12-17-2016

Being In Relationship: The Experience of a Female Dance/Movement Therapy Intern on a Male Residential Unit for Sexually Problematic Behaviors

Krista Tyner
Columbia College Chicago

BEING IN RELATIONSHIP: THE EXPERIENCE OF A FEMALE DANCE/MOVEMENT THERAPY INTERN ON A MALE RESIDENTIAL UNIT FOR SEXUALLY PROBLEMATIC BEHAVIORS

Krista Tyner

Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Department of Creative Arts Therapies

17 December 2016

Committee:

Susan Imus, MA, BC-DMT, LCPC, GL-CMA
Chair, Dance/Movement Therapy and Counseling

Laura Downey, MA, BC-DMT, LPC, GL-CMA
Research Coordinator

Andrea Brown, BC-DMT, LCPC, NCC
Thesis Advisor

Kyla Gilmore, BC-DMT, LCPC
Reader

Abstract

This study serves to explore the experience of a female dance/movement therapy intern working with males on a residential unit for sexually problematic behaviors. It enlightened me on how it was to be in relationship with them, through both a mind and body therapeutic lens. It addresses stereotypes and preconceived notions pertaining to this population. The questions attempted to be answered were as follows: How is it to be in relationship with males who are on a residential unit for sexually problematic behavior, as a female dance/movement therapy intern? How do I experience male/female relationships, gender, and sexuality on the unit? What is my positive or negative countertransference response to the male patients? How do I experience and respond to comments and/or gestures that feel uncomfortable? How do my thoughts, feelings, and sensations affect my clinical interventions? In this study, as it is heuristic in nature, I was both the inquirer and the inquired-into. I used body tracking, journaling, and self-interviews as qualitative data collection methods. To complete my research I utilized Forinash's qualitative data analysis method to analyze my data. I also used the peer debriefer model and conducted a resonance panel to discuss my findings. My findings are that of a generally positive experience, thoughts/feelings/sensations, of being in relationship with the males on the residential unit for sexually problematic behaviors. In doing this research I hope to increase the body of knowledge on the process of establishing/maintaining relationships with populations who are generally viewed as undesirable to work with as well as the positive or negative countertransference responses that may have surfaced.

Acknowledgements

To my thesis advisor, Andrea Brown, thank you for your balance of encouragement and pressure to finish this thesis. Your nurturing presence helped me feel safe in exploring this topic but you always knew when to light that fire and keep me on track. Your expansive knowledge and the work you have done with this population is an inspiration to me. And, a special thank you for not being too hard on me when I returned from my unannounced many months long hiatus to get my life back on track.

To my clinical supervisor and reader, Kyla Gilmore, thank you for guiding me through this very difficult experience. You were confident in my abilities long before I was able to recognize them myself. I cherish the supervision sessions we had together and how much I have learned from you. I am incredibly appreciative of the feedback you provided for my thesis and how it helped me expand on my experience. To have you as both my clinical supervisor during this process and my reader is a gift.

To my therapist, Susan Cahill, thank you for helping me understand my process in the deepest way possible. Your ability to hold space in challenging times is extraordinary.

To my family and friends, thank you for being a constant source of support and guidance throughout this process. Your love and sometimes not so gentle nudges have helped me grow exponentially. You have taught me to be authentic in everything I do. I am forever grateful to have you in my life. I love you.

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Chapter One: Introduction

I was often asked why I chose to work with males with sexually problematic behaviors. In exploring my interests for my thesis topic I initially had a desire to explore the use of dance/movement therapy with survivors of sexual trauma. As someone who has experienced unwanted sexual behaviors I feel it is important to break the code of silence in order to shed light on the experiences I and others have had. In my personal experience I have noticed that survivors are encouraged, verbally and nonverbally, to move past their experience without expressing their anger, vulnerabilities, sadness, and confusion. It can be difficult to disclose and explore the impact of sexual trauma and I intended to use dance/movement therapy as a vehicle for that exploration. I wanted to take a new perspective, however, and focus on the male survivor's experience as it seemed to be a seldom explored topic. In reviewing the literature I recognized a lack of literature on males who had experienced sexual trauma. Instead, the majority of the literature on sexual trauma and males was from the aspect of being perpetrators. This sparked an interest in me in then wanting to understand the experience of the ones who engaged in the sexually problematic behaviors. I was also curious to see how my own experiences shaped my relationship with this population.

Part of this interest came in relation to rape culture. Rape culture is "a complex set of beliefs that encourage male sexual aggression and supports violence against women. It is a society where violence is seen as sexy and sexuality as violent" (Buchwald, 1994, p. xi). This perpetuates the cycle of sexually problematic behaviors as the behaviors are seen as inevitable, a fact of life. When people encounter these unwanted sexual behaviors they are often blamed for the experience; they are questioned about their appearance, their substance use, and their sexual history. In my perspective it appears that society praises sexual violence and aggression on

television and sexual offenders are rarely sentenced to full term; when perpetrators are convicted there is often little done to eliminate the behaviors. Instead these offenders are marginalized and considered an undesirable population to work with. This furthers the cycle of privilege and objectification. The influence of race and socioeconomic status on conviction and sentencing of any type of offenders is tremendous (Gao, 2014). People who have spent their lives being marginalized by the system continue to be marginalized after they have acted on what they have been taught by society; that sexuality, aggression, and power go hand in hand.

The system fails to understand the importance of healing sexual trauma in order to break the cycle of abuse. Many of those who engage in sexually problematic behaviors have experienced sexual trauma of their own (Report on the task force, 2006). Women tend to internalize their trauma. They are taught to normalize their experience and forgive. The acceptance of unwanted sexual behaviors makes it easier to protect themselves from experiencing their anger. When women experience and act on their anger they are perceived in a negative manner, often being called "crazy." I have noticed that males, however, often externalize their emotions by engaging in more aggressive behaviors as they are taught is acceptable by society. Men who do not display forms of aggression in response to being violated are considered weak. This leads to further acts of sexual violence in order to regain power (Charles, 2010). In order to break these cycles and challenge rape culture it is important to work toward healing the trauma of all people involved. One of the ways in which healing is possible is through understanding the importance of connection.

My knowledge on attachment theory shaped my understanding of the basic need for humans to experience connection and being in relationship. I felt that the people who had committed acts of sexual aggression and violence were no different. I felt a desire to understand

the connection I could make with these males and use dance/movement therapy to understand that connection. While I maintained an open mind in my decision to work with the residents, I knew the work would be difficult and potentially bring out my own vulnerabilities. However, I wanted to push myself out of my comfort zone using dance/movement therapy with males with sexually problematic behaviors in order to grow as a therapist and as a person. My theoretical orientation is based on attachment theory.

Purpose of the research

The purpose of this study was to explore the relationship between myself, a female dance/movement therapy intern, and male patients in a residential in-patient unit for sexually problematic behaviors and the thoughts/feelings/experiences I had with each interaction. This study aimed to address any positive or negative countertransference responses that arose and how they influenced my ability to establish/maintain a therapeutic relationship with the residents. With this study I hoped to establish a meaningful relationship with the residents and understand how it felt, mind and body, to be in relationship with them. I was also curious to understand how my own preconceived notions and life experiences could lead to potential bias in my work and how to manage any prejudices that arose.

Motivation for the study

The motivation for this study stemmed from my understanding, through a constructivist framework, that subjective experiences influence how people are in relationship (Mertens, 2005). I was curious as to how my own subjective experiences as a female dance/movement therapy intern, interacting with males in a residential unit for sexually problematic behaviors, influenced how I was able to establish/maintain the therapeutic relationship as well as provide therapeutic

interventions. I believe strongly in the importance of compassion and empathy in relationship and that all human beings deserve positive interpersonal connection. Individuals who exhibit sexually problematic behaviors are often dehumanized and become societal outcasts. In a society where we glorify sexuality and power we label the individuals deviants who act on these concepts, using sexuality in a harmful way to gain a sense of power. It is understandable that many clinicians refrain from working with this population. In my own experience I have noticed that sexually problematic behaviors cause us to feel vulnerable and violated, often by simply talking about them. Working with the population is difficult. But it is necessary. Through this heuristic study I hoped to emphasize the importance of being in relationship with and having compassion and empathy for otherwise undesirable populations.

Research Questions

How is it to be in relationship with males who are in residential treatment for sexually problematic behaviors, as a female dance/movement therapy intern? How do I experience male/female relationships, gender, and sexuality on the unit? What is my positive or negative countertransference response to the male patients? How do I experience and respond to comments and/or gestures that feel uncomfortable? How do my thoughts, feelings, and sensations affect my clinical interventions?

Value of the Study

This study provides information related to the experience of establishing and maintaining a relationship with patients in a residential unit for sexually problematic behavior. It served to enlighten me, as the researcher and dance/movement therapy intern, on how it is, mind and body, to be in relationship with patients who have a history of sexually problematic behavior. It

addresses my stereotypes and preconceived notions pertaining to this population. My hope is that my experience provides therapists with information about the process of establishing/maintaining relationships with clients who are generally viewed as challenging to work with as well as the positive or negative countertransference responses that may have surfaced throughout my own process. By exploring my own compassion in working with this particular population I hope to help other clinicians gain insight into the experience of working with sexually problematic behaviors. It is my belief that all individuals should be met with unconditional positive regard. I feel this is especially important with populations who are seen as deviant and outcast, due to their socially unacceptable behaviors, because of their frequent lack of constructive relationships. I hope to provide a deeper understanding of working with this population and their need for relationship, as all human beings desire and benefit from interpersonal connection.

Chapter Two: Literature Review

Definition of sexually problematic behavior

While sexual play and exploration is a natural developmental process that aids children in understanding their own bodies as well as the social and cultural expectations of sexuality, there is a distinct difference between normal sexual explorative behaviors and sexually problematic behaviors. "Sexual play" and "sexualized behaviors" are terms used when developmentally appropriate sexual behaviors occur in children with no risk factors for abuse (Kellogg, 2010). Forty-two to seventy-three percent of children under the age of thirteen engage in normative sexual behaviors such as attempting to view another's breasts or genitals, touching their own genitals, and standing too close to another person; this behavior occurs less commonly, less frequently, and more covertly after the age of five (Kellogg, 2010). This behavior is natural and, as previously mentioned, helps a child understand their body and what is acceptable in their society and culture. Normal sexual play in children is intermittent, spontaneous, and mutual when other children are involved; these behaviors do not cause emotional distress (Report on the task force, 2006). When age-appropriate sexual behaviors become aggressive or disruptive to the child's life the behaviors are considered sexually problematic.

Sexually problematic behavior is not specific to any one group of children and can occur in children of all ages, cultures, socioeconomic statuses, familial structures, and living circumstances (Understanding and coping, 2012). Sexually problematic behaviors are not considered one specific disorder, rather, they are a set of behaviors which fall outside of socially acceptable limits (Report on the task force, 2006). The degree of severity of sexually problematic behavior and potential harm to others in children widely varies and while there are many

common features of sexually problematic behavior there is no universal profile (Report on the task force, 2006). It is important to consider whether a child's sexual behavior is common or rare for their age and culture, whether the child discontinues the behavior after adult correction, the extent to which the child is preoccupied with sexual behaviors, and the frequency of the behaviors to determine whether the child's behavior is sexually problematic (Report on the task force, 2006).

In the literature, sexually problematic behaviors, also known as "sexual acting out" or "sexually abusive behaviors", are defined as sexual behaviors that are "developmentally inappropriate, coercive, or potentially harmful emotionally or physically" (Kellogg, 2010, p. 1233 - 1234). "Developmentally inappropriate behavior can be defined as behavior that occurs at a greater frequency or at a much earlier age than would be developmentally or culturally expected, becomes a preoccupation for the child, or recurs after adult intervention or corrective efforts" (Kellogg, 2010, p. 1235). Sexually problematic behaviors have one or more of the following characteristics: beyond the child's stage of development, association with strong emotional responses, interference with normal childhood activities, involvement of children with drastic age differences or abilities, harmful or inappropriate use of a sexual body part such as insertion of objects into the child's rectum or vagina, and involvement of force, aggression, and/or threats – and continue to occur despite adult interference (Understanding and coping, 2012). Other literature defines sexually problematic behavior as having intrusive characteristics such as "touches other child's sex parts, tries to have intercourse, puts mouth on sex parts, touches adult sex parts, touches animal sex parts, asks others to do sex acts, tries to look at people when they are nude or undressing, tries to undress other children, shows sex parts to children, and tries to undress adults against their will" (Baker, Gries, Schneiderman, Parker,

Archer, & Friedrich, 2008, p. 12). Despite what the behaviors are, sexually problematic behaviors generally tend to occur with other children and is often with younger children, siblings, and/or friends (Understanding and coping, 2012). These behaviors are most concerning when there is a drastic age difference or developmental inequality, when the sexual behavior is advanced for the child's age, when it is forced, and when it is harmful or could potentially cause harm (Report on the task force, 2006).

There are varying degrees of severity of sexually problematic behaviors. Cavanagh-Johnson differentiates between four groups of sexually problematic behavior in children. She also notes in her research that not all sexual behavior in children is to be considered sexually problematic behavior, as some sexual behavior can be appropriate at certain ages while others are not (Gil & Cavanagh-Johnson, 1993). The following are the distinct groups, as defined by Cavanagh-Johnson, of sexual behavior, ranging from normal sexual exploration to sexually problematic behaviors.

