client will allow himself or herself to divulge any information. In Tortora's work (2011), focusing on the infant and mother dyad, she witnessed the mothers physically creating a safe space by making an embracing shape around their child. This physical act is only one way to create the environment of a safe space. Other ways include using postural movements in spatial relationship to the client. This can be done by leaning forward or backwards in relationship depending on the client's needs for more or less personal space to feel comfortable. It can also be adjusted through how the client and therapist face each other. If the client is uncomfortable with direct eye contact or face-to-face dialogue changing the rotation of the body in relation to one another can be key in helping the client to feel safe. Amighi, Loman, Lewis, and Sossin (1999) have noted that safety can be

established through adjustments to tension flow, shape flow, and the use of ritual. They found that feelings of trust and acceptance are expressed through free flow; growing towards something while adjusting to space, the self, or the situation can promote feelings of safety. Adjustments in shape flow—growing and shrinking in one's kinesphere—serve as early sensations of comfort, safety, and support (Amighi et al., 1999; Moore, 2014). Lastly, it is beneficial to meet the client at whichever level they are at in space. It is essential not to stand over or look down on a client. Coming to their level in space helps to minimize the power differential not only in hierarchy but also physically in the space (Amighi et al., 1999).

Another way to develop a therapeutic relationship through nonverbal communication is by creating a space to hold and support clients' emotions and help to regulate them, so that they can learn self-regulation (Tortora, 2006). Tortora (2006) explained this notion as being held in another's mind, while Siegel (2012) explained this as 'mindsighting'—the ability to understand another's mind. This implies that every client has a need to feel special within the therapist's thoughts (Tortora, 2006). Being held is necessary to promote healthy growth and development of the therapeutic relationship and can be done literally through touch (i.e. holding, embracing) or symbolically (Tortora, 2006). Allowing the client to explore their emotional reactions as they work towards their goals will also support them in creating a secure attachment and a better therapeutic relationship with the therapist (Siegel, 2012). As the client is being held it is important for the client to be aware of their sense of body to acknowledge what is happening. Additionally, nonverbal communication supports this creation of being held in space (Tortora, 2006). The client's subtle internal shifts and insights into these sensations helps to regulate them, and establishes if the attachment of the relationship will be successful (Tortora, 2011). Therefore, therapists want the client to understand these sensations as we create the space to hold

and support the process of emotional regulation; this understanding and insight are steps along the path to creating a successful therapeutic relationship.

In addition to attuning to a client, allowing them to feel seen, supporting their emotional regulation, and creating a safe space to connect with them, it is important to also consider defining qualities that make forging a therapeutic relationship challenging. These include symptoms that negatively impact biological, psychological, and social functioning as well as developmental challenges and limitations across the lifespan. Observing nonverbal communication adds an additional level of assessment, especially when verbal communication is limited due to developmental challenges or diagnostic reasons. Porter (2012) stated that, specifically for someone with Autism Spectrum Disorder, the relationship is often assessed without regard for the individual's movement expressions. This contributes to the nature and stereotype of the diagnosis and its qualifying characteristics (Porter, 2012). Without assessing the client's full experience and expression, a clinician can miss a unique way of relating if the diagnostic language does not address or suggest other ways of relating that may benefit the client (Porter, 2012). Similarly, the developmental stage of clients needs to be considered when developing a therapeutic relationship. Because of the changes happening on a neuronal level, therapists must find new and creative ways to engage with clients during the initial relationship-building phase (Roaten, 2011). Art making, movement, and music are some creative strategies to engage clients in the therapeutic relationship across developmental and diagnostic categories. Once a means for nonverbal communication has opened up between client and therapist, it will become easier to start building the foundation of a therapeutic relationship (Roaten, 2011).

Building Therapeutic Relationship

The therapeutic relationship plays a role in all therapy approaches; however, it may look different across various theories, techniques, and interventions. The intentional use of nonverbal communication in building the therapeutic relationship is found within numerous approaches to therapy that have been highlighted in the literature. These include talk therapy (Ray, 2007; Rogers, 1961), child-centered play therapy (Axline, 1947), Suzi Tortora's Ways of Seeing method (Tortora, 2010), humor (Sultanoff, 2013), and approaches informed by the Kestenberg Movement Profile (KMP), an assessment tool, (Amighi et al., 1999) and Attachment Theory (Bowlby, 2005). Due to the nature of how individualized each client's therapy will be it is necessary to approach therapy through many avenues; what may work for one client in building a therapeutic relationship may not work for another (Rubin, 2001).

Talk therapy is the most widely recognized form of therapy used today. Its purpose is to provide support in whichever way the client may need and the therapist is open to discussing any issues that may be concerning the client (Ray, 2007). These conversations are kept confidential and usually take place over many consecutive sessions. A therapeutic relationship is established through the client feeling trust and authenticity with the therapist. The therapist develops a therapeutic relationship through building rapport with the client, being non-judgmental, and having unconditional positive regard (Ray, 2007). Carl Rogers, creator of client-centered therapy, explained that unconditional positive regard in a therapeutic relationship will help the client to feel safe to relate to and open up to the therapist when unconditional positive feelings are expressed (Rogers, 1961). Once trust is established, the client will feel free to engage in meaningful conversations that shine a light into the hidden parts of themselves (Ray, 2007).

Child-centered play therapy focuses on the developmental needs of the child and is intended for children with behavioral and emotional concerns (Axline, 1947). While children play, they reflect much of what is taking place in their lives through the use of toys as transitional objects. This play reflects how children view themselves, others, and their world (Axline, 1947). In this approach, children use toys to create their world and they discuss what is happening in it through the stories they play out (Axline, 1947). Because the toys serve as transitional objects, the children are able to avoid direct contact and conversation with the therapist. Due to their development stage, the use of toys allows them to comfortably relate to the therapist by sharing something they may not have in a typical face-to-face conversation.

Focusing on building the therapeutic relationship using dance/movement therapy, Suzi Tortora's (2010) Ways of Seeing method is an example of how to build the therapeutic relationship with children. This method is based on principles of dance/movement therapy that incorporate creative expression through dance, movement, music, and Laban Nonverbal Movement Analysis to facilitate healing and change (Tortora, 2010). Tortora's approach is a psychotherapeutic way of analyzing nonverbal movement and play in order to assess the client and facilitate an intervention during the development of the therapeutic relationship (Tortora, 2006). The Ways of Seeing approach utilizes the unspoken truths of the body and nonverbal movement to communicate a client's experiences. Through observing the body and movement, the therapist can gather information and then communicate verbally or nonverbally what has been witnessed to the client (Tortora, 2010).

Marian Chace, a pioneer in the field of dance/movement therapy, focused her work not on treating patients, but rather forming relationships with patients and sharing the gift of dance with them (Sandel, Chaiklin, & Lohn, 1993). Chace primarily worked with adults who

experienced chronic schizophrenia by teaching dance classes in the hospital setting. A main component of Chace's work was the group rhythmic activity she incorporated into her sessions (Sandel, Chaiklin, & Lohn, 1993). This group rhythmic activity supported the expression of thoughts and feelings, while cutting through isolative barriers and allowing patients to interact in ways that encouraged the formation of a relational bond (Levy, 2005; Sandel, Chaiklin, & Lohn, 1993). This engaged clients in therapeutic relationships with others that could be adapted to future use in relationships outside of the hospital or therapeutic setting.

Additionally, Devereaux (2014) brought attention to building relationships through dance/movement therapy with children with Autism. Those with Autism Spectrum Disorder often times prefer to engage their interest in objects rather than social interactions, so Devereaux engaged in relationship with her clients through nonverbal communication via transitional objects. Similarly to Chace's group rhythmic activity, Devereaux encouraged the children to incorporate the use of a rhythm that unified them in relationship; this assisted in calming the children when they were experiencing sensory overload and connecting Devereaux and the clients together in relationship (Devereaux, 2014).

The Kestenberg Movement Profile (KMP) is another useful DMT tool, which can assist clinicians in their approach to building therapeutic relationships with clients. This is a method of analyzing movement that describes innate and developmental movement phrases exhibited by the client (Amighi et al., 1999). The KMP provides a way to observe, document, and analyze variations in muscle tension and how the body moves and changes shape, which in turn informs interventions, including how to foster the therapeutic relationship (Amighi et al., 1999). Amighi et al. (1999) stated:

> The KMP contains four movement clusters that have been derived from Laban's description of efforts…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). (p. 30)

Through incorporating the KMP in a repertoire of approaches to develop and maintain the therapeutic relationship, the therapist can access and attune to the client's unconscious needs, gain an understanding of the client's temperament and affect, and identify the client's ways of coping and defensive behaviors.

Yet another approach to building relationships that incorporates nonverbal communication is through applying the principles of Attachment Theory. Bowlby (2005) emphasized that the attachments developed with an infant's primary caregiver in the first years of life are crucial to the development of their future interpersonal relationships. It is the responsibility of the therapist to begin with the establishment of a secure attachment to our clients. This is the gateway to building successful relationships and is exemplified in the work of John Bowlby. Bowlby (2005) explained that child-parent attachment styles are brought into the therapeutic relationship and enacted between therapist and client. It is through exploration and openness that the therapist and client can decipher the healthy and unhealthy patterns and rework them to create a secure attachment (Bowlby, 2005). Establishing a secure attachment allows the client to feel open, acknowledged, and trusted by the therapist so that they may be able to grow not only in the relationship with the therapist but in other outside relationships (Bowlby, 2005). Schore and Schore (2007) explained the critical importance of the underlying attachment theory that Bowlby outlines as driving all human emotion, cognition, and behavior in society. It is

important to acknowledge that attachment is something that transpires out of interactions of nature and nurture; it is malleable and can be gained and lost overtime (Schore & Schore, 2007).

Lastly, it is important to acknowledge that there can be fun, lighthearted moments in the therapeutic relationship just as there are in other interpersonal relationships. An intervention to keep the relationship upbeat and positive is to incorporate humor. This technique is highly regarded by Sultanoff (2013) as he explains that through incorporating humor, a therapist can elicit change in one aspect of the client's cognition, such as emotion, which will likely cause change in another area such as behavior. Humor as an intervention can promote change in four aspects of a client—their emotions, behaviors, cognitions, and their biochemistry (Sultanoff, 2013). When establishing and developing a therapeutic relationship, humor can break down walls, allowing a client to feel more at ease and better able to see the therapist as a genuine human being.

External Factors

In addition to the aforementioned approaches to building relationships and communication through nonverbal means, it is highly imperative to consider the large role that outside factors play on a therapeutic relationship. Things that happen in the client's outside world largely affect the therapeutic relationship (Naidu & Behari, 2010). Examples of these external influences are support systems outside of therapy, consistency in location of therapy, continuity in the reoccurrence of sessions, and differing communication styles.

One of the key roles of a therapist is to provide support to their clients. It is imperative that the clients are being supported inside as well as outside of the therapy session for the best treatment outcome possible. This outside support can come from various people: friends, family, parents, support groups, sponsors, etc. Naidu and Behari (2010) exemplified this in his family

therapy work. Showing support to the family/parents through accepting their identity and history as well as communicating with them genuinely, can contribute to a successful therapeutic relationship (Naidu & Behari, 2010). When working with children, Naidu and Behari (2010) emphasized how it is essential to support the family/parents in their decision to seek help for their child and acknowledge how much courage it takes to admit that they were unable to give the child the help they needed on their own (Naidu & Behari, 2010). In addition, it is helpful for the therapist to affirm the areas in which the parents are succeeding. It is out of love and support of their child that they are seeking the help of the therapist, not because they are failures as parents (Naidu & Behari, 2010). If a therapist can engage a parent, family member, or outside support system in the treatment, the therapy process will go much smoother for the client (Naidu & Behari, 2010). The client will feel supported outside and have a witness and confidant to keep them in check when they are not in session. Unfortunately, many clients do not have outside support systems or are affected negatively by those in their surroundings. Involving outside parties' support and maintaining a consistent emphasis on the therapeutic relationship will strengthen the bonds both inside and outside of the therapy room and allow the client to model outside relationships after the one created inside the therapy room (Naidu & Behari, 2010).

In addition to having external support, it is essential for the client to feel supported and stable in therapy. Consistency in time and session frequency can aid in this. In fact, Reese (2011) found that attending more sessions in a shorter amount of time was more effective than the same number of sessions spread out over the course of a long time. Having a constant and consistent meeting time with a client can allow for therapeutic relationship growth; continuity can foster dependability and trust. Advancing the client through the work and showing them that

what you can do as a team will help them to progress individually and will enhance the client-therapist relationship (Reese, Toland, & Hopkins, 2011).