> GROUP ONE: Normal sexual exploration: Children of all ages show normal, sexual behavior based on the discovery and development of their physical and sexual selves.
>
> GROUP TWO: Sexually reactive behaviors: preoccupation with sexuality. Many of these children have been abused or exposed to pornography and sexual stimulation (Kellogg, 2010, p. 1234).
>
> GROUP THREE: Extensive mutual sexual behaviors: use coercion and manipulation but rarely resort to violence.
>
> GROUP FOUR: Children who molest: The children in this category go far beyond developmentally appropriate play. They are obsessed with sexual thoughts and engage in

> full range of sexual behaviors that becomes a pattern, rather than solitary incidents. These children often link sexually problematic behaviors to feelings of anger, rage, loneliness, or fear. They lack compassion with their victims and feel regret in getting caught, not with hurting another child. (Gil & Cavanagh-Johnson, 1993, pg. 41-51)

Why sexually problematic behaviors occur

The origin of sexually problematic behaviors is unclear. There seems to be a lack of adequate literature regarding therapeutic work with males who exhibit sexually problematic behavior. Much of the literature focuses solely on survivors of sexual abuse, and while sexual abuse happens to both males and females a majority of the literature highlights only the female survivors' experience. This may be due in part to that male sexual abuse occurrences are less frequent than female sexual abuse and that males are less likely to disclose experiences of sexual trauma (Hensley, 2002). Hensley (2002) noted that 1 in 6 women reported having been sexually abused whereas 1 in 33 men reported sexual abuse. It is unknown what the exact origins of sexually problematic behavior. Each case is unique in its variables. According to the National Center for Victims of Crime, 40-80% of juvenile sexual offenders have been victims of sexual abuse (Statistics on perpetrators, 2014). It was also found that males who were sexually abused by women, in childhood, may be at higher risk for repeating the cycle of abuse (Glasser, 2001).

However, a history of sexual abuse does not necessarily result in sexually problematic behaviors. "Evidence suggests that there probably are multiple pathways to [sexually problematic behavior], some of which involve sexual abuse and some which do not" (Report on the task force, 2006, p. 11). While many children who display sexually problematic behaviors have a history of sexual abuse it is uncommon for children who have been sexually abused to

develop sexually problematic behaviors (Kellogg, 2010). Some studies (Bonner, Walker, & Berliner, 1999; Silovsky & Niec, 2002) have found that many children who exhibit sexually problematic behaviors in fact have no history of sexual abuse. Despite early studies showing a strong correlation between sexual abuse histories and sexually problematic behaviors, more recent studies suggest a number of other variables that can potentially lead to sexually problematic behaviors. The origin of sexually problematic behavior is unclear (Report on the task force, 2006). Children's sexually problematic behavior is rarely for sexual pleasure, rather, much more likely to be in response to traumatic experiences, anxiety, curiosity, poor impulse control, imitation, attention-seeking, self-calming, and other factors (Understanding and coping, 2012; Report on the task force, 2006; Silovsky & Bonner, 2003). It is believed that there are many other contributing factors to sexual acting out behaviors including familial, socio-economic, and developmental factors as well as physical abuse and neglect, poor parenting techniques, exposure to violence in the home living in a highly sexualized environment, and exposure to sexually explicit media (Friedrich, Davies, Feher, & Wright, 2003; Report on the task force, 2006). Other studies cite risk factors as exposure to trauma, exposure to domestic violence, exposure to adult sexual activity or nudity (including internet and television exposure), lack of modesty and privacy in the home, and inadequate supervision stemming from parental substance abuse, depression, or absences due to work (Understanding and coping, 2012). "… recent technology, such as the internet, chat rooms, and texting, has expanded the way children are exposed to sexually explicit information. Contemporary television and music provide more frequent exposure to sexual material; there are an average of eight sexual acts per hour on television, and increase of more than fourfold since 1976" (Kellogg, 2010, p. 1233).

One common factor in all studies is familial and societal context which appears to have a greater influence than history of sexual abuse. "The family environment and social ecology is a key area in assessing all childhood behavior problems, including sexually problematic behaviors … Current and future environmental context may be more influential than individual child factors or the child's individual psychological makeup" (Report on the task force, 2006 p. 7). Family discord, including neglect, violence, and abuse can cause or magnify sexually problematic behaviors in children (Kellogg, 2010). Even seemingly benign family stressors such as separation or divorce can increase a child's sexually problematic behaviors (Kellogg, 2010). Albeit not all children and adolescents who experience familial and societal tumult will react in displaying sexually problematic behaviors it is a significant factor in those who do exhibit such behaviors. It is important to assess all factors and the level of sexually problematic behaviors in order to determine the appropriate course of action.

Assessment inventories

There are two primary assessment inventories used when working with children and adolescents who display sexually problematic behaviors; the Juvenile Sex Offender Assessment Protocol – II (J-SOAP-II) and the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR 2.0). While both of these tools assess similar behaviors and factors they are each beneficial in different ways. The J-SOAP-II is a greater assessment tool when conducting a one-time risk assessment for juvenile court or to make recommendations during investigation or determine initial level of care for treatment (Yokley, 2003). The ERASOR 2.0, on the other hand, is better suited for repeated risk assessments during long-term treatment in order to help determine when a recommendation for a lower level of care may be appropriate (Yokley, 2003). Each of these tools takes both static and dynamic factors into consideration when determining an

individual's level of risk – although the J-SOAP-II identifies factors as static or dynamic while the ERASOR 2.0 does not.

Static factors are factors that cannot typically be altered, for example, age, history of offense, and age at first sex offense related arrest or conviction (Yokley, 2003). Dynamic factors are more fluid and can change throughout the duration of one's life, for example, intimacy problems, substance use, and level of remorse (Yokley, 2003). Dynamic factors can be broken down further into stable and acute categories (Yokley, 2003). Although stable dynamic factors can change over time they are longer lasting. Substance abuse or deviant sexual preferences are examples of stable dynamic factors (Yokley, 2003). Acute dynamic factors are factors that can change over a short amount of time, such as intoxication or sexual arousal immediately prior to the offense (Yokley, 2003). When assessing risk factors it is important to include all key informants, including but not limited to "biological, adoptive, and foster parents, probation and parole officers, human services caseworkers, client advocates, and guardian at litems" (Yokley, 2003, p. 5). Each assessment tool used with sexually problematic behaviors has a unique way of understanding a weighing these factors.

The J-SOAP-II aids in the "systematic review of risk factors that have been identified in the professional literature as being associated with sexual criminal offending" (Prentky & Righthand, 2003, p. 309). These risk factors were identified after reviewing literature on clinical studies of juvenile sex offenders and risk assessments/outcomes of juvenile sex offenders, adult sex offenders, general juvenile delinquency literature, and mixed adult populations (Prentky & Righthand, 2003). Risk factor items are scored on a 0 to 2 scale with "0" being absence of the item, "1" being present with insufficient or unclear information, and "2" being clear presence of the item (Prentky & Righthand, 2003). As previously noted, the J-SOAP-II identifies risk factors

as belonging to two scales – static/historical and dynamic. Static/historical scales include sexual drive/preoccupation items and impulsive/antisocial items (Prentky & Righthand, 2003). Dynamic scales include intervention items and community stability/adjustment items.

The ERASOR 2.0 "is an empirically-guided approach to estimating the risk of a sexual re-offense for an adolescent, presently aged 12 to 18 years, who has previously committed a sexual assault" (Worling & Curwen, 2001, p. 339). When using the ERASOR 2.0 scores are determined by whether a factor is present, partially/possibly present, not present, or unknown (Worling & Curwen, 2001). The following categories are assessed: (1) sexual interests, attitudes, and behaviors (2) historical sexual assaults (3) psychosocial functioning (4) family/environment functioning (5) treatment and (6) other factors (Worling & Curwen, 2001). Although it is likely that higher risk factors and indicators will suggest higher risk, the ultimate decision is more dependent on combinations of risk factors as opposed to the number (Worling & Curwen, 2001). "Furthermore, it is possible that the presence of a single risk factor – such as the adolescent's stated intentions to reoffend – could be indicative of high risk" (Worling & Curwen, 2001, p. 339).

Despite which assessment inventory is used when determining risk in children and adolescents with sexually problematic behavior it is imperative to assess carefully and conscientiously. "Decisions based on our evaluation can have a profound impact: on the one hand, protecting society from genuinely high-risk youths, while on the other hand, possibly resulting in severe, life-altering consequences for low-risk youths" (Prentky & Righthand, 2003, p. 309). It is important for the social worker or therapist utilizing these tools to assess an individual uses clinical judgment to decide the course of treatment for the individual. While treatment for sexually problematic behavior itself is imperative it is worthwhile to consider other

diagnostic issues that the individual may be experiencing in order to provide more adequate treatment and further reduce the risk of reoffending sexually and nonsexually.

Diagnostic considerations

Children and adolescents who engage in sexually problematic behavior often times have other non-sexual problems. Some of these non-sexual problems include externalizing behavior problems such as aggressive or oppositional behavior, internalizing problems such as anxiety, depression, and post-traumatic stress disorder, learning and developmental problems, and disadvantageous environments such as neglect, physical abuse or exposure to violence (Report on the task force, 2006). Many children with sexually problematic behaviors demonstrate social and behavioral difficulties: impulsivity, difficulties following rules at home, school, and in the community, difficulty making friends their own age, and an inability to utilize positive coping skills instead using masturbation as a calming technique and to relieve stress (Understanding and coping, 2012). "Children with more intense sexually problematic behaviors tend to have more co-morbid mental health, social and family problems" (Report on the task force, 2006, p. 5). Often times children and adolescents with sexually problematic behaviors do not only display other social and behavioral difficulties but will also be diagnosed with a co-occurring mental illness. Research has shown, when sampling children with sexually problematic behavior six to 12 years of age, "the most common comorbid diagnoses were conduct disorder (76 percent), followed by attention-deficit/hyperactivity disorder (40 percent) and oppositional defiant disorder (27 percent)" (Kellogg, 2010, p. 1236). It is necessary to understand the implications of a child or adolescents sexually problematic behaviors in order to understand the necessary course of action.

Adult versus adolescent treatment

"Despite considerable concern about the progression on to later adolescent and adult sexual offending, the available evidence suggests that children with sexually problematic behaviors are at very low risk to commit future sex offenses, especially if provided with appropriate treatment" (Report on the task force, 2006, p. 2). It is imperative to note that children and adolescents with sexually problematic behavior differ greatly from adult sexual offenders. These are two different populations, not just adult offenders at a younger age (Report on the task force, 2006). Although some believe that children with sexually problematic behaviors will grow up to be adult sexual offenders, the literature shows us that children who receive treatment for sexually problematic behaviors rarely commit sexual offenses as adults and are no more likely to commit sexual offenses than children with no history of sexually problematic behaviors, especially those who meet criteria for Cavanagh-Johnson's group four (Understanding and coping, 2012). While many adult offenders began offending during childhood and adolescence (Worling & Curwen, 1998) "we should avoid the logical fallacy of reasoning backwards and assuming that all or most children with sexually problematic behavior are therefore on a path toward serious sexual aggression" (Report on the task force, 2006, p. 22).

Studies show that adolescents respond more positively to treatment than adults. Children and adolescents can learn respect, healthy boundaries, and appropriate behaviors with proper treatment (Understanding and coping, 2012). Adolescents are in a stage of development that is neither fixed nor stable and their behavior and status can change over time as they develop and mature and their social environment changes, unlike adults, allowing for treatment to have a greater impact on sexually problematic behaviors (Prentky & Righthand, 2003; Report on the task force, 2006). With adult intervention, there appears to be a considerable improvement in

sexually problematic behaviors (Report on the task force, 2006). With focused treatment, children and adolescents who display sexually problematic behaviors have an even greater rate of improvement (Report on the task force, 2006). Generally, children and adolescents with sexually problematic behavior appear to respond well to treatment, in particular, cognitive-behavioral and psychoeducational interventions that involve caregivers (Report on the task force, 2006). Some studies support cognitive-behavioral-therapy as the most effective treatment for sexually problematic behaviors with a focus on "identifying, recognizing the inappropriateness of, and apologizing for rule-violating sexual behaviors that occurred, learning and practicing basic, simple rules about sexual behavior and physical boundaries, age-appropriate sex education, coping and self-control strategies, basic sexual abuse prevention/safety skills, and social skills" (Report on the task force, 2006). Although research regarding the efficacy of treatment with adult offenders is lacking, studies show that community-based treatment with a cognitive behavioral focus is more impactful with adolescent offenders (Worling & Curwen, 1998). There is a lack of research regarding long-term recidivism rates of adolescent offenders who receive focused treatment. One study, however, found that "comparison groups were similar with respect to a wide array of variables that could have influenced subsequent recidivism such as history of previous offending, victim-preference characteristics, and family environment. The sexual assault recidivism rate (criminal charges) for the comparison group was 3.6 times higher (18%) than the recidivism rate for the treatment group (5%)" (Worling & Curwen, 1998, p. 2). This means that with treatment the rates of reoffending are significantly reduced. This study also found that treatment can effectively reduce recidivism rates of nonsexual offenses, despite previous research stating that sexual offenders are likely to commit nonsexual offenses (Worling & Curwen, 1998).