Lynch (2012) stated how internal factors, such as empathy for the client, client's level of motivation, client characteristics and symptomology, all affect the success of therapy. Empathy is pertinent to the therapeutic relationship as it helps the client to feel understood and validated (Lynch, 2012). Norcross (2002) agreed that empathy correlates highly with the therapeutic alliance. The theoretical framework and worldviews are less important if the therapist is able to empathically relate to the client (Norcross, 2002). To express empathy towards a client, the therapist must be open, flexible and have a continued awareness of their own mental and physical states as well as their clients' (Norcross, 2002). Closely related to this concept is kinesthetic empathy. Reason and Reynolds (2012) described the concept of kinesthetic empathy as the ability to experience empathy merely by observing the movements of another. In dance/movement therapy, kinesthetic empathy is fundamental to the therapeutic relationship and a catalyst for positive change (Reason & Reynolds, 2012). It can manifest itself at any moment through stillness, silence, and movement metaphors (Reason & Reynolds, 2012).

Client characteristics play a large role in determining how the therapeutic relationship will grow, based on factors such as the client's motivation level and their ability to form relationships (Black et al., 2005). Patients often vary in their readiness to change. Miller and Rollnick (1991) emphasized in their motivational interviewing literature that therapists working with unmotivated clients must be less confrontational and more motivation generating. Approaching a therapeutic relationship in this manner often consists of multiple stages of change for the client including: pre-contemplation, contemplation, preparation, action and maintenance (DiClemente & Velasquez, 2002). A client's motivation varies at each stage and can be difficult

if the client is resistant; however, these stages help concretize the idea that change is possible (DiClemente & Velasquez, 2002). Intrinsic motivation can be thought of as an interpersonal process. By implementing the five basic principles of motivational interviewing—expressing empathy towards a client, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting the client's self-efficacy—a therapist can be the catalyst for change (DiClemente & Velasquez, 2002). Bachelor, Laverdiere, Gamache, & Bordeleu (2007) suggested that a client presenting with increased symptomology might have a lesser ability to be engaged and work in relationship with the therapist. Lynch (2012) and Black, Hardy, Turpin, & Parry (2005) agreed that symptomology and motivation play a large role in relationship building and the outcome of therapy. Clients who seek out therapy are generally more open to engaging in relationship than clients who may be court mandated or in therapy to please others (Lynch, 2012).

Lastly, it is important to take differing communication styles into account when working to develop a therapeutic relationship. For example, it is important to acknowledge that adults and adolescents barely share the same language (Roaten, 2011). Often times therapists make the mistake of recalling their own memories of being a child or teenager and assuming their clients behavior should be modified in terms of what the therapist would have done (Roaten, 2011). This empathic understanding can be applied to clients at any stage of life, not exclusively adolescents. It is key to keep in mind that our clients experience life differently than we might, and thus have differing ways of thinking and communicating.

We must consider others' differing communication styles not only verbally, but also nonverbally. As stated earlier, Moore and Yamamoto (2012) explained that movement preferences, experienced through body knowledge and body prejudice, allow us to attach a

positive or negative meaning to movement based on personal experiences in the world. If a therapist and client's movement preferences clash, this can be brought out as dissonance in the therapeutic relationship. However, similar movement preferences aid in attunement and progression of the therapeutic relationship and positive outcomes to therapy (Moore & Yamamoto, 2012).

Countertransference

Countertransference is something therapists experience that can affect the therapeutic relationship (Prasko et al., 2010). Prasko et al. (2010) stated that countertransference occurs when a therapist acts in a complementary or similar way to that of a client's transference; countertransference is something that lives in all individuals as part of who they are, similar to a personality trait. The literature supported opposing views of countertransference, stating that it can be beneficial as well as disruptive to the therapeutic relationship (Marshall & Smith, 1995; Prasko et al., 2010). Countertransference can serve as a gauge when working in relationship with clients. For example, a therapist who feels irritated by a client for no clear reason may discover subtle unconscious annoyances by the client that irritate and repel others; this unintentionally keeps the client unwittingly lonely and isolated (Reidbord, 2010). When faced with feelings of countertransference, Reidbord (2010) stressed the importance of the following steps: identify whether the feeling is characteristic of yourself as a therapist and person, address whether the feeling is being triggered by something unrelated to the client, notice if the feelings are related to the client in an obvious way, and lastly, take note if the feelings are uncharacteristic and if the trigger is not readily obvious. Countertransference, when acknowledged and addressed by the therapist, can be used to inform the development of the

therapeutic relationship in such a way that it benefits the therapeutic process and progress of the client (Marshall & Smith, 1995; Prasko et al., 2010).

However, countertransference is not always beneficial; it can interfere with effective treatment and a positive therapeutic relationship when it is not acknowledged and addressed by the therapist (Marshall & Smith, 1995). Both Sigmund Freud and Carl Jung struggled with the concept of countertransference and deemed it to be inhibiting to the client's psychological treatment when left unattended (Bradley & Ladany, 2001). It is essential for clinicians to address how countertransference can be both helpful and harmful to the therapeutic relationship.

Many modern therapists self-disclose in relationship with clients and use the feelings brought up through countertransference to enhance their understanding of an experience and the client's understanding of a similar experience (Fisher, 1990). Farber (2006) stated that self-disclosure from the therapist can have positive and negative effects on the therapeutic relationship. Self-disclosure can be understood as a way to better understand others and one's self. According to Farber (2006), self-disclosure can positively affect the therapeutic relationship in the following ways: the therapist and client experience a greater sense of emotional closeness through sharing meaningful parts of one's self, validation and affirmation are felt by one another, insight and identity formation occur, the therapist or client is able to find differentiation of the self, a greater sense of authenticity is achieved, and it can be cathartic for one to share his or her experiences.

In opposition, Farber (2006) outlined how self-disclosure from the therapist can be potentially harmful to the therapeutic relationship: by revealing one's self there is the potential to be rejected by the other, it can feel like the therapist is burdening the client with their secrets, self-disclosure can create an undesirable impression of one's self, one may feel regretful for not

having shared their secret earlier, there could be an increase in vulnerability, and one could experience feelings of shame after disclosure (Schaeffer, 1998). Marshall and Smith (1995) also noted that countertransference can be harmful to the relationship when resistance is high, and when the psychopathology limits the client's judgment, rational thought, self-observation, and executive functioning skills. In moments like these, the client could create boundaries and may act out in harmful ways to themselves or others (Marshall & Smith, 1995).