Attachment and relationships

Males who exhibit sexually problematic behavior often report experiencing profound loneliness and disconnectedness (Charles, 2010). Research has indicated that some sexually problematic behavior is committed in response to those feelings of isolation (Ward, Mann, & Gannon, 2007). One way clinicians have found to successfully address feelings of loneliness, disconnectedness, and isolation in patients with sexually problematic behavior is to stress the importance of relationship. For some clients with sexually problematic behaviors offending is a way to attempt to reach out to others, no matter how inappropriate this attempt may be (Charles, 2010). Patients with sexually problematic behaviors should be treated as human beings and not as animals. Charles (2010) noted that relationship is the key to change in all relationships. Not only should clinicians establish a strong therapeutic relationship with the patients but they should also provide psychoeducation on how to appropriately respond to sexual urges and create healthy relationships and intimacy (Charles, 2010). Ward and Durrant (2013) believe that in order to establish healthy intimate relationships an individual must have the ability to respond empathically in shared experiences. Lack of empathy causes dysfunctional and destructive social behavior while empathic understanding allowed for the establishment and maintenance of intimate relationships (Ward & Durrant, 2013). Another study suggests that mindfulness also plays a large role in an individual with sexually problematic behavior's treatment. Jennings, Apshe, Blossom, and Bayles (2013) stated that methods that fail to use mindfulness are less likely to be effective in treating patients displaying sexually problematic behavior. Although literature on therapy for individuals who display sexually problematic behavior is relatively scarce there is an indication that relationship, empathy, and mindfulness are all beneficial in the treatment process. As dance/movement therapy utilizes each of these principles while exploring

the mind/body connection it could be further concluded that dance/movement therapy would be a beneficial treatment approach to working with sexually problematic behaviors.

As Rich states "we will most likely bring about change through the connections, the attachments, and the driving force of relationships and social relatedness" (Rich, 2013, p. 5). He also notes that attachment simply describes social connectedness and attachment during childhood and adolescence can develop into adult attachment and relationship patterns (Rich, 2013). Rich further states "it is the capacity to express ideas and emotions through the communication, the content of the communication, the intensity of the level of communication, and the accuracy of the response to communication that defines not only the quality of that communication, but the quality of the attachment bond that forms through repeated and sustained communication over time" (Rich, 2013, p. 31). This is especially important in working with clients who exhibit sexually problematic behavior as we therapists can work to mend attachment patterns, in turn potentially repairing negative behavioral patterns. Finally, Rich (2013) notes that in addition to attachment the exploration of empathy, remorse, morality, intimacy, social competence, self-efficacy are important concepts in the treatment of clients with sexually problematic behaviors.

Therapeutic approach to treatment

Treatment for children and adolescents with sexually problematic behaviors has grown exponentially over the past 30 years. While in the early 1980s there was only one specialized treatment center for sexually problematic behaviors by 1995 there were approximately 1,000 and that number continues to grow (Worling & Curwen, 1998). As treatment has become more accessible the way we are approaching work with sexually problematic behaviors has started

shifting. Traditional approaches to therapy with children and adolescents who display sexually problematic behaviors uses loud and aggressive confrontation in which the therapist exerts their power over the client (Charles, 2010). More recent studies have shown that this type of approach is unsuccessful as it teaches these young people that power and control is the way to get their needs met – further reinforcing their "offense-type behavior" (Charles, 2010, p. 24).

Rather than utilizing power and control techniques to manage sexually problematic behaviors newer method work to "… increase offender accountability; assist offenders to understand and interrupt the thoughts, feelings, and behaviors, and behaviors that maintain sexual offending; reducing deviant sexual arousal; improve family relationships; enhance victim empathy; improve social skills; develop healthy attitudes towards sex and relationships; and reduce the offender's personal trauma (if present)" (Worling & Curwen, 1998, p. 3). As sexually problematic behaviors are only one aspect of the child or adolescent's life it is important to develop treatment goals that improve social skills, self-esteem, appropriate emotional expression, body image, familial discord, intimacy, and trust (Worling & Curwen, 1998). It has been found that the majority of children and adolescents treated with an approach that does not focus on power and control responded well to treatment (Charles, Dale, & Collins, 1995; Charles, 2010). Studies have found that, in fact, with these types of treatment programs the risk of recidivism was reduced (Worling & Curwen, 1998).

Unfortunately, even with the growing options for treatment of children and adolescents with sexually problematic behaviors and the clear need for help, this population receives the least services and is most marginalized (Charles, 2010). As mentioned, children and adolescents with sexually problematic behaviors often have troublesome pasts that in some way or another influenced their behaviors. Strong histories of physical and sexual abuse are common in this

population (Rich, 2013). These factors are many times not the only factors affecting their behaviors. It is common for children and adolescents to have histories of developmental and emotional disturbances as well (Rich, 2013). Sensitivity to these factors is imperative (Report on the task force, 2006). It is important to understand that these clients are not monsters but are children and adolescents who have dealt with their experiences in an unproductive way; learning through their own victimizations that victimizing others is acceptable (Charles, 2010). They have yet to learn the appropriate ways to connect with others (Charles, 2010). By viewing these children and adolescents as victims as well as offenders we can begin treating them in their entirety rather than focusing on one aspect of their being.

Rich noted that "good treatment focuses on the *whole* child and resists seeing the juvenile as simply a sexual offender" (Rich, 2013, p. 145). Rich further states that "despite the label of juvenile sexual offender, our clients are first children and adolescents, as they are the entire time they are in treatment with us. Thus, kids who have often felt uncared for, unloved, unsupported, misunderstood, and disconnected may, through treatment and the treatment environment, reclaim their humanity and begin to feel a sense of connection to others" (Rich, 2013, p. 296). An intervention we can use to help us better understand the client's experiences is intersubjectivity (Stern, 2005); "the capacity to share, know, understand, empathize with, feel, participate in, resonate with and enter into the lived subjective experience of another" (Dosamantes-Beaudry, 2007, p. 74). The therapist works with the client to co-construct and help discover the patient's sense of self and their narrative (Aron, 1996; Dosamantes-Beaudry, 2007). By working with the client in this way we can connect on a deeper level and begin to see all aspects of the client, the *whole* child, and set aside some of our preconceived notions of sexually problematic behaviors. By focusing on our clients as a *whole* child or adolescent we can connect on a deeper level and

make greater strides in healing. While treating the client we must separate the behavior from the person (Charles, 2010). It is important for the client to feel valued and loved while still deeming their behavior as inappropriate (Charles, 2010).

When working with children and adolescents with sexually problematic behaviors it is imperative to explore the concept of attachment, as discussed earlier in this chapter. Many of these youth with sexually problematic behaviors suffer from unhealthy attachment patterns and benefit greatly from attachment-informed therapy. Unproductive attachments such as disorganized attachment patterns can damage the therapeutic relationship. However, working toward a secure attachment pattern can heal relationships and unresolved issues from previous traumas. Rich stated "ultimately the emphasis in an attachment-informed therapy is on the development of and understanding, supportive, and caring relationship, marked by attunement between the therapist and the patient" (Rich, 2013, p.269). He further noted that in order to produce security in the therapeutic relationship we must first make the environment emotionally secure, responsive, and attuned (Rich, 2013). James (1994) believed that five conditions must be present in order to evoke change during treatment: attachment-informed clinical skills, safety, therapeutic parenting, a protective environment, and a therapeutic relationship. As Bowlby (1980) and later Marrone (1998) point out, therapy does not begin until the child or adolescent feels secure and the clinician provides a sensitivity and responsiveness to the youth's needs. This sometimes does not occur until many months into therapy if the client has learned to distrust adult or has insecure attachment patterns. While understanding attachment is important in working with any client population we can see why, due to the sensitive nature of sexually problematic behaviors, it is absolutely essential to understand this concept when working with population.

Another concept believed to be important when working with children and adolescents with sexually problematic behaviors is the concept of empathy. Empathy, as defined by Rogers (1980) is the therapist's ability to enter the client's perceptions and demonstrate sensitivity to the client's experiences. Although many programs provide empathy training for clients "in order to truly teach clients empathy we must understand and model empathy ourselves" (Fernandez & Serran, 2002, p. 131). Fernandez and Serran (2002) note that empathy helps the clinician not only understand the experience of the client but motivates the clinician to help the client. Providing an empathic environment and allowing the client to feel the clinician's empathy also enhances the effectiveness of treatment (Feshbach, 1997). Rich believes that "through the warmth, concern, support, caring, safety, and structure provided by the empathic therapist and treatment staff, children and adolescents in treatment are seen and *feel* seen" (Rich, 2013, p. 296). The positive relationship that comes from this experience promotes great change.

Many clinicians, myself included, believe that relationship is the key to change and that "through the driving force of relationships and *feeling* connected to others that we are most likely to bring about change and stand the best chance of eliminating sexually abusive behavior" (Charles, 2010, p. 24). The ability to communicate emotions and ideas and the response to that communication defines the quality of that relationship formed through repeated communication over time (Rich, 2013). By developing a strong therapeutic relationship the children and adolescents with sexually problematic behaviors learn healthy relationships and how to engage positively with others. This is why it is so important that we as clinicians provide these clients to express themselves positively in a safe space. "Being able to emotionally respond to other people and to share their experiences is a core psychological skill and an essential ingredient of healthy intimate relationships and strong communities" (Ward & Durrant, 2013, p. 66).

Preconceived notions of working with sexually problematic behaviors in clients

When working with children and adolescents with sexually problematic behaviors we must be aware of any preconceived notions we may have that could affect treatment. People have a strong reaction toward children with sexually problematic behaviors due to their offenses being sexual in nature, despite them being similar to children with non-sexual behavior problems (Understanding and coping, 2012). When working with sexually problematic behaviors or "sex offenders" we often accept ideas that are not empirically proven facts (Rich, 2013). We often think of sex offenders as being the very worst, "violent crazed outcasts who lurk in the shadows of our world" (Charles, 2010, p. 18).

Although labels can be beneficial in developing a common language and understanding (Charles, 2010) it is important to not use labels as the only guide to identifying the client in order to not let the label sway our work. This is most evident in the use of the word "sex offender" as society has a strong emotional reaction to the term (Charles, 2010). "Many of us have stereotypical views of sex offenders. We see them as monsters and deviants who are beyond help. We create an image of them as untreatable and then treat them as such" (Charles, 2010, p. 20). "Adults should take every precaution against policies that label children as deviant, perverted, as sex offenders, or destined to persist in sexual harm. Professionals increasingly use the term children with sexual behavior problems because it labels the behavior and not the identity of the child" (Report on the task force, 2006, p. 24).

Countertransference

When working with any patient population it is common to experience countertransference. Countertransference comes from psychoanalytic therapy and it was initially used to refer to a therapist's emotional response to a patient's transference; "the patient's reproduction of past relationships in the current relationship established with a neutral analyst" (Dosamantes-Beaudry, 2007, p. 75). Countertransference has recently been defined by cognitive therapists as "the activation of a clinician's automatic thoughts and schemas by the therapeutic relationship (Wright, Basco, & Thase, 2006) into the cognitive paradigm". (Ivey, 2013, p. 231) A schema is the clinician's worldview or conceptual framework. Gelso and Hayes have defined countertransference as: "the therapist's internal and external reactions that are shaped by the therapist's past or present emotional conflicts and vulnerabilities" (Gelso & Hayes, 2007, p. 25). Despite its roots in psychoanalytic therapy, the idea of countertransference is transtheoretical and is experienced by all practitioners, despite their theoretical orientation (Hayes, 2004). Although many cognitive therapists are hesitant to adopt psychoanalytic language they have found the benefits of exploring countertransference in understanding the importance of the therapeutic relationship in its productive and obstructive aspects (Ivey, 2013).

Countertransference often emerges in response to certain types of clients or when encountering strong resistance (Ivey, 2013). This can aid a therapist in understanding the client's worldview and what should be further explored during therapy or, on the other hand, can disrupt the therapist's objectivity (Ivey, 2013). "Cognitive therapists discovered that exposure to emotional intensity of a patient's maladaptive relational styles mobilized their own automatic thoughts and irrational actions, thereby enlisting them as inadvertent participants in the interpersonal dramas at play in the patients' external relationships". (Ivey, 2013, p. 232). The

difference, however, between the trained therapist and their client is the ability to observe their countertransference experience and reflect upon its impact on the therapeutic interaction (Ivey, 2013). What many cognitive therapists have discovered is that countertransference can bea means of gaining useful information regarding the client's experience but can also invoke the therapist's personal vulnerabilities (Leahy, 2001, 2007). It is important that the therapist be aware of their own schemas and cognitive distortions in order to anticipate negative impacts they may have on the therapeutic relationship (Ivey, 2013; Leahy, 2001). Research has shown "it is important for the analyst to always strive for a reflective engagement with their countertransference experiences. This involves keeping in mind the whole of the relational dynamic occurring in the analytic situation, thinking about what type of interpersonal and intrapsychic relationship the patient is unconsciously creating in the transference and how to interpretively work in that dynamic. However, some more difficult to reach patients relate in a manner that brings the analyst into areas of more enactment and less understanding" (Waska, 2013, p. 472).

Haarhoff reported that the demands of countertransference "is characteristic of beginning therapists (Haarhoff, 2006, p.129). While this may be accurate in that beginning therapists are less experienced in understanding and managing countertransference, countertransference can occur in any therapeutic relationship regardless of length of practice. Dosamantes-Beaudry noted two types of countertransference: "(a) concordant countertransference reactions in which the analyst felt compelled to identify empathically with the patient's thoughts and feelings and (b) complementary countertransference reactions where the analyst experienced himself being transformed by the patient into an unwanted or despised aspect of the patient's self". (Dosamantes-Beaudry, 2007, p. 75) Certain, more difficult, patients can easily invoke acting out

and enactment behaviors in the therapist in which their own personal emotions are triggered (Waska, 2013). While countertransference is triggered by a patient's words or actions in order for the therapist to have a countertransferential experience "it must centrally implicate some unresolved issue or vulnerability in the therapist" (Gelso & Hayes, 2007, p.26). It can be difficult for therapists to make fully aware their implicit responses as these issues and vulnerabilities carry emotional weight that a therapist may feel more comfortable avoiding (Ivey, 2013) "Due to the intensity of some patient's projective efforts, these countertransference moments of imbalance include periods of deep immersion within the patient's emotional struggles with love, hate, and knowledge in which desire, aggression and learning are part of complicated internal battles" (Waska, 2013, p. 467). When the clinician is immersed in the countertransference experience it can be difficult to manage their own internal experience. Countertransference responses can be particularly difficult to explore when working with a population with sexually problematic behaviors as the topic of sex and sexual relationships are areas that some therapists may be vulnerable in. Therapists may also be sensitive to power and gender issues. In my own work and personal experiences, I have found that for many people, sexual content is charged and can elicit feelings of shame, denial, and avoidance. This is why it is imperative for therapists to take the uncomfortable step toward exploring these responses in their own practice of self-reflection and clinical supervision in order to benefit the therapeutic relationship and process and their own therapeutic work.

Although the idea of countertransference can seem overwhelming there are many benefits to exploring and utilizing the countertransference experience when working with clients. It is important to understand the reason for these experiences to enter into our minds and bodies in order for us as clinicians to understand the client's specific need to use or misuse us (Waska,

2013). This can help us, as previously mentioned, better direct our work with them. We develop an intimate contact with the client's core being when our countertransference is shaped by the client's projective identification (Waska, 2013). "We must notice, understand, and resist the temptation to give up hope and simply retaliate. Instead, we must constantly struggle to regain our analytic balance and convey our hope, understanding and fortitude, however small or tenuous, to the patient through interpretations and emotional containment" (Waska, 2013, p. 478). Positive and negative experiences appear in all relationships and the therapeutic relationship is not immune to this. Immersing ourselves in the countertransferential experience is an "example of how hate can overshadow love and learning unless contained, understood, and translated" (Waska, 2013, p. 479). Although we cannot avoid countertransference we can utilize it as a positive therapeutic device when working with our clients (Waska, 2013). Understanding our explicit as well as our implicit countertransferential experience is most beneficial in the work that we do.

Creative arts therapies

Dance/movement therapy

There is a clear lack of adequate literature pertaining to both sexual abuse and/or sexually problematic behavior and dance/movement therapy as a mode of therapeutic intervention. Only one study has been done concerning dance/movement therapy and a sexual offender. Klibanow (2000) found that her client was able to use dance/movement therapy to explore issues that he was unable to address on a verbal level. She also found that her awareness of her countertransference responses helped in being able to adapt her therapeutic interventions (Klibanow, 2000). Another study explores dance/movement therapy and

transference/countertransference. Dosamantes-Beaudry (1997) uses the term "somatic transference" which she explains is the client's somatic responses toward the therapist and "somatic countertransference" as the somatic responses the therapist has toward the client during treatment. In order to use these experiences to our benefit we must explore the implications they have on our relationship with the client. Avstreih (1981) notes that affective exchanges can occur when an attuned dance/movement therapy creates the transitional space needed for a client to heal.

Drama therapy

Other research has noted the importance of the unspoken connection between therapist and client when working with children and adolescents with sexually problematic behavior but do not directly refer to dance/movement therapy. Certain programs have implemented drama work with adolescents in treatment for sexually problematic behaviors as a means of appropriately expressing their emotions, exploring creativity, and coping will difficult situations in a safe space (Charles, 2010). Non-verbal aspects of therapy are considered beneficial because through this felt experience we bring light to the hidden dynamics and regulators present in such interactions (Rich, 2013). Stern (2005) recommends that the therapist delves deeply into the client's nonverbally communicated experience in order to have a complete understanding of what is going on in the client's mind. Fosha (2003) emphasizes the importance of engagement in the nonverbal connection in order for the therapist to improve the therapeutic relationship. In this aspect dance/movement therapy can be a great asset to the work with sexually problematic behaviors as it uses various nonverbal tools to understand the client's perspective and improve the relationship.

Research contributions

In reviewing the literature, I recognized a gap in the understanding of dance/movement therapy, countertransference, and working with clients with sexually problematic behaviors. While the literature on countertransference and working with sexually problematic behaviors in itself is relatively scarce, the literature on dance/movement therapy with sexually problematic behaviors is even less, and the literature on countertransference while utilizing dance/movement therapy with sexually problematic behaviors is truly non-existent. This provided me with the opportunity to use my research in a way that would focus on the connection between all three in order to better understand a dance/movement therapist's experience when working with this particular population.

Looking back at my initial research questions: How is it to be in relationship with males who are in a residential unit for sexually problematic behaviors, as a female dance/movement therapy intern; how do I experience male/female relationships, gender, and sexuality on the unit; what is my positive or negative countertransference response to the male residents; how do I experience and respond to comments and/or gestures that feel uncomfortable; and how do my thoughts, feelings, and sensations affect my clinical interventions, it is clear that my research was guided by a few concepts from the literature. The two biggest concepts that I was most inspired by were the theory of attachment, especially when working with sexually problematic behaviors, and countertransference implicitly and explicitly.

The research on attachment theory related to working with children and adolescents with sexually problematic behaviors was of particular interest to me and something I wanted to expand on, adding in dance/movement therapy. Attachment is, in essence, how one person

connects and is in relationship with another person. Siegel (1999) points out that our attachment patterns also influence our worldview as well as our means of self-regulation. Sometimes these attachment patterns are positive such as with secure attachments and other times they can be damaging such as with disorganized attachment patterns. Dance/movement therapy is a great way to examine attachment patterns because by using dance/movement therapy we allow ourselves as clinicians to open our minds and our bodies to experience the process to its fullest extent. I wanted to use my research to explore how this theory of attachment when working with children and adolescents with sexually problematic behaviors can be understood through movement and the body. This led to the development of my first two research questions: how is it to be in relationship with males who are in a residential unit for sexually problematic behaviors, as a female dance/movement therapist and how do I experience male/female relationships, gender, and sexuality on the unit. I hoped that by better understanding this connection I could use the knowledge to provide stronger interventions and have more positive interactions with the patients with whom I was working. Ergo, another research question arose: How do my thoughts, feelings, and sensations affect my clinical interventions? By exploring this concept of attachment and how it influenced my treatment process not only did I strengthen my relationship with my clients I also strengthened my sense of self as a therapist and human being, which I will further explore in my discussion chapter.

Secondly, I believe that countertransference is an equally important concept to focus on when using dance/movement therapy with children and adolescents with sexually problematic behaviors. We often perceive countertransference as an emotional response to the client or therapeutic relationship, which it is, but we fail to explore the implications of somatic countertransference and how that guides our treatment with clients. It was essential for me to

analyze both my emotional and somatic countertransference responses to situations that arose throughout my period of research as well as the connection between my emotional and somatic responses. This led me to more research questions: what is my positive or negative countertransference response to the male residents and how do I experience and respond to comments and/or gestures that feel uncomfortable? As a dance/movement therapist I open myself both emotionally and energetically to my clients and I believed I would be doing a disservice to the process for myself and the clients if I did not explore the implications of all aspects of countertransference. As with the concept of attachment, I was curious to understand how my countertransference experience shaped my dance/movement therapy work with a population with sexually problematic behaviors – an area that other research had not yet touched.

Chapter Three: Methods

Methodology

The constructivist paradigm guided my study, as it is closely related to my personal worldview. One of the most basic tenets of the constructivist paradigm is that reality is socially constructed. This means that the mind is active in constructing knowledge and that realities may change through the process of study (Mertens, 2005). Mertens (2005) goes on to state that "the inquirer and inquired-into are interlocked in an interactive process" therefore the constructivist chooses a more interactive method of data collection (p. 14). In this study, as it is heuristic in nature, I was both the inquirer and the inquired-into. For this reason I used body tracking, journaling, and self-interviews as qualitative data collection methods.

The methodology I used to conduct this study was a heuristic inquiry. As noted by Moustakas (1990), the term "heuristic" comes from the Greek work "heuriskein" which means to discover or find. In the heuristic inquiry the researcher attempts to deepen the understanding of their experience of the world around them and in which they are interacting. For this particular inquiry, the goal was to further explore the relationship between myself (a female dance/movement therapy intern) and male patients in a residential unit for sexually problematic behaviors and the thoughts/feelings/experiences I had with each interaction. Through this study I hoped to discover the positive and/or negative countertransference responses that arose when working with this particular population and to find my own personal meaning of being in relationship with these individuals.

According to Moustakas (1990) there are six phases of the heuristic inquiry including initial engagement, immersion, incubation, illumination, explication, and creative synthesis. Each of these phases can occur organically throughout the heuristic inquiry process and do not necessarily occur in any particular order, although in my study I believe they did in fact occur in the stated order. In the initial engagement phase the researcher finds themselves drawn to a certain area of study that they feel is of interest and value (Cruz & Berrol, 2004). Moustakas notes that the researcher "permits intuition to run freely, and elucidates the context from which the question takes form and significance" (Moustakes, 1990, p. 27). Although unsure of the initial impetus for my interest in working with this population I believed from the very beginning that dance/movement therapy and the therapeutic relationship with clients with sexually problematic behaviors would be a worthwhile area to explore. I had initially been interested in exploring dance/movement therapy with survivors of sexual assault but in doing my preliminary research I noticed a lack of literature on male survivors. The limited research I was able to find on male survivors was intertwined with the literature on sexual perpetrators. I had an idea then that this aspect of literature provided an opportunity for exploration and I felt drawn to it both intellectually and emotionally.

In the immersion phase the researcher engages fully with the research question(s), living and growing in the knowledge and understanding (Moustakas, 1990). At this point, Moustakas notes that the researcher is concentrated on exploring the research to the fullest degree, constantly "pursuing intuitive clues and hunches, and drawing from the mystery and sourced of energy and knowledge within the tacit dimension" (Moustakes, 1990, p. 28). For this study the immersion phase occurred in the actual therapy session I conducted with the residents as well as

in my semi-structured journaling and structured self-interview process. At this point I was most focused on exploring my research questions in every aspect.

The next phase, incubation, encourages the researcher to take time away from the research in order to allow new understanding to occur. Although the researcher is not actively engaged in exploring the research topic, new perspectives emerge to deepen the understanding of the material (Moustakas, 1990). I believe this phase occurred multiple times throughout my research process, each week between sessions with the residents and when I took a small hiatus from my thesis altogether. By allowing for incubation each week between sessions I was able to reflect on my experiences consciously and unconsciously and gain deeper knowledge for how to approach my session and research topic the following week. During my unintentional hiatus, brought on by burn out, unexpected experiences occurred that caused me to take a deeper look at the work I did and the impact it had on my life both personally and professionally. Each of these incubation phases allowed for a deeper understanding and meaning to my study. This led to the next phase of illumination.

Moustakas (1990) defines the illumination phase as a time in which new ideas help clarify and bring new awareness. This phase "occurs naturally when the researcher is open and receptive to tacit knowledge and intuition" (Moustakas, 1990, p. 29). It allows for new perspectives, the correction of distorted meanings, can help reveal previously hidden meanings to the researcher, and can bring about discoveries that may have been beyond immediate awareness (Moustakas, 1990). The findings from my illumination phase will be further explored in the results and discussion chapters.

In the explication phase the researcher articulates and integrates their discoveries (Moustakas, 1990). They develop and organize themes to highlight the importance of the experience. In this phase the researcher has fully examined "what has awakened in consciousness, in order to understand its various layers of meaning" (Moustakas, 1990, p. 31). All important aspects are brought together to understand the whole experience (Moustakas, 1990). Some of the themes I discovered in this study were the importance of being in relationship, being open, intentional, and nonjudgmental, the similarities between working with this population and "normal" (non-offending) populations, resistance, and the use of the therapeutic approach to develop interventions. As with the illumination phase, the themes which arose during the explication phase will be further explored in the results and discussion chapters.

The final phase of the heuristic inquiry, creative synthesis, is the phase in which the researcher presents their discoveries in relation to the current research and knowledge in the field (Cruz & Berrol, 2004). It is the opportunity for the researcher to gather the information they have acquired and bring it to their audience. This presentation can be through a number of forms including movement, video, poetry, narratives, or any other creative means. This written thesis, including narratives of my experience, is the culmination of my work and therefore my creative synthesis phase.

Population and Recruitment Procedure

I, the researcher, was the sole participant, as it was a heuristic study. Due to the nature of this study there was no recruitment process.

Risks of the Study

There were a few risks associated with this study. First, physical safety was a risk that I encountered. Although there were no times at which I felt my physical safety was threatened it was something I needed to be aware of as the population had a history of physically aggressive behaviors. I was also conscious of the emotional risks I was facing, including being triggered by verbal and non-verbal interactions with the residents. In order to minimize each of these major risks I communicated any concerns directly with the residential unit staff and sought clinical supervision as well as personal therapy.

Setting

The setting of this research was two locations. The first location being a residential treatment program at a behavioral health hospital in the Chicago area. Part of my data collection (body tracking) took place on the residential unit for male patients with a history of sexually problematic behavior. Data collection occurred during group sessions in the unit dayroom, as I attempted to continuously track body sensations during group and individual interactions with the patients. The second location was my studio apartment where I was the sole inhabitant. The data collection taking place at my apartment (journaling and self-interviews) was conducted at a desk, in a quiet area, designated for thesis research. The types of data that were collected in each setting will be further discussed in the data collection methods section.