Prasko et al. (2010) noted that it is important to acknowledge that feelings of countertransference can be experienced from the therapist and can be used to gain insight into the interpersonal relationship. Countertransference can be used as a valuable source of information regarding a client or therapist's inner world and worldviews (Prasko et al., 2010). When addressed it can be beneficial to the therapeutic relationship (Prasko et al., 2010). Often, addressing feelings of countertransference can lead to a deeper understanding of each other's experience and open the door to treatment ideas the therapist may not have been uncovered in any other way (Murphy, 2013). Acknowledgement and understanding of the therapist's countertransference is ideally done in a supervisory relationship. Supervision is a place similar to a support group for therapists where they are able to share their clinical experiences and gain a greater understanding of times when feelings of countertransference arise (Murphy, 2013).

Countertransference can also arise somatically, specifically through the practice of dance/movement therapy. Somatic countertransference, as defined by Levy (2005), is an unconscious to conscious connection that occurs when the dance/movement therapist somatically receives sensations, images, feelings, and thoughts from the client's body and unconscious thoughts. The therapist holds these feelings or sensations and reflects them back to the client through images or movement. Depending on the readiness of the client to reclaim and accept the

reflection of their thoughts and feelings the therapist will “hold” them until it is manageable for the client to receive the intensity or even the overflow of their feelings (Levy, 2005). Somatic countertransference allows the therapist to better understand the client on a kinesthetic, emotional, and intuitive level. It allows the therapist to understand how the client feels in their movement and emotions while expressing a particular feeling or image through the body (Cruz & Berrol, 2004). If the therapist notices incongruent feelings in themselves compared to what is being presented by the client, it can be helpful to address these feelings with other clinicians and with the client (Cruz & Berrol, 2004).

Counselor Development and Somatic Identity

Finally, it is important to consider how the professional development of clinicians informs their approach to developing the therapeutic relationship. Counselors and therapists develop their skill set over the entirety of their career, as Skovholt and Rønnestad (1995) presented in their eight-stage career model. These eight stages include: conventional learning, transition to professional training, imitation of experts, conditional autonomy, exploration, integration, individuation, and integrity (Skovholt & Rønnestad, 1995). This model describes the stages of development a counselor or therapist must go through in order to become their truest and most autonomous self as a clinician (Skovholt & Rønnestad, 1995). Over the course of a clinician’s development, one must create a professional identity, develop the skills needed to facilitate therapy, and identify what has influenced them as well as their methods of learning (Skovholt & Rønnestad, 1995). Through this process the clinician begins to understand their current approaches to relationship and can identify how they adapt over time and with various settings and populations.

Additionally, Trotter-Mathison, Koch, Sanger, and Skovholt (2010) noted that a major catalyst of growth and development comes in the form of a critical incident or defining moment. These defining moments can be positive or negative influences that play a large role in the subsequent development of the clinician's professional identity (Trotter-Mathison et al., 2010). In these instances, counselors become inspired by their clients, discover something meaningful about themselves, or find the true essence of what counseling means for them personally and professionally (Trotter-Mathison et al., 2010). In experiencing these defining moments the clinician's relationship to the work will shift, and so will the therapeutic relationships with their clients.

Beyond the cognitive and emotional development of counselors and individuals, the importance of one's body knowledge and body prejudice must be taken into account as previously discussed (Moore & Yamamoto, 2012) in addition to one's body identity. Gender theorist Judith Butler (1993) provided an in-depth and specialized understanding of the construction of our identities and bodies. Our bodies are shaped through the reiteration of societal norms and are more than the materiality of what we see on the surface (Butler, 1993). Butler's notion of "performativity" explains that one's identity is constructed through the reiteration of acts and gestures that form repeated bodily habits over time (1993). Through performativity, the body's movements shift from being composed of 'what a body is' towards 'what a body does' (1993). Butler (1993) explained 'what a body is' as the physical make-up of the body—the bones, skin, muscles, shape—and explained 'what a body does' as how the bones, skin, muscles, and shape work to move the body into action and expressivity. In relationship, it is key to understand that each person is comprised of his or her own personal performativity (Butler, 1993). As a clinician, it is necessary to become aware of one's body identity as well as

be open to others' unique identity, to see clients as more than what their body is or is not, but for what their body can do and how it contributes to the therapeutic relationship.

Conclusion

As evidenced above, many researchers have studied the development of therapeutic relationships. The literature states the importance of nonverbal communication through attunement, feeling seen, the support of emotion regulation, creating safe spaces to connect, and aiding to decrease the power differential/barrier between therapist and client (Betty, 2013; Ramseyer & Tschacher 2011; Roaten, 2011; Tortora, 2011). The literature also indicates numerous approaches to building therapeutic relationships, including: the Ways of Seeing (Tortora, 2009), creating a secure attachment (Black, Hardy, Turpin, & Parry, 2005; Bowlby, 2005), the use of child-centered play therapy and transitional objects (Axline, 1947; Porter, 2012), the Kestenberg Movement Profile (Amighi, Loman, Lewis, & Sossin, 1999; O'Connell, 2010) traditional talk therapy (Ray, 2007), and humor (Sultanoff, 2013).

A common theme throughout the literature was the influence of outside factors on the therapeutic relationship, including: support from family, friends, parents, and support groups; consistent and regularly scheduled sessions; and addressing differing communication styles (Naidu & Behari, 2010; Reese, Toland, & Hopkins, 2011; Roaten, 2011). In addition, attending to countertransference plays a significant role in developing a therapeutic relationship. Countertransference can be disruptive to the therapeutic relationship if it is not addressed (Prasko et al., 2010), but it can also aid in growing the therapeutic relationship if the therapist and client engage in conversations about what is coming up (Murphy, 2013; Prasko et al., 2010). The literature also indicated the importance of acknowledging somatic countertransference in dance/movement therapy. This occurs unconsciously in the therapist's body and movement

responses to the expression of the client's thoughts and movements (Cruz & Berrol, 2004; Levy, 2005). Lastly, the development of somatic identity and professional identity can contribute to the therapeutic relationship. Butler (1993) provided an in depth and specialized understanding of the construction of our identities and bodies and how they can communicate a great deal about our identities that may not be physically visible.

This literature review is a culmination of information gathered to inform my practice as an emerging dance/movement therapist. It is my intent to move forward in my studies and put what I have learned into practice. My research questions include: What is it that made me feel uncomfortable developing and engaging in the therapeutic relationship with my internship clients? How was I able to overcome these challenges? Which dance/movement therapy techniques seemed to work best to connect with or develop therapeutic relationships? Which non-dance/movement therapy techniques worked best in the development of the therapeutic relationship? My research focused on my internship experiences that involved developing therapeutic relationships with clients who had physical or mental disabilities, were unclean, or hard for me to relate to in many ways.