Data collection methods

Data collection began in Spring of 2015 and took place over the course of 8-12 weeks. Data was collected through body tracking, journaling, and self-interviews. The first form of data collection, body tracking, happened continuously during any group or individual interactions I

had with the patients. To do this I kept a small journal with me and noted any bodily sensations that arose at any time during dance/movement therapy sessions. The sensations I experienced were tracked as they arose so as to not forget any of them after leaving the session. These particular dance/movement therapy sessions were structured in a way that noting my personal bodily sensations did not detract from the therapeutic process. Later I transferred the notations I made during group onto a body outline in order to have a better visual representation of the sensations I experienced. My second form of data collection, journaling, occurred each Friday, as Fridays are the day I facilitated dance/movement therapy sessions on the unit. It occurred at my apartment in a designated a quiet desk area, specifically for thesis work, after my day at the hospital ended. The topics of my journal entries were semi-structured and focused on the emotions I recognized throughout the day while interacting with the residents on the unit. These emotions were related to my experience of male/female relationships, gender, sexuality, countertransference responses, comments and/or gestures that felt uncomfortable, and how my thoughts, feelings, and sensations affected my clinical interventions. The final form of data collection, self-interviews, also occurred on Friday afternoons at my apartment in the aforementioned designated area. These self-interview questions, which asked the same set of questions each week, were a structured way to track my experiences when interacting with the residents during our sessions and individually on the unit. By using structured questions I noticed trends that may not have been as overt in the semi-structured journal entries. These structured questions included: what were positive reactions? What was my response? What were negative interactions? What was my response? Was there any sexually problematic behavior? What was my response? How comfortable did I feel interacting with the residents? How did I interact with the residents? How did my body respond during interaction? And, overall thoughts/feelings?

Data analysis methods

I used Forinash's Qualitative Data Analysis Method to analyze the data from this study. Forinash's method is a five step process used to determine recurring themes in the data. Data was viewed in its entirety and organized loosely into categories; reviewed again and marked based on significant and meaningful content; and then meaningful content was organized into themes (Cruz & Berrol, 2012). Body tracking, journals, and self-interviews were analyzed to determine recurring themes related to the proposed research questions. Data was then used to generate new perspectives, explored in this thesis.

Throughout this process I had a peer debriefer with whom I met frequently to share my experience. Our meetings were informal and consisted of conversations regarding my research process and my experiences on the unit, paying special attention to my proposed research questions. This person was someone who knows me both personally and professionally and brought concerns and new insights to my research and experiences. Their guidance regarding the research process ensured validation (Creswell, 2007). I also ensured validation by consulting a resonance panel, a panel of professionals or experts, after I completed my research and analysis. Similar to my meetings with a peer debriefer my consultation with the resonance panel was an informal discussion of my research process and my experiences with the patients. This panel provided further guidance in my analysis as well as deeper theoretical insight.

Chapter Four: Results

The purpose of this study was to explore the relationship between myself, a female dance/movement therapy intern, with males living in a residential unit for sexually problematic behaviors and the thoughts/feelings/experiences I had during my interactions with the residents. This study addressed the positive and negative countertransference responses that arose and how they influenced my ability to establish/maintain a therapeutic relationship with the residents. My intention was to attempt to establish a meaningful relationship with the residents and to understand how it feels, mind and body, to be in relationship with them.

In this study I came to understand the importance of the therapeutic relationship while also understanding how my personal experiences and worldview allowed me to interact with this population. I came to realize, shortly after beginning this study, that although I believed I had an open mind about working with male adolescents in a residential unit for sexually problematic behaviors my views were in fact skewed more negatively. I believe this was due, at least in part, to society's views on people who act out sexually. I expected our sessions to be filled with experiences focused on male/female relationships, gender, and sexuality and to feel exploited. This was generally not the case. Although I did have negative experiences while working with this population it is my belief that the majority of these negative experiences are common to any therapist working with any population. Many of the negative experiences I had were related to resistance and negative somatic experiences that in turn helped me better understand how to provide effective treatment to the residents.

Throughout this study I attempted to answer the following questions: How is it to be in relationship with males who are in a residential unit for sexually problematic behaviors, as a

female dance/movement therapy intern? How do I experience male/female relationships, gender, and sexuality on the unit? What is my positive or negative countertransference response to the male residents? How do I experience and respond to comments and/or gestures that feel uncomfortable? How do my thoughts, feelings, and sensations affect my clinical interventions?

In order to answer how it was to be in relationship with males who are in a residential unit for sexually problematic behaviors, as a female dance/movement therapy intern I attempted to look at my overall experience on the unit as opposed to focusing on specific situations I encountered. To do this I analyzed my thoughts, feelings, and body sensations and the trend of how these experiences changed over time. What I found was that my thoughts were consistently positive throughout my study. In my journaling and self-interview questions I often noted thinking that this particular population was similar to "normal" in-patient populations I was concurrently working with. I was able to connect with them and build a therapeutic relationship as I did with my other patients.

Somatic Responses

	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	NINE	TEN	ELEVEN
Forgot/no overwhelming			X		X						X
Calm/even breath		X					X				X
Calmness		X		X	X		X	X			X
Slowed heartbeat		X									
Tension in chest	X		SLIGHT						X		X
Tension in neck	X	SLIGHT	X	SLIGHT		X	MINIMAL	X			
Tension in back	X				X						
Tension in shoulders		X		X				X			
Tension in throat						X				x	
Fast heartbeat	X	X				X					
Lack of/short breath		X				X					X
Headache			X		X		SLIGHT		X		
Hot					X	X			X	X	
Soft arms					X						
Weak arms					X						
Shaky hand						X					
Anxiety in chest										X	
Heavy chest	X										
Sweaty palms	X										
Wringing hands	x										

In this first chart you find the somatic sensations I experienced and in which session they occurred. It is important to note that there is a section named “forgot/no overwhelming”. The reason being that at one point during those particular sessions I either forgot to track my sensations or did not experience any overwhelming positive or negative sensations. I refer to any sensations as being negative due to how I experienced them in my body and the discomfort they caused me. For example, tension, shortness of breath, and shakiness were a few of the sensations that felt uncomfortable in my body. While they were unpleasant, these sensations allowed me to have a deeper understanding of my experience and the experience of the residents. You can see that while I appeared to experience calmness fairly regularly throughout the beginning, middle, and end of my data collection my negative somatic sensations appear to have decreased in frequency as well as strength. I believe that in the beginning of my data collection I was experiencing negative somatic responses without necessarily being able to identify a trigger whereas my negative somatic experiences over time have more definite identifiable triggers. I think this was due, at least in part, to my mind/body disconnect in the beginning of my work. I was unable to identify my sensations and how they related to my thoughts because I was overwhelmed with the experience. Throughout the start of my process I was unable to recognize feeling overwhelmed but am able to do so looking back.

I did not feel afraid, as I imagined I would. What I did feel varied from the beginning to the end of this study. In the beginning my feelings appeared to be more negatively focused. I questioned whether they were putting on “front stage” behavior to try to impress me and I felt frustrated and annoyed when encountering resistance. I noted feeling nervous about facilitating my first group alone with them. Over time I continued to experience frustration with resistance but I also began feeling more comfortable in my role and honored to have the experience I was

having with the residents. What I came to understand was that my negative feelings were not specific to the population I was working with but rather in response to resistance from the residents. I have recognized that resistance occurs when working with any population and seems to be a good sign. It has meant in my own experience that there is growth. So although the experiences felt negative they could be viewed as positive in that they helped me grow as a therapist while being a sign of the residents' growing in their treatment process. Another negative feeling that I experienced was often sadness in response to their stories of their own past experiences of trauma. While this was a negative feeling I believe it was an indicator of our therapeutic relationship and my own ability to connect with the residents. Despite the discomfort in my body it was a sign that I was experiencing somatic empathy for the residents. I was able to open myself to exploring their experiences on a deeper level and not be as guarded in my own body.

Throughout this process I have struggled with whether my negative somatic reactions were my own mind/body disconnect or if they were somatic countertransference that involved me experiencing what the residents were experiencing in their own bodies. On one hand I do believe that society's negative views of those who exhibit sexually problematic behaviors could have unconsciously manifested in my body. Despite my active intention to not let negative views of them infiltrate my mind. I believe that my own experiences as a woman living in a society filled with rape culture could have allowed my body to hold onto traumas that were and were not my own. On the other hand I believe that some of the negative body sensations I was experiencing could have been those of the residents I was working with. As a dance/movement therapist I regularly open myself to experiencing other people's sensations in the own body and as an emerging therapist it was and continues to be difficult at times to determine whether my

sensations are truly mine. Regardless of the reason for these negative body sensations over time they began to dissipate and I had more positive somatic experiences. I believe the reason for this change was due to the strengthening therapeutic relationship between myself and the residents. As we built our therapeutic relationship it was easier to feel a sense of calmness in my body, either mine or theirs. Negative body sensations continued to occur but often with a reason I was able to identify; whether it be a personal experience outside of this study, simply feeling hot due to the air conditioning on the unit being broken, or having to tell the residents my internship was coming to an end. However, overall the trend in my body sensations, as seen in the above graph, was that they began negatively and ended more positively, first disconnected then aligned with what I thought my experience was.

I recognized that my somatic experience was disconnected from my thoughts and feelings as soon as the first two weeks of my data collection. After my first week facilitating group by myself with the residents I experienced a strong somatic response, extreme tension in my back to the point of making me physically ill, that lasted until the following week. I found this odd because in my mind the experience I had during the session was overall very positive. After consulting with my clinical supervisor I was able to better understand some of the connections between my somatic experience and the experience I had during the session. I learned that the body holds different emotions in different areas. The back for example, where I was holding much of my tension, is related to grief, shame, anger, and fear (D'Ascenzo, 2009). I think this could easily be my own experience or my body picking up the somatic sensations from the residents. Grief, shame, anger, and fear are all emotions closely related to sexually problematic behaviors both for society as a whole as well as survivors and offenders. The experience from all aspects is so intertwined that it is impossible for me to distinguish, as I previously mentioned,

which sensations originated in my own body and which originated in the residents'. But, again, as our therapeutic relationship strengthened the experience of negative somatic responses without an identifiable trigger were far less prevalent. Much of this change was made possible through the extensive clinical supervision sessions I had during my experience. In these sessions I was able to explore my own experience and better understand the experiences of the residents as well as make a distinction between the two. Working with my clinical supervisor allowed me to gain deeper insight into the transferential and countertransferential responses that occurred in my therapy sessions with the residents.

Feelings – Self-Interviews

	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	NINE	TEN	ELEVEN
Honored	X			X X			X X	X			X X
Curious	X										
Hopeful	X	X					X				
Happy			X X			X				X	
Comfortable		X	X X	X X	X		X	X	X	X X	X
Enjoy	X	X		X X	X			X			
Excited			X	X X							
Fun			X	X	X X						
Great			X	X	X		X	X			
Proud			X						X X	X	X X X
Impressed								X	X		
Protective										X	
Relieved						X X					
Surprised		X									
Not afraid			X						X	X	
Arrive/drop-in							X X				
Frustrated	X	X X	X	X X X	X	X X		X	X X		
Irritated	X		X								
Nervous	X	X X									
Sad				X	X		X	X			X
Annoyed	X			X					X		X
Anxious					X						
Confused					X						
Angry									X		
Uncomfortable					X						
Tired						X					
Helpless						X					
On edge						X					
Not good/bad										X X	
Lack compassion	X										

The above chart depicts the feelings I experienced and in which session they occurred as noted in my self-interview questions. My feelings related to working with the residents are rather consistent over time, experiencing both positive and negative feelings in the beginning, middle, and end of my data collection. With each positive and negative feeling there is data in the session

descriptions that support my experience. I believe this reflects my finding that my experience was similar to that of working with any population, experiencing both positives and negatives throughout.

Possibly in relation to feeling that my experiences on the residential unit were similar to my experiences working with the general population, I found it difficult to answer my second question of how I experienced male/female relationships, gender, and sexuality on the unit. Initially I felt that I did not experience those things on the unit. However, as a human in society I experience male/female relationships, gender, and sexuality all the time I just did not experience it on the unit as I thought I would. I believe that I experienced male/female relationships and gender in the sense of a power struggle, through the resistance. As a woman in a position of power (therapist) some males (residents) had difficulty accepting this. I do not think this is simply because I am a woman and they are males (although possible) but because of many of their experiences with women. Many of the residents had extensive histories of witnessing the abuse of female caregivers as well as experiencing their own abuse at the hands of female caregivers. This potentially made our relationship more difficult in terms of their transference toward me. I do not feel, however, that my experience of male/female relationships and gender on the unit were drastically different than when working with other populations. In terms of experiencing sexuality I do believe there was a significant difference between working with this population as opposed to other populations. When working with the males in the residential unit I felt far less sexualized than I did when working with other male populations. That is not to say I was not being sexualized by the male residents but it was not blatant as I had experienced with other populations. This is potentially due to the fact that these sexually problematic behaviors are often covert, making it less likely for me to notice during our sessions or because the residents

were actively engaged in intensive treatment related to their sexually problematic behaviors whereas patients in the general population setting were not. That brings me to the question of how I experienced and responded to comments and/or gestures that felt uncomfortable. I feel that this question highlighted my own preconceived notion of what I expected my experience to be. As I previously stated I felt far less sexualized and uncomfortable when working with this population than with other populations. In my reflection, though, I do believe that there was one instance of sexualized behavior toward me from one of the residents. At one point one of the residents made a statement that he just got a new tattoo (which was untrue) and it happened to be on the first day I wore a short-sleeved shirt in which my own tattoo was exposed. My response to this was confusion. I did not understand until later that this was an inappropriate reference directed toward me and the residents were not allowed to talk about tattoos. The reason for this is that, I learned at a later time, this particular population sees women with tattoos as more sexually provocative than women without and in turn tend to sexualize women with tattoos much more. This resident's comment about having a tattoo could very well have been a response to his being triggered by seeing mine and in turn a sexualization of me. Taking away for a moment the sexual aspect, it may also have been a response to attempt to equalize our power differential. Staff have freedom and the power to choose to get tattoos or not whereas the residents do not have that option, some because they are underage and some due to being in a locked residential facility. This comment may have been a way to circumvent the rules and exhibit power. There is also a high possibility that the reason for this comment was both motivated by sexuality and power as these two are intertwined for this population. For this population sexually problematic behaviors are a way of gaining power in situations which they feel powerless. Had I been more aware of

these subtle references I may have noted more instances of feeling sexualized or exploited but in my own experience I did not feel as though I was being seen or interacted with in that manner.

Feelings – Journal Entries

	ONE	TWO	THREE	FOUR	FIVE	SIX	SEVEN	EIGHT	NINE	TEN	ELEVEN
Honored	X						X		X		X X
Comfortable	X							X			
Excited	X			X							
Surprised		X		X							
Hope		X X									
Happy		X									
Attachment		X									
Relieved						X					
Good						X					
Amazing							X				
Proud									X X		X
Nervous	X										
Anxious	X				X						
Sad	X	X		X			X				X
Frustrated				X					X	X	
Frus. w self									X		
Regretted					X						
Annoyed									X		

In this final chart the feelings I experienced are identified, as noted in my journal entries. As with the self-interview questions the feelings I experienced appear to be consistent over time. Positive and negative feelings occurred through the beginning, middle, and end of my study. I find it important to note that one of the feelings I experienced was something I noted as "attachment." While I left the original wording as was written in my journal entry this feeling could more adequately be described as feeling a connection to the residents. Interestingly enough, I believe that my decision to reference an attachment or connection was a superficial aspect of the beginning of my research. At that point I was still very surface level and almost forced in trying to establish a positive experience. Later in my work it is clear that there was a connection through more authentic feelings such as comfort, pride, and even frustration or sadness.

The question I had the most difficulty answering was "what is my positive or negative countertransference response to the male residents?" While this is an integral aspect of my thesis I found it was challenging for me to conceptualize my countertransference response as a whole. To begin, I believe it is important to identify some instances in which I experienced countertransference, in both the traditional cognitive sense as well as the somatic experience. In the traditional sense I feel that I was triggered at times by the residents' resistance which sparked feelings of vulnerability and insecurity. I questioned whether or not I had any idea what I was doing and my capabilities as a therapist. At times I became fixated on my failures and was unable to identify the positive work I was doing. The resistance also invoked a sense of irritation in me. When the residents were resistant I felt annoyed and frustrated. Sometimes I wanted to (and one time did) raise my voice to them. Other times I found myself trapped in a power struggle, feeling defeated and angry at both the residents and myself. In terms of the somatic experience many of the sensations I experienced felt more negative in my body, especially in the beginning. As I previously mentioned, during the first week of my research I experienced an excessive amount of tension and physical illness. After some consideration I have realized that it's difficult to identify "positive" countertransference experiences because by definition countertransference responses are shaped by the therapist's past or present emotional conflicts and vulnerabilities. Despite the seemingly negative countertransference responses, I was able to experience positivity and a shared motivation with the group as a whole and we were able to strengthen our relationship as well as grow together throughout the process. So while the countertransference responses may have felt negative in the moment I believe that they were a positive aspect of our work together because they allowed me to deepen my understanding of the residents' experiences and develop a stronger therapeutic relationship. With each seemingly

negative experience I was able to use them as a measure of where growth needed to occur. In exploring my countertransference responses, it seemed as though my experience of working with this population was not drastically different than my experience of working with any non-offending population. As I reflected I realized that I often felt the same with any population in which I encountered resistance or uncomfortable situations. It is important to note, however, that this population is different from non-offending populations due to the nature of their reason for being in treatment. Upon further consideration I believe my experience of working with the residents may have felt similar to my experience with the general population because I was consciously and unconsciously taking exceptional precautions to maintain my physical and emotional safety.

The question I believe I answered most directly in my study was how my thoughts, feelings, and sensations affected my clinical interventions. In short, my thoughts, feelings, and sensations directly affected my clinical interventions and the way in which I interacted with the residents. I was constantly aware, or at the very least attempted to be as aware as I could, of how to build and improve the therapeutic relationship as intentionally as possible. In order to do this, it was important for me to reflect on each interaction in the moment as well as prior to the next session. I used my thoughts, feelings, and sensations to do this. What I first focused on was understanding my role in working with the residents. At times I felt it was better for me to be a participant facilitator, in order for them to get to know me a little better which in turn allowed them to open up to me more. Other times, such as when the group was focused on exaggerated movement, I was intentional in facilitating in order for my body to not be a trigger for the residents. Although I can't be certain that exaggerating my own movements would trigger or sexually arouse the residents it was my own perception that by facilitating rather than

participating in the intervention I would minimize the risk of such things happening. Despite my experience of them being similar to other non-sexually problematic populations there was still a necessity to be conscious of their relationship to others' bodies. This was not a judgment on their experiences with others' bodies but a fact of the population to be aware of. This population's offenses are body based as they have physically used their bodies to offend another person and in that we can come to the reasonable conclusion that this population does not or, at least at one point, did not have a positive and healthy understanding of how to interact with others' bodies. Most importantly, I believe, was to attempt to understand each resident as a whole person without focusing on and judging their sexually problematic behaviors. This allowed me to set aside my preconceived notions and provide treatment to the resident and not the "juvenile sex offender". In this way I was able to connect to them on a deeper level – simply as human beings. Further, this helped me be more open to having a reciprocal relationship with the residents and learning from them as well as providing them treatment. Being aware of their own traumas along with their strengths and weaknesses allowed me to better understand their resistance and look for new ways to approach our interactions. My conclusion is that approaching treatment in an intentional, open, and nonjudgmental way allows for a strong therapeutic relationship to form.

The following is a brief description of each session and important interactions or facts about each session:

It is important to note that while session one was the beginning of my data collection and the first group I facilitated alone it was not the first time I met the residents. I had been shadowing other therapists on the unit for approximately one month prior to beginning my data collection.

SESSION ONE: In session one I was a participant facilitator in an intervention in which myself and the residents tossed a bean bag around the room, in a particular pattern, and answered a set of questions. Some of these questions included favorite color, favorite dessert, coping skills, support system, and triggers. I felt that it was important to be a participant facilitator in this group because it was the first session I was facilitating by myself with the residents and I believed that by engaging in the intervention with them it would allow for us to get to know one another better and begin building a strong therapeutic relationship. My self-disclosure (although minimal) allowed the residents to feel I was being open with them and in turn I believe they were more willing to engage. This intervention was also beneficial in introducing dance/movement therapy as a method of treatment as it involved movement but I did not feel it would be intimidating. Along with introducing movement it non-verbally addressed directness and a sense of routine that would be important to carry out in our work together. Throughout the intervention most of the residents were open with their feelings of anger, sadness, and what makes them happy. One resident in particular engaged minimally and answered most prompts with "I don't know" which caused me frustration when I attempted to encourage his participation and he continued to be resistant.

SESSION TWO: During session two I began as a participant facilitator but then decided it was best to simply facilitate the intervention. The reason for this was that in the intervention, embodying emotions, there were exaggerated body movements and I did not want to be a trigger for the residents by bringing attention to my own body. I was surprised during the session when many of the residents were able to identify sensations and responses their bodies had to different emotions. I had expected that due to their offenses being body based that they would have an extreme mind/body disconnect; this was my own negative theory about the population that had

no data to support it either way. Realizing that the residents had more of an understanding of their bodies than I thought they would made me hopeful for future interventions and being able to provide them with treatment that would help strengthen their mind/body connection. While many of the residents were engaged in the intervention and exploring their body sensations in relation to their emotions there were a few that were withdrawn and engaged only minimally. I must note that this could be for a variety of reasons. First being that some of the residents were "on ban" which meant that they were not allowed to be within a certain distance of another resident due to previous of current sexually problematic behaviors between the residents; second that any time I have done this intervention with adolescents (sexually problematic or inpatient psychiatric unit, male or female) there is a level of resistance in not wanting to exaggerate body movements because adolescents are typically self-conscious of their bodies. That is completely normal. However, regardless of the reason for their lack of engagement it caused me frustration because in my own mind it felt as though they just didn't want to move.

SESSION THREE: In session three the residents engaged in a coping skills charades intervention in which they acted out various coping skills for their peers to guess. The majority of the residents engaged very positively and expressed that they were having fun with the exception of one resident who appeared agitated and disrupted group by leaving a rejoining multiple times. In response to his disruption I was able to set firm boundaries which made me proud of myself.

SESSION FOUR: In session four I provided the residents with an intervention in which they identified emotion faces and worked in groups to create an emotions dance. Many of the residents were very open about their experiences with their emotions, namely sadness and anger. I could sense their emotions as they opened up to me, experiencing their sadness and anger in my

own body through tension in my neck and shoulders (D'Ascenzo, 2009). It felt as though they were beginning to feel safer in the therapeutic relationship and were able to express deeper emotions during our sessions. Again, however, there was a resident that appeared very resistant and stated he could not draw any emotions because he had no idea how emotions looked on himself or other people. I felt very annoyed with this resident because it seemed that he was monopolizing the group but in reality, knowing his history and looking at the patterns of his engagement in treatment over time, I believe he truly did not know the identify the ways emotions look. Understanding resistance and being more aware of residents' strengths and limitations allowed me, over time, to provide better treatment. Although sometimes it was difficult to be therapeutic when encountering resistance and it caused me frustration and annoyance I think it important to point out as I have before that this experience was similar to working with other populations. During the second half of group I encouraged the residents to work in groups to create emotions dances. This was the first time they could express themselves freely through movement and I saw many of the residents light up. I think their comfort in being able to express themselves through movement is due in part to our therapeutic relationship allowing them to feel safe in their minds and bodies.

SESSION FIVE: Session five was a test of the therapeutic relationship and a true turning point in the way I approached my interactions with the residents moving forward. Over the previous four sessions I felt this profound sense of comfortability in working with the residents. Everything felt great and groups were going well, with the exception of the frustration from the resistance I was facing. I noted how honored I felt to be a part of their process and to have this experience of my own and that was all absolutely true however I did not realize until session five how appropriately superficial it was. I say *appropriately* superficial because the therapeutic

relationship must start on a superficial level. It would be unrealistic to expect any client to have an automatic deep and unfaltering connection with the therapist. As an emerging therapist there was a huge part of me that believed the therapeutic relationship I established with the residents had become deep enough that it could not be broken and that they felt completely comfortable with me. This was my own misjudgment and wishful thinking. In session five I pushed the residents to a place in which they felt uncomfortable exploring, asking them to explore how their actions affect others, and the group completely shut down. Although I did not necessarily mean this prompt to be directly interpreted as how their offenses affected others it seemed that the residents took the prompt in that way. This caused me to question my own abilities as a therapist and feel as though I had ruined the entire relationship we had been working toward. I began second guessing myself and attempted to overcompensate for the shutdown by rewording my prompts and becoming hyperverbal and expansive. The residents, on the other hand, were enclosed in their body posture and made minimal movements. I became incredibly flustered and the group did not end on a positive note.

After processing the situation with two of my supervisors I was able to gain more insights. First, on a body level I was disconnected from the residents; my body language did not at all match theirs which caused me to be unable to connect with them on the most basic level. My lack of awareness of this was likely due to my anxiety about feeling that I had ruined our relationship by pushing them too far too fast but it didn't allow me to be there with them in the moment when being with them in the moment was probably what they needed the most. Second, I was able to process some of their reactions and I gained better clarity into the shame they hold around the reasons they are in treatment and their resistance to discuss this in any setting because they do not want anyone to truly know why they are in treatment. Lastly, I gained a better understanding

of their perceptions of expressive therapy groups and their feelings that expressive therapy groups are a time for them to have fun and not have to address their treatment. Up until that point the groups had been mostly fun but I wanted them to not only have fun but to also grow in their treatment process.

Looking at these new insights helped me, as I previously mentioned, approach my interactions with the residents in a different way. I found that I had to be very intentional in my interventions by connecting deeper and being open to the resistance I was facing, no matter if it made me uncomfortable. In order to provide the best treatment possible I had to understand their needs instead of focusing on my own.

SESSION SIX: Session six was a direct example of how I took my experience with the residents from the previous week and turned it into a productive therapy session. I addressed the previous week right away and encouraged them to explore how their actions had affected others and how others' actions had affected them. Many of them opened up and shared their experiences. I believe that our ability to move forward, myself and the residents, was truly due to the relationship we had started building over the previous weeks. It was important to address the resistance the previous week and use it as a tool to continue strengthening our relationship. I realized that the previous week there had been a miscommunication, both in how the residents received my prompt and in how I received or failed to receive their response in my body. I took that as an opportunity to provide the residents with a communication intervention. Some of the residents were still resistant but I was able to understand their resistance better than I had before and despite the resistance continuing to frustrate me I was able to acknowledge that those residents may need more time to feel safe again in the therapeutic relationship.