Chapter Three: Methodology

To answer my research questions, I conducted a heuristic inquiry using qualitative methods (Given, 2008). Moustakas described the process as an inner search for knowledge, aimed at discovering the nature and meaning of one's experience (Given, 2008). It is a passionate and discerning personal involvement in problem solving—an effort to know the essence of some aspect of life through the internal pathways of the self (Douglass & Moustakas, 1985). Moustakas' six steps of introspection are as follows: initial engagement, immersion, incubation, illumination, explication, and creative synthesis (Moustakas, 1990).

During the initial engagement the goal is to discover an intense interest on a topic, theme, problem, or question (Moustakas, 1990). I did this by identifying my struggle with wanting to work with and be in relationship to those at my internship sites. Immersion occurs when the researcher begins to gain knowledge and understanding and events in his or her life begin to come back to or revolve around the question (Moustakas 1990). During this stage, I examined my own personal biases and prejudices towards my clients and questioned what spawned these thoughts and feelings. I started to note how I talked about these populations and society's views around those with mental illness and disability. Next, in the incubation stage, the researcher retreats from the intense concentration on the question (Moustakas, 1990). Due to my preference for accelerating in time and persevering through tough situations I do not believe I accomplished this stage, rather I pressed forward to the next stage in which I started to make conclusions; I reflect upon how this affected my research in the discussion chapter. Next, the researcher experiences illumination, which occurs naturally when one is open and receptive to knowledge and intuition (Moustakas, 1990). As I wrote about my experiences in working with clients and engaged in conversations with other clinicians, I started to become receptive to my own intuition.

In the explication stage, the goal is to fully examine what has risen to the researcher's consciousness (Moustakas, 1990). Here, the researcher will focus, dwell on the topic or research question, self-search, and self-disclose (Moustakas, 1990). During this stage, I examined my journal entries and noted the honest feelings rising to the surface about my experiences in relationship. Lastly, creative synthesis takes place in the form of a narrative depiction of the data in a creative form (Moustakas, 1990). For this to occur the researcher must have a deep understanding of data collected, understand how the data relates to the presented question, and begin to bring the concepts and themes together (Moustakas, 1990). Creative synthesis is enabled by inspiration and can only be achieved through the intuition of the researcher (Moustakas, 1990). My creative synthesis took place through movement explorations surrounding the journal entries, culminating in a dance performance that reflected my findings.

This methodology supports my theoretical orientation as a clinician and a researcher, because I gravitate towards subjective experiences and believe that every experience is valuable and unique. The depth that is held in each individual's process is important and can reach beyond the individual partaking in the experience. This approach is applicable to examining the therapeutic relationship, but it should be known that a relationship is a subjective experience even though there are objective ways to develop them. For example, my relationship with a client may affect how the client interacts with others, and similarly how it will affect my relationships in future work. Additionally, I have a preference towards qualitative methods over quantitative, because I feel that such methods offer more ways to examine the new and ever-changing ways of approaching a question or situation. Qualitative methods afford me the opportunity to be flexible as I navigate through the adaptable and dynamic qualities of a relationship.

The inspiration of my study stemmed from my challenge in creating relationships with my clinical internship population at the therapeutic school. Because of this I made use of the opportunity to examine how I approach relationship building and the difficulty that sometimes surrounds it. I believe this methodology allowed me the freedom needed to fulfill the exploration of my experiences. To answer my research questions, I needed the creative capacity to discover the answers with flexible boundaries. Based on the unique and adaptable experiences that occur in therapeutic relationships, it was fitting for the study to encompass such a creative and flexible methodology.

Participants

I, as the researcher of a heuristic inquiry, was the sole participant of this study. As a 23 year-old, Caucasian, female graduate student at Columbia College Chicago working to receive my Master of Arts in Dance/Movement Therapy and Counseling, my background was quite different from those that I worked with at my internships. I had a very sheltered upbringing; I was not exposed to adversity due to physical or mental illness, differences in disability, race, substance use, homelessness, or varying socioeconomic status. As an emerging clinician, I recognized the need to further my skills in developing a therapeutic relationship with others who have had vastly differing life experiences and backgrounds. I wanted to find a way to be open to the individual as well as the history that lives within him or her.

Clinical Settings and Populations

I engaged in the therapeutic relationship with students/patients throughout the day at both of my clinical internship sites: a therapeutic day school and a hospital on an adult inpatient psychiatric unit. At the therapeutic day school, my work was split between two classrooms: the

physical education room and a sensory room. They were both filled with a variety of sensory simulating equipment for children to use as they pleased. These include swings, waterbeds, soft mattresses, foam wedges, ball pits, light boards, different textured ropes and balls, and adaptive bikes. The two spaces differed in that the gym had bright fluorescent lights and loud music playing while the sensory room often had the shades drawn, lights low, and softer music playing. The students at this site were between the ages of 4 and 10. I only conducted individual sessions at this site.

On the inpatient psychiatric unit, I facilitated groups in the day rooms and conducted intake assessments in the patients' rooms or common spaces – wherever they felt most comfortable. The day rooms were filled with numerous couches, chairs, and a long table. Every item, with the exception of the chairs, was moved out of the way to facilitate room for movement to take place. Group sizes were between eight and 12 people, varying in ages from 18-65.

Data Collection

Data was collected over eight weeks through journaling. At the therapeutic day school my data collection was a reflection on two sessions over the course of one day per week for eight weeks. One journal entry was collected after the morning sessions were completed and the other was completed at the end of the school day. Due to the fact that there were multiple sessions in the morning and afternoon, I picked one to reflect upon based on difficult or forced- feeling connections with the students. On the psychiatric inpatient unit, I collected data once per day over the course of two days per week for eight weeks. In both settings, the journaling process was completed at a personal desk in a shared office space. Each journal entry focused on exploring a therapeutic relationship that was most difficult for me that day. The relationship

could have been difficult because the student/patient may not have wanted to engage with me, he or she could have been upset or visibly having a bad day, he or she may have been ill as it was not uncommon for students to attend school when sick and contagious. Additionally, I may not have wanted to engage with the client if they were ill, if the individual had not bathed recently, or if I had been having a rough day and did not wholeheartedly want to engage in the relationship. Each journal entry consisted of a chart (see Appendix B) that identified why I was drawn to the specific therapeutic relationship, strengths or positive aspects of the therapeutic relationship, why this therapeutic relationship was challenging or difficult, what techniques worked best to connect with the student/client, and the main idea about how to improve my ability to forge the therapeutic relationship that I could apply in my next session.