SESSION SEVEN: In session seven I facilitated a roadmap intervention in which the residents created a roadmap of their lives noting any roadblocks they have encountered. Many of the residents opened up about their past, various traumas, and their offenses and how their lives were changed because of their experiences. I could feel their pain and sadness and felt sad that there was nothing I could do to comfort them or help them through it. However, by providing a safe space to explore these past experiences I was allowing the residents to open up which may have been what they needed at that point. It was important for me to assess and understand the residents' needs in order to not push them too far or try to "fix" their negative experiences. It was especially important for me to approach the session with empathy, understanding, and nonjudgment. It would have been very easy to have a negative reaction to some of the experiences they shared but instead it was more beneficial to our relationship and their treatment to view them as a whole person rather than a juvenile sex offender and to stress that people's experiences do not define who they are as a person. Through building a strong therapeutic relationship and receiving intentional, open, and nonjudgmental treatment people who have offended sexually can change their lives and, I believe, not offend again. During this session I feel that it was the first time I was able to completely drop in and feel comfortable with the residents. We were able to explore deeper topics that were previously unsuccessful, such as in session five. Again, I believe this was due directly to the shift in my approach in working with the residents and being able to connect with them on the most basic level, understanding their needs and not allowing my own thoughts and feelings to cloud their treatment.

SESSION EIGHT: During session eight I continued to encounter resistance but it was minimal. While I felt frustrated as I had in previous sessions when facing resistance, I also noted feeling a sense of sadness knowing this particular resident had the potential to deal with a negative

interaction with a peer in a more positive way than becoming oppositional in group. This highlights, once again, the therapeutic relationship. Through the therapeutic relationship I was able to understand the complexities of the resistance and instead of becoming overwhelmingly frustrated I connected with the resident on a deeper level, expecting more from him rather than dismissing him. I continued throughout this session to have positive thoughts and feelings about working with the residents. I did recognize, however, that I noted some negative somatic experiences on this day. I find it difficult to discern whether these negative somatic experiences were in response to the session or if they were in response to a personal experience I was encountering outside of this research. It is impossible to know for sure as I did not track body sensations before or after the session, which will be further discussed in the limitations of my research.

SESSION NINE: In session nine I engaged in an intervention with the residents in which we discussed negative patterns in life and how to change them. One resident, who had been consistently oppositional throughout the previous weeks, continued to be resistant throughout the session. I allowed him the opportunity to take a break and return to group but his oppositional behavior continued and he was sent out for the remainder of group. I felt frustrated with his resistance but also frustrated with myself for feeling at a loss of how to connect with him. With other residents I had built a strong therapeutic relationship and the resistance was diminishing over time. With this particular resident, however, it was incessant. I found it hard to be empathic and provide him with open and nonjudgmental treatment but what I realized was that I had to be even more intentional in my treatment with him. It was important to set firm boundaries and reinforce them but also make sure he knew he was always welcome back into group and to provide a safe space for him to process and grow. I believe that his resistance was a form of limit

testing to see how far he could push me before I gave up on him as many other people (particularly women) in his life had done. It was imperative that I continue my "tough love" approach with him to show him, parallel to the intervention for that day, that negative patterns in relationships can change.

SESSION TEN: For session ten we attempted to have a dance party, per the residents' request. Together the residents came up with a playlist and they shared creative and fun dance moves. Shortly into the dance party, however, it began to fall apart. There were issues to begin with that I feel led to the dance party being unsuccessful. First, it is difficult to find appropriate popular music to dance to. Most of the music today is riddled with profanity and sexual innuendos – while this is not appropriate for almost any therapeutic group it is especially important to refrain from this music when facilitating a group for residents with sexually problematic behaviors. Profanity and specifically sexual innuendos in music can trigger sexual thoughts and urges in this population which can put them at risk for acting out. This factor alone made it difficult to find enough music to keep the dance party going. Second, the air conditioning on the unit was broken which made the room hot, humid, and uncomfortable to move in. With the lack of popular songs and air conditioning many of the residents ended up standing in a circle, arguing about why a peer wasn't dancing or which song they wanted to hear next. The group became out of control and the only way, I felt at that time, I could regain control was the raise my voice above all of theirs. This very clearly startled them and when I realized this I was able to adjust my tone of voice and set aside my own frustration to try to make the session more productive. Despite one newer resident becoming verbally aggressive with me after raising my voice I feel that after adjusting my interaction the group ran much more smoothly. Again, I will relate this back to the therapeutic relationship and the importance of understanding the population in order to provide

effective treatment. I could have easily allowed myself to continue raising my voice and reprimanding the residents out of my own frustration. Instead, because we had built a strong relationship and I had a better understanding of their histories and their responses in the moment I was able to take this knowledge and provide them with what they needed – a calmer environment. I also believe the therapeutic relationship allowed for this to not cause the session to completely fall apart. The residents trusted me and my ability to provide a safe space for the remainder of group with the exception of the one newer resident who I had not yet had the chance to build a strong relationship with. I addressed the negative energy in the room and asked for suggestions from the residents of how to end our group on a positive note showing them that I also trusted them. In the end the residents decided to each go around a share their favorite part of the dance party. I do not believe this would have been possible had we not worked so hard together to build a strong therapeutic relationship in which we could trust each other and grow together.

SESSION ELEVEN: In session eleven I provided the residents with a meditation. It was incredible to see how relaxed the majority of them were, with the exception of one new resident who was sent out of the group early on due to disruptive behavior. When watching the residents meditate and be peaceful I felt a deep nurturing connection to each of them. I was able to hold the space for them to relax; something many of them are not often able to do. The room overall, the residents as well as myself, had an overwhelming sense of calm that I believe proved how strong our therapeutic relationship was. The most difficult moment of my time with them, from session one to eleven, was when I had to tell the residents that my internship was coming to an end and I was unsure if I would be able to continue working with them. Many of the residents expressed sadness that our time together could potentially end soon as well as excitement for

what we had experienced together and for me to continue on with my journey as a therapist. I also shared with them my thoughts and feelings of working with them. I felt it was important, as I felt from our first session together, that our relationship was reciprocal. Our ability to share with one another and for me to be open with them allowed our relationship to be an open and strong relationship. I noticed at this point in the session that I lost track of my body sensations. I believe that this was a way of managing my sensations in order to manage my emotions and not bring the focus to myself. I wanted to continue to provide a safe space for them to express how they felt, not me. It was important to open up to them and for them to understand the positive impact they had on me but it was most important to allow and honor their experiences.

I went into this experience hoping to gain a better understanding of working with "undesirable" populations and to shed some light on the positive aspects of working with them. I did not realize how much of a positive impact we would have on each other's lives. I saw and heard the impact I had on them and every one of them helped me grow as a therapist and as a human being.

Again, it is important to note that session eleven was the final session of my data collection, however, it was not the final group I had with the residents. I continued to work with them well after my data collection ended.

Chapter Five: Discussion

I learned a number of valuable things throughout this study including how my perception of working with clients with sexually problematic behaviors shifted, the importance of being open, intentional, and nonjudgmental in my work with the population, how my own experiences in the therapeutic relationship shifted my work, and how working with this population helped me grow both professionally and personally. The findings of this study not only expand upon the research already being done in the fields of dance/movement therapy and psychology but allow the two to be connected through a topic not yet fully explored: the therapeutic relationship and countertransference with clients who have a history of sexually problematic behaviors through a dance/movement therapy lens.

The purpose of this study, in its simplest form, was to fully explore how it was to be in relationship with a population that displayed a history of sexually problematic behaviors. This is a population which is defined as deviant and is outcast due to their socially unacceptable behaviors. Throughout my process I found it important to be as open and compassionate as possible which allowed me to build a constructive relationship which many in this population lack. It is clear how much my perception of this population changed when looking back at the questions which guided my study: How is it to be in relationship with males who are on a residential unit for sexually problematic behavior, as a female dance/movement therapy intern? How do I experience male/female relationships, gender, and sexuality on the unit? What is my positive or negative countertransference response to the male patients? How do I experience and respond to comments and/or gestures that feel uncomfortable? How do my thoughts, feelings, and sensations affect my clinical interventions?

Prior to working with this population I believed I was already open and coming from a place of non-judgment. I was, of course, willing to work with this population when so many other therapists were averse or simply flat out refused to work with them. I believed this in and of itself made me non-judgmental. I realized throughout my work that despite my intention of being open I was holding onto preconceived notions that lived in my mind and body about this population. Despite experiencing positive emotions in my work I often felt discomfort in my body that could be related to how my body held those unconscious perceptions of the residents. As the literature clearly states we have a strong emotional reaction to the term "sex offender" (Charles, 2010, p. 18). This is largely in part due to cultural influences. In society we often hear people openly voice their disapproval of sexually problematic behavior. I have found myself on social media platforms at times reading comments in which people state they believe people who offend sexually should be punished with further sexual violence. Sexually problematic behavior causes us to feel violated and vulnerable and to confront this society often uses further aggressive means. My own reaction was implicit even though I was actively working from a perspective of acceptance. It came out in the wording of some of my research questions. For example, entire questions based on my expectation of blatantly experiencing gender and sexuality on the unit and using wording such as comments and/or gestures feeling "exploitative" rather than "uncomfortable" as I later decided to use. As I previously mentioned in my findings, I also felt this in my body when I had strong somatic experiences that were disconnected from my thoughts. As my work with the residents continued I found it easier to separate their behaviors from their identity as a person by dropping the label of "sex offender" as the literature suggests to do (Report on the task force, 2006). While dropping the label "sex offender" seemed to benefit the therapeutic relationship and my work with the residents I believe it also may have been a

coping mechanism for myself. I was beginning to feel a deeper connection to the residents and it was difficult to balance that positive connection with labeling them "offenders." I feel that part of me had to disconnect from that label in order to relate to them on a more personal level and detach from any internal discord that was preventing me from moving forward in our work.

Throughout this process and near the end I utilized a peer debriefer and resonance panel to help bring new insights to my study. By meeting with my peer debriefer multiple times while analyzing my work I was able to gain a new perspective on the work I was doing. The biggest benefit to having a peer debriefer was that they pushed me to be more authentic in my presentation of my study. Although my experience with the residents was overall positive my peer debriefer noted that at times I tended to be trying too hard to be convincing. This forced me to take a look at my raw experience and accept that there were times throughout my process that I struggled and felt negative. I realized I was biased in wanting the experience to be perfect and at times had difficulty accepting that it wasn't. As with my peer debriefer, my resonance panel compelled me to take an even deeper look into my authenticity in the work. They pushed me to confront my honest feelings and reach beyond any superficiality. Despite completing my data collection and a fair part of my analysis I continued to explore my work on a surface level. I found myself attempting to convince others that I had this remarkable experience. While I did have a positive experience my resonance panel allowed me to explore the difficulties of the work without feeling like I was diminishing its value. I was able to examine the raw experience with all of the complications and frustrations that arose. My resonance panel also encouraged me to further explore my motivation for the work I did as well as to have compassion for myself in my vulnerabilities. They served as an avenue to explore my work with others in a safe space.

Many patterns that emerged while working with this population connect strongly to and are supported by the literature. Some of the patterns I recognized throughout my study were the importance of being in relationship, being open, intentional, and nonjudgmental, the similarities between working with this population and "normal" (non-offending) populations, resistance, and the use of the therapeutic approach to develop interventions. The majority of, if not all of, these patterns are intertwined but each is significant enough to stand out as a pattern of its own.

The concept of the importance of being in relationship was not only something that was the main focus of my study but was equally stressed in the literature. As Rich (2013) noted, many youth with sexually problematic behavior have unhealthy attachment patterns and, in turn, benefit greatly from therapy in which a supportive and caring relationship is developed. I found the same in my own research. As my relationship with each client strengthened it appeared that their involvement and positive progress in therapy was greater. We, as a collective group, were able to grow together and explore thoughts, feelings, and sensations that would likely not have been explored had the relationship not been built. While I understood the importance of the therapeutic relationship for the client's benefit prior to beginning my process I did not realize that the relationship would be just as important to me. By building and growing my therapeutic relationship, using a dance/movement therapy lens, with the residents I was able to expand my own worldview in many ways.

The second pattern that emerged in my study was the idea of being open, intentional, and nonjudgmental in working with this population. I believe that without using this as a base for my interactions with the residents I would have failed at building our relationship and providing meaningful treatment. Being open, intentional, and nonjudgmental was imperative for the residents to feel that they could trust me and benefit from our sessions together. I found this to be

true in how our sessions progressed as I was able to be less guarded in my own body. When I began to allow a deeper connection for myself the sessions became more fruitful. It was crucial to take this approach in order to develop my own connection to the work as well as provide the residents with the full benefits of the treatment they were there to receive. As Ward and Durrant (2013) note, a lack of empathy in the therapeutic relationship leads to further pernicious societal behaviors whereas positive relationships grow from an empathic understanding. It is often easier to hold onto judgments and provide clients with interventions that we as therapists deem appropriate. These are not always the interventions the clients need most. Although this was, at times, a hit to my own ego I had to be intentional going into our sessions to do what was best for the residents and not myself.