Data Analysis

Data collection and analysis occurred simultaneously over the course of eight weeks. Using Forinash's (2004) six-step model, I found common trends and repeated themes throughout my journal entries. Forinash's (2004) six steps consist of reviewing the data in its entirety in order to organize it into loose categories, reviewing the data again marking significant or meaningful parts, organizing marked content into themes, rechecking themes back with the source of data, constructing a description of the phenomenon being studied looking for generalizations and powerful information, and lastly, presenting the findings in a way that communicates understanding. At the end of each week, I synthesized my data by identifying patterns and themes across the three days of data collection. I also analyzed my data through movement exploration that occurred at the end of each week in a private location at my personal residence for approximately 20 to 30 minutes. I embodied my experiences of the therapeutic relationship and the themes that emerged from my journal entries throughout the week. I

embodied each of the four journal entries independently and then embodied the entire week's data through movement. I then organically moved my response to these themes to reinforce the content. . I completed another journal entry immediately following the completion of the movement exploration about my experience of synthesis and review of the journals from that week, which enhanced validity. Upon the completion of my data collection and analysis, I had eight synthesized journal entries from the end of each week after eight consecutive weeks. These final entries, in combination with the embodied movement themes, culminated in a creative synthesis of a choreographic performance at the end of the process that represented the final results and my evolved understanding of how to create deeper connections nonverbally in future therapeutic relationships.

Validation Strategies

I utilized an external consultant as a validation strategy who observed me in relationship during sessions. This external consultant observed me once at each site over the course of my data collection to ensure my bias towards the clients and my movement prejudice was minimized and that I achieved the depth of exploration that I aspired to with a population that was difficult and stigmatized for me. For example, the populations of my clinical internships were difficult for me due to differences in ability/disability, race, substance use, homelessness, or varying socioeconomic status, etc. (Creswell, 2003). My external consultant lent an objective perspective that shed new light on what I may have been too immersed in to see. In addition, I went back to all previous data and re-analyzed it after the consultation. This entailed revisiting each journal entry and repeating the movement and synthesis processes. The hope was to find increased validity after repeating the synthesis process and possibly gaining new information I missed the first time.

Chapter Four: Results

In this study, I set out to develop techniques to help me form therapeutic relationships more easily with clients whom I did not relate to, whom I felt uncomfortable around or whom I was put off by due to their disability, personality, or illness. My initial research question was: How do I develop therapeutic relationships with clients whom I find challenging to relate to or with whom I feel uncomfortable? This initial question was answered through my data collection and analysis processes. While analyzing my data I was able to concretize recurring themes that emerged in my written journal and through the movement explorations that occurred over the eight-week data collection period. I was excited by the fact that even before the completion of my data collection, I was noticing themes that continued to arise as I engaged in therapeutic relationships with my clients at both internship sites. The main themes that emerged in my written journal were mirroring, readjusting my wants and needs to facilitate the development of therapeutic relationships, and supporting growth in the client (see Table 1).

Table 1

Themes

Mirroring	Readjusting My Wants/Needs	Supporting the Client
Reflecting client's movement or affect	Finding balance	Allow client to lead/come to me
Call and response through movement	Compromise/Noticing my dislike for stillness/slow use of	Meeting client psychologically or physically at their level in

	time/decreasing pressure	space
Verbally affirming/validating client	Finding flexibility in my approach	Establishing boundaries
	Curiosity, wonderment, openness	Redirecting client's focus through directing/indirecting interventions
	Patience	
	Relinquishing control	

Through the process of data collection and analysis, I was able to answer my secondary research questions. In my journal template (see Appendix B), I directly asked what was challenging or different about the relationship, addressing the question: What is it that made me feel uncomfortable developing and engaging in the therapeutic relationship with my internship clients? Most commonly, I was uncomfortable developing and engaging in the therapeutic relationship with my clients for the following reasons: 1. My personal prejudices or biases interfered with developing and maintaining the relationship. 2. I was afraid of hurting the students who had minimal movement capabilities. 3. I had a lack of desire to connect with clients who smelled or acted out on the unit. 4. I was uncomfortable with various diagnoses that presented with symptoms of sexually acting out, aggressive behavior, or behavior I was unable to redirect.

My reflections on both the tips and techniques that worked best to connect with my students/clients and the positive aspects of the relationship (see Appendix B), aided in answering the question, How was I able to overcome these challenges? By embodying my reflections through movement, I was able to develop more optimistic feelings about my relationship with my students/clients and more readily identify and implement strategies that had worked in the past to facilitate future moments of connection with a client with greater ease.

Reflecting on my journal entries and the salient movement themes that arose out of my journaling, I identified which dance/movement therapy techniques seemed to work best to connect with clients and to develop therapeutic relationships. Mirroring is one of my favorite techniques and often the first one I access when entering into relationship. Mirroring occurred through movement by reflecting the client's affect or movements simultaneously, with call and response, and by verbally affirming or validating the client. As I reflected on my experiences through movement, mirroring came up frequently. I found myself mirroring my own movements in a call and response manner using different parts of my body. An example of this is a flicking motion in my fingers that was echoed in my foot, my fingers representing the client's movement and my foot echoing the way I mirrored them during the session. Mirroring also occurred as I found symmetry in my movement; if my right arm raised so did my right leg, if one knee turned in the other did simultaneously. Synchronous mirroring, echoing and verbal affirmation aided in the development of the therapeutic relationship. These techniques validated the client, allowing him or her to feel seen and heard. There were moments during a few sessions where my mirroring was not effective in developing and furthering the relationship. In these instances, it was because I was trying to push the client farther than he or she was ready to go or I was trying to infer meaning from the client's movement instead of letting the theme come from them.

The most salient non-dance/movement therapy technique that worked best in the development of the therapeutic relationship was a theme that continued to arise in my journaling and movement exploration - readjustment. My data collection detailed the challenges I faced in forming a therapeutic relationship, which led me to expand my approach. This involved readjusting my wants and needs by learning to give into the balance that was needed to facilitate growth in a relationship. Often times this took place by allowing for flexibility in my approach, relinquishing my desire to want to control the outcome of the sessions and the client's role in the session, having a curiosity and openness to my approach in relationship, and lastly, exercising patience by allowing time and moments of stillness where I could 'just be' with the client. In my movement exploration, this was exemplified by instances of attuning to the clients needs and putting theirs before my own as I found myself taking on movement qualities that are not what I have an affinity towards; these were moments of stillness, slow or sustained use of time, or decreasing pressure applied to movement. I also noticed increased curiosity, wonderment, and exploration instead of feelings, thoughts, and sensations of bias and prejudice, which I had previously experienced as nervousness, reflected in the binding of my chest and hands. Instead, these moments of curiosity were expressed with open or forward facing palms.