By taking the open, intentional, and nonjudgmental approach I was able to view the residents as a *whole* person, a term I have previously used and is used in the literature. Meaning, looking at the residents as not simply sex offenders and differentiating between them as a person and their sexually problematic behaviors. Looking at them in this way helped me realize that much of the frustration I was facing when working with them was no different than "normal" populations. This was a much different experience than I imagined prior to working with the residents. It was a great opportunity for growth in reassessing my own perceptions of the population. As I previously mentioned, I held onto many thoughts and feelings about clients with sexually problematic behaviors. It was refreshing throughout my work with them to recognize their commonality with some of the other clients I had worked with. While strong boundaries were necessary due to the nature of their offenses much of our therapy was simply based in helping them heal their trauma through dance/movement therapy which was something I was doing with every client I worked with. And with every population I encountered resistance.

Coming to this understanding helped me become a better therapist because rather than becoming overwhelmed I was able to recognize that was I was experiencing was natural and was not impossible to handle. I had handled it with other populations and the label of "sex offender" population did not have to skew anything. The uniqueness of using dance/movement therapy as the intervention may have invoked stronger instances of resistance due to the nature of the work but I believe it was also the factor that brought about the most change. Through both verbal and nonverbal means I was able to provide the space needed for the residents to grow as well as have a special perspective to understand my own thoughts, feelings, and sensations.

Recognizing each of the previous patterns would have been irrelevant if I didn't use them. Fortunately, throughout my work with the population I was constantly analyzing the experience in order to continue strengthening our relationship and providing the best treatment I could. I used my own experiences and reflected on them in the moment as well as before the next session in order to develop more meaningful interventions for the residents. This, I believe, is one of the most constructive ways I was able to engage with the residents. While it was often distressing it pushed me to take an honest look at my therapeutic approach and what was or was not working. Without reflecting on each of our interactions and pushing myself to critique the uncomfortable moments or my own failures our work together would have been unproductive.

Although the importance of the therapeutic relationship is clear in this study the question then is how is this relevant to the bigger picture? This study is meaningful because it expands on and further supports the research done on attachment theory with sexually problematic behaviors and the research done on understanding countertransference through dance/movement therapy while combining the two areas to explore a topic that has little to no previous research. In looking at attachment theory, specifically, this study helps deepen the understanding of

relationship with this population. Working through an attachment lens promotes positive relationship in the therapeutic process. Dance/movement therapy and my approach to the work also focuses on the importance of a positive relationship. Rich (2013) stated that change occurs through connection, attachment, and relationship. This was also my personal perspective on the work. By working through an attachment/relationship lens we are able to promote positive change because our clients feel "seen" and are more willing to engage in deep and meaningful sessions. Without an attachment based approach we are more likely to fall back into the traditional ways of working with sexually problematic behaviors – enforcing our power over them. I was very careful to refrain from engaging in this type of treatment with the residents. As much as possible I attempted to approach our relationship as a reciprocal one – stressing that we were working together to grow together. Although it was important to maintain boundaries of therapist and client I feel that it was equally important to allow the residents to feel safe in their process by stressing the mutuality of our relationship.

One of the reasons I approached treatment through an attachment lens was due to my prior understanding of many of the resident's trauma histories with women. If I went into the sessions being overly assertive or trying to enforce power over them I believe the sessions would be unsuccessful. When working with any population it is important to understand their triggers. With this particular population, women in positions of power can be triggering. Despite actually being the one in power I was intentional in not overly exerting my position in order to not unnecessarily trigger the residents. I achieved positive results in our treatment process with using my position of power very sparingly. Another reason I believe it was important to use an attachment approach was because I believe that the therapeutic relationship can help heal and shift unhealthy attachment patterns learned in early childhood/adolescence. By working with the

resistance I encountered in an open, intentional, and nonjudgmental way I allowed the residents to feel secure and safe in the therapeutic relationship. I believe that through this process they were able to alter some of their attachment patterns and recognize that when they did something "wrong" the relationship could be repaired in a positive way.

This study expands on the almost non-existent research done on relationship in dance/movement therapy when working with sexually problematic behaviors. A number of studies have looked at countertransference in the therapeutic relationship, dance/movement therapy and somatic countertransference, and the therapeutic relationship when working with sexually problematic behaviors. No study, to my knowledge, has combined all aspects. Reflecting on dance/movement therapy and the somatic countertransference in the therapeutic relationship when working with sexually problematic behaviors is crucial. As dance/movement therapists we use our bodies as tools to understand and experience the world around us. Often times we "pick up" sensations from our clients that help us understand their experience on a body level. This is advantageous because our clients are frequently unable to verbalize their thoughts and feelings. While using our somatic knowledge is undoubtedly beneficial it can become dangerous when working with the sexually problematic population.

Experiencing sexual behaviors in our bodies can make us feel vulnerable, ashamed, and often times uncomfortable, especially when the experience has been forced or violent. When working with clients who had committed a body-based sexual offense it was easy to absorb the negative sensations that go along with that experience. I found it difficult in the beginning of my sessions with the residents to distinguish what sensations belonged to me and which belonged to them. On one hand my thoughts were telling me that my experience was a positive one and that I was enjoying the work we were doing together. On the other hand, my body felt fatigued, tense,

and sick. As I previously mentioned, in my reflection of the experience I explored whether these sensations were unconscious feelings I held onto in my body or if I were taking on the sensations the residents were feeling. While it is impossible to know the true source of the sensations I was experiencing it was imperative that I investigate this aspect of my experience.

The way in which I was able to explore and overcome this culturally instilled bias was through my own practice of dance/movement therapy. First, I was able to recognize the sensations I was experiencing. My training in dance/movement therapy gave me an advantage in successfully identifying and tracking the somatic experiences I was having. However, with the knowledge I gained through the program I was better able to understand each sensation and its implication. After the first week of my research when I began noticing my strong negative somatic response I was able to explore the sensations and their connection to certain emotions. For example, the places in which I held tension were related to shame, guilt, and sadness. This allowed me to have a better idea of their source, whether it be my own personal experiences or the experiences of the residents. Once I was able to identify the emotions connected to my sensations I was able to process and work through them. Dance/movement therapy was, again, my means of processing my work. In both my supervisory sessions and my personal therapy sessions I was able to gain deeper insight into my experience.

There are a number of benefits that came from questioning this part of my process. First, I was able to use my somatic countertransference as an intervention to better understand the residents' experience. An example of this was when there was a disruption in our therapeutic process and I seemed to push the residents further than they were ready to go at that point. By reenacting the body postures and movements I observed in the actual moment I was able to understand their perception of the situation through the sensations they may have been feeling. I

believe this was actually the first time I intentionally embodied the residents' experience. This allowed me to have a new perspective and bring interventions to the residents that were more in line with what they were ready to explore. From then on I was more conscious of intentionally embodying their experience to better benefit our session. I was able to use my own body knowledge throughout each session with the residents. At times when I began to experience negative sensations I was able to alter the intervention or way in which I was interacting with the residents to provide a more positive experience. As a dance/movement therapist I used my body as a useful intervention and was able to view my work from a unique perspective. When fully acknowledging and exploring the sensation I was experiencing and keeping an open mind regarding where the sensations may stem from I was able to use that knowledge to engage the residents through both verbal and non-verbal means.

The part where this gets complex is that the majority of us feel highly vulnerable when experiencing sexuality in our bodies. If we fail to take care of ourselves when experiencing such triggering sensations we put ourselves at a physical and emotional risk. This is why it is crucial to maintain a self-care routine when working with this population. Upon reflection, I feel that my self-care routine was inadequate. As a master's student commuting more than two hours each way to my internship each day while still having a job and attempting to have a social life I neglected to take care of my mind and body in the way I could have and should have. I did, however, faithfully attend therapy sessions to process my experience and keep myself emotionally safe. Without therapy I would not have been able to manage my experience in a healthy way. At the time I didn't recognize the toll everything was having on me. If I were able to relive this experience I would make time to incorporate some relaxation into my schedule,

including something as seemingly simple as lighting a candle and closing my eyes and allowing myself to just breathe for a few minutes before delving into my next project or commitment.

While this study was assuredly difficult I feel that the benefits have far outweighed the obstacles I encountered. First and foremost, on a cellular level I am no longer afraid of this population. Despite being open-minded and eager to work with this population I started the process with apprehensions both consciously and unconsciously. Consciously I questioned my abilities at times and wondered whether my own experiences as a woman in society would prevent me from connecting to the residents in a therapeutic way. Unconsciously my mind viewed the population more negatively than I anticipated and my body held onto unfavorable sensations. As a result of working with this population these anxieties have disappeared. I am now more comfortable in my skin and able to be more present in my work. I have mastered the ability to experience challenging situations and face them head on. I am able to go through the tough times with the client as opposed to avoiding the difficult work. This is the most important part of the therapeutic process: presence. By being present the client is able to feel seen and heard and can explore painful experiences with someone they trust to guide them through. Being a catalyst for change is dependent upon the therapist being comfortable. The uncomfortable moments I experienced with the residents allowed me to grow and become comfortable so I can provide emotional healing with all the knowledge I have gained. In short, the experiences I had with the residents have made me a better and more effective therapist.

This study helped me evolve not only professionally but personally as well. As a professional I was able to take a look at my own experience to better understand who I am as a developing therapist and how I view my own work with my clients. I came to realize how truly important I believe connection, verbal or nonverbal, is. While I always appreciated the influence

of connection on the therapeutic process it was working with these residents that allowed me to fully comprehend it. In order to work honestly with this population I first had to inspire empathy in myself. Experiencing the connection I had with the residents did in fact help me find more compassion. It has always been my belief that persons should not be marginalized or outcast due to their socially unacceptable behaviors, that everyone deserves unconditional positive regard in order to help them heal. The persons who are generally the least desirable to work with are often the ones who need it the most because they are most troubled. By marginalizing these populations we are doing a disservice to them as well as society as a whole because we are avoiding dealing with the problem at the root. These beliefs have only deepened since working with this population and have inspired in me deeper understanding and empathy that I have taken in my work with all of my clients and in my personal experiences.

Interestingly enough, I was faced with multiple situations while finishing this thesis that caused me to take a profound look at my beliefs and how my work has shaped who I am as a person in all aspects of my life. On more than one occasion I came into contact with exhibitionists who made me feel violated and angry. I believe, however, that my experiences working with clients with sexually problematic behavior helped me navigate my way through these difficult situations. The experience I had with the residents allowed me to handle the situation in a pragmatic way without becoming fearful. I was able to confront each situation and take back the control. While these situations undeniably made me feel angry I was able to hold the anger and feelings of violation in a way that did not break me. In some ways it helped me have compassion. In no way was I excusing the perpetrators actions, just as I have never excused to actions of the residents, but I attempted to understand rather than let it consume me. I believe my experience with the residents also helped me to not blame myself as many people who

experience various forms of sexual aggression often do. All of this was, of course, difficult because my first reaction was anger, frustration, shame, and violation. I could have easily let it devalue the work I did with the residents. For a moment I almost let the experience alter my perception of the residents. How could someone be so vile and intrusive? Instead I used the work the residents and I did together to have compassion for myself as someone who has a history of experiencing unwanted sexual behaviors and recently experienced a form of sexual aggression as well as the population displaying sexually problematic behaviors. It showed me how much I had grown through the process. I think it also highlights how common this problem is and the need for more work to be done with this population to understand and shift the behaviors. I am not advocating for or excusing sexual aggression in any way, rather, I am encouraging therapists and other social service professionals to look at this population as whole people and not let their sexually problematic behaviors define them so we can provide them with the crucial help they need.

While this study is beneficial to the fields of dance/movement therapy and psychology there were a few limitations. First, I have to recognize that there is a certain level of superficiality in this study stemming from the need to remain safe in my own body when working with this population. Despite the experience being a positive one it was also very triggering in many aspects. As a survivor of unwanted sexual behaviors who is also finding my voice as a researcher I recognize there is a gap in how deep the work can go. However, at this point in my process I did explore as deeply as possible while remaining safe. Another limitation is that the study looked only at my own experience as opposed to looking at multiple dance/movement therapists working with clients with sexually problematic behavior. My experience sheds some light on how it is to work with this population and supports much of the

literature on similar work, however, it would be valuable to understand other dance/movement therapist's experiences of being in relationship with this population as well. Second, the study is wholly subjective. This is, of course, due to the nature of the study but is still a limitation in that it is my own experience and can't be proved wrong through scientific measure. Lastly, the study was conducted over a short span of time and no breaks were taken throughout the process to fully analyze the experience. My thought is that it could be beneficial to have multiple parts, reflecting on how the relationship changes after analysis of each part. More exploration will need to be conducted to further validate this study.

While I believe I did an adequate job of covering the topics I set out to research I feel there are a few areas of potential research that could continue to be explored. First, it would be beneficial to better understand the clients' perspective of the experience. Although it is important to have self-knowledge as a clinician it is equally important to understand how the treatment is affecting the clients themselves. It would be interesting to study, over time, how a client's attachment patterns shift in response to the therapeutic relationship while using dance/movement therapy through the therapist's own lens as well as client-reported changes. One could also explore how dance/movement therapy effects this population's connection to their bodies – most notably if/how it can be used to better understand their cycle of offense. Another area of research that would be useful to explore is the concept of rape culture and how we as a society glorify sex and power yet marginalize the people who have sexually offended.

This study allowed me to fully understand the experience of working with this population. I was able to address stereotypes and preconceived notions that were both conscious and unconscious. I found that my experience of using dance/movement therapy to work with males who had a history of sexually problematic behaviors was overall a positive one. Although

I encountered resistance and frustration I found that, for me, working with this population was similar to working with non-offending clients in that we were able to build a therapeutic relationship and both grow from it. In exploring my own experience and being able to go deeper within myself I was able to go deeper with the residents and be a more present and effective therapist.

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