Additionally, I learned that I had to support the client in growing interpersonally as well intrapersonally in the following ways: allowing the client to take more initiation in the relationship; physically supporting him or her; verbally showing support in my affirmations; meeting the client psychologically, at their level in space, and in movement; and letting him or her take the lead in sessions, empowering the client to decide if we would use props, music, or play games while redirecting the client when necessary and establishing boundaries. In my movement exploration, I was able to represent themes of supporting the client through changing

my level in space—usually to a lower level, meeting them where they were at—and by fluctuating between directing and indirecting my focus, which exemplified times when I needed to redirect the clients. The refinement of my approach to connecting with clients was continuous throughout my research process. I learned to become softer in my approach and to connect with clients through various mirroring techniques. I also realized that readjusting my wants and needs in the moment in order to best support the needs of clients can lead to a greater therapeutic outcome as well as a more successful therapeutic relationship.

My external consultant validated my results by observing my sessions and conversing about any discrepancy she witnessed against how I perceived the sessions to go. Our conversation focused on the relationships I engaged in with clients and how to deepen them even further. Additionally, she brought to light some things I had not previously considered, such as how I greet my clients and say good-bye. I realized that I was quick to begin engaging with clients before I said hello and reminded them of who I was. Similarly, I would leave without giving proper closure to the session. My external consultant offered feedback on how I can use my body in relationship to physically assist my clients, allowing me to find a way to relax into the relationship. After these meetings, I returned to my data and synthesized the themes of the journal entries once more. This consistently led me to gain new knowledge that I missed the first time around.

Chapter 5: Discussion

My primary research question was, How do I develop therapeutic relationships with clients whom I find challenging to relate with or with whom I feel uncomfortable? My findings answered this question: I discovered that by observing and analyzing my approach I could strengthen my connection in the therapeutic relationship through various mirroring techniques, negotiating my wants and needs in relationship, and in finding new ways to support the client.

Not long after I began my study, I found that many little things can help in building a therapeutic relationship and it is unfair to quickly judge an awkward or slow-to-develop relationship. Relationships take time and effort and, through studying numerous theories and approaches and implementing them into my sessions, I began to build a foundation from which a positive therapeutic relationship could grow. By examining the literature, I was able to study how others created therapeutic relationships with clients, and I adapted their techniques to fit into my clinical work. Over time, the clients and I were able to share some beautiful and powerful moments together as we navigated our therapeutic relationship. This was evidenced by moments of connection through eye contact, positive shifts in the client's affect, willingness of him or her to participate in the group activity, and client engagement with me outside of the therapy session. For myself, these relationships started as a challenge, but through Moustakas' (Douglass & Moustakas, 1985) six steps of introspection and forming connections with clients by applying my findings, my resistance began to fade. I discovered that this process was less about my expectation of forming a strong therapeutic relationship that would foster the highest potential for growth, and more about being with the client and letting our relationship unfold. This, in turn, fostered my personal growth as a clinician.

Mirroring was one of the most salient themes that I found in the literature on ways to connect with clients in dance/movement therapy (Ramseyer & Tschacher, 2011; Siegel, 2012; Tortora, 2006) and a technique I had learned throughout my coursework. However, as I began putting it into practice in my clinical work, I learned that my interpretation of mime-like mirroring would not produce the results I wanted from these therapeutic relationships. Chace found this to be true and stated that direct mirroring of one's movement could be perceived as mimicking or ridiculing to the patient (Sandel, Chaiklin, & Lohn, 1993). I began to experiment with the idea of mirroring and started to adapt its qualities into new ways that could be conducive to my work with the populations I served. With the students, it became a call and response game, a favorite exercise I used often with them. The student and I would lie next to each other on a foam mattress and as I moved/shifted my body position on the mat it would in turn cause the student to have an involuntary reaction in which part of his or her body would soften into the mat or another part may become tense due to how the student's body had to accommodate the new unstable mat beneath him or her. This exercise was beneficial and used most frequently with students who could not move independently, and became a fun game. As Sultanoff (2013) stated, incorporating humor or lightheartedness can allow the client to feel more at ease in the therapeutic relationship.

Sometimes, with the students and those on the adult psychiatric unit, mirroring was as simple as matching breath and noticing how our chests would rise and fall in unison. Additionally, mirroring also took place verbally through affirmation and validation as I reflected back what I heard. Similarly to reflective listening in motivational interviewing, if the client feels listened to they will be less reluctant to change (DiClemente & Velasquez, 2002). In verbally mirroring the children, I echoed their vocalizations, and with adults in the inpatient

psychiatric unit, I matched their tone and would clarify what they were saying to ensure I understood them fully. It was my goal that by using this form of mirroring, the client would feel heard and understood in the moment; thus, establishing empathy (Berrol, 2006; Betty, 2013; Ramseyer & Tschacher, 2011; Sandel, Chaiklin & Lohn, 1993; Tortora, 2006), safety (Amighi et al., 1999; Tortora, 2011), and trust (Siegel, 2012; Tortora, 2006; Tortora, 2011).

As time progressed, and I noticed the shifts that were happening in myself as a clinician, I found that I was readjusting my wants, needs, and personal agenda to facilitate the growth of the therapeutic relationship. It is in my nature, and aligns with my preference for a cognitive behavioral therapy approach, to want to progress quickly, see change, and work towards a goal (Prasko et al., 2010). However, I quickly realized that change comes from within the client and for me to place external pressure on them, while also trying to connect therapeutically, often created a barrier. Once I was able to relinquish my desire to control how to establish relationships, I found that they grew more naturally; the relationships flourished more quickly and our connections were deeper as evidenced by the clients leading the session, opening up verbally, and wanting to engage in movement more frequently. My wants, needs, and desires to control the course of the relationship began to decrease as I gained experience and became more comfortable in the role of a dance/movement therapist. Naidu and Behari (2010) noted that outside factors can have a great impact on therapeutic relationships, and I noticed that the external factors of being a novice therapist, accompanied by my own expectations of how dance/movement therapy should look and what I was "supposed" to be doing as a dance/movement therapist added a disservice to the therapeutic relationship. I learned to practice patience with the clients and myself in times where I wanted to dictate the course of our work and relationship. I readjusted this want and found a balance between my desire for the clients

and the needs and goals expressed by the clients, which allowed me to become more flexible in my approach.

Lastly, I noticed a sense of curiosity and wonderment emerge as I let go of the feelings of pushing towards what I wanted. This experience aligns closely with the concept of COAL, an acronym created by Siegel (2012) that stands for curiosity, openness, acceptance and love—all descriptive qualities of mindfulness. As it turned out, the more I pushed the client, the less mindful I was about my personal goals for the relationship the relationship and the more the client pushed back. This resistance, or sustained behavior as described by DiClemente and Velasquez (2002) in the motivational interviewing literature, prevented the development of our relationship. I adapted this newfound insight into my clinical work, which felt less forced and more exploratory. In turn, it led to greater growth of the therapeutic relationship as well as more personal growth for the clients, as they began to reach more goals in a shorter amount of time.

Supporting the client was a major theme throughout the literature that I also noticed emerge in my relationships with the clients (Betty, 2013; Ramseyer & Tschacher, 2011; Roaten, 2011; Tortora, 2011). I often found myself redirecting clients' focus when the work went off track or off topic, shifting back to the task at hand. I supported their will to have choice and allowed for space and time for them to come to me; they led where the relationship and the therapeutic work would go each day. Through this, I noticed a strengthening in our therapeutic relationship as I became their support system (Naidu, 2010; Reese, 2011; Roaten, 2011) and worked towards establishing a secure attachment (Bowlby, 2005; Tortora, 2006). Boundary setting was also essential for some clients, as reminders were necessary to conduct productive therapy and keep the relationship strictly therapeutic. I also found it quite beneficial to physically support the clients who needed assistance in movement. Sometimes this meant

physically holding the students who had not yet built up the strength to support themselves, while other times it meant matching their level in space by lying down next to them on the floor. Supporting the client nonverbally, physically, and in space, facilitated growth in the therapeutic relationship and my own personal knowledge as I found ways to relate while also staying true to myself. Over the course of my clinical work at my internship site, in combination with my research and writing process, I have encountered many instances that could be deemed defining moments. These moments have and will continue to inform my current work as well as my personal and my professional identity. As Skovholt and Rønnestad (1995) have outlined, I feel that through conventional learning, professional training, imitating my supervisors or experts in the field, experiencing conditional autonomy, exploration, integration, individuation, and integrity I am establishing myself and my professional identity.

There is some research regarding the use of DMT for children with disabilities in school settings (Ray, 2007; Tortora, 2010) and adult inpatient psychiatric patients (Sandel et al., 1993), as well as on building therapeutic relationships (Amighi et al. yr.; Bowlby, 2005; 1999; Ray, 2007; Siegel, 2012; Sultanoff, 2013; Tortora, 2006). However, my research adds one way of understanding how to establish therapeutic relationships with clients whom therapists may find difficult to relate to by emphasizing the application of dance/movement therapy skills. I acknowledge that this illustration of the information is from the perspective of a heuristic study, and is only one example of what this gap in the research looks like. Within the literature, Klasson (2014) examined the work of dance/movement therapists who incorporate the techniques of motivational interviewing into their practice. She found that the motivational interviewing framework could offer guidance and structure in working with clients both verbally and nonverbally. Through my research, I found that my skills as an emerging dance/movement

therapist increased the effectiveness of building therapeutic relationships; I was able to implement various strategies to building therapeutic relationships and supplement them with my body knowledge and experience of the mind-body connection.

Some limitations of my study were my own personal biases and tendencies towards the work I was engaging in. During my data collection process, I did not spend much time in the incubation stage. This bias, as identified in chapter three, of my preference towards accelerating in time and persevering through tough situations impacted the study in that I was unable to step away from it and give myself time to internalize and gain a more global understanding of what I was experiencing. Another limitation was that, at the therapeutic day school, I had a hard time seeing past the children's disabilities and it was not until months after I began my work there that I was able to begin my research. However, I believe if I had begun my research simultaneously with the start of my clinical work, then my results may have had a much different outcome. Due to starting my research months after starting my clinical work, I had already established a foundation with some clients in which to continue building the relationship. Additionally, I think this study is skewed to my personal preferences and experiences. This study could be easily recreated; however, I feel that the outcome of the results would differ for each person who conducted it, as it is a self-study.

To summarize, this study was inspired by my first clinical internship placement at an adaptive elementary school, which led to the question: How do I develop therapeutic relationships with clients whom I find challenging to relate to or with whom I feel uncomfortable? Through an eight-week data collection and analysis process, three main themes emerged that answered my question of how I personally develop therapeutic relationships that I find difficult—mirroring, negotiating my wants and needs, and discovering ways to support the

client.   These implications impact the field of dance/movement therapy, because they align with the concepts that movement and the body-mind connection affect interventions and can facilitate how one approaches therapeutic relationships.

To guide further research on this topic, I would recommend addressing the questions: How does one overcome personal bias affect relationship? How does the therapist's preference in his/her dance/movement therapy theoretical framework dictate the therapeutic relationship? These questions could advance the field of dance/movement therapy by challenging clinicians to consider when their personal prejudices or biases are counterproductive to the therapeutic relationship. Additionally, by examining the clinician's preferences in their theoretical framework to dance/movement therapy, they may note changes in their effectiveness with specific clients or populations.

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Appendix A

Definitions of Key Terms

Countertransference.

When a therapist reacts emotionally in a complementary or similar way to that of a client's transference; something that lives in all individuals as part of who they are, similar to a personality trait (Prasko et al., 2010).

Kinesthetic attunement.

An act in which the client is able to feel seen or acknowledged through physical mirroring by the therapist (Tortora, 2009).

Nonverbal-communication.

Aspects of communication such as gestures and facial expressions that do not involve verbal communication, but may include nonverbal aspects of speech itself (accent, tone of voice, speed, etc.) (Nonverbal-communication, n.d.).

Therapeutic Relationship.

An expressive, communicative, and adaptive way in which to connect that serves to focus on movement as it emerges (American Dance Therapy Association, 2016).

Ways of Seeing.

A therapeutic method based on principles of dance/movement therapy that incorporates creative expression through dance, movement, music, and Laban Nonverbal Movement Analysis to facilitate healing and change (Tortora, 2010).

Appendix B

Data Collection Journal Template

Date: ________________ Location: _________________________

Why I was drawn to this specific therapeutic relationship today	Strength/Positive aspect of the therapeutic relationship today	Why this therapeutic relationship was different or challenging	Tips/techniques that worked best to connect with student/client	Main idea of how to improve my ability to forge the therapeutic relationship in my next session