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Finding My Feet: A Dance/Movement Therapy Intern's Heuristic Inquiry of Clinician Self-Care

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Finding My Feet:
A Dance/Movement Therapy Intern's Heuristic Inquiry of
Clinician Self-Care

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Thesis submitted to the faculty of Columbia College Chicago

In partial fulfillment of the requirements for

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Abstract

This study is a heuristic exploration of the internship experience of one dance/movement therapy intern and the search for effective self-care methods to assist in maintaining a sense of calm and stability, as well as a sense of focus during the final academic year of a dance/movement therapy master's program. Themes of personal and emotional stressors such as premenstrual dysphoric disorder, balancing personal and a newly emerging professional life, fitting personal religion into a secular field, trying to find self-confidence in a new creative and therapeutic role, and determining how much self-care is too much are all discussed. Previous research on clinician self-care, the effects of movement therapy on depression and stress, and the effects of intern and new clinician burnout are also touched upon to provide the reader with a clear lens through which to view this information.

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Wild Geese

You do not have to be good.

You do not have to walk on your knees
for a hundred miles through the desert, repenting.
You only have to let the soft animal of your body
love what it loves.

Tell me about despair, yours, and I will tell you mine.

Meanwhile the world goes on.

Meanwhile the sun and the clear pebbles of the rain
are moving across the landscapes,
over the prairies and the deep trees,
the mountains and the rivers.

Meanwhile the wild geese, high in the clean blue air,
are heading home again.

Whoever you are, no matter how lonely,
the world offers itself to your imagination,
calls to you like the wild geese, harsh and exciting--
over and over announcing your place
in the family of things.

-Mary Oliver

Introduction

This is the heuristic research of one dance/movement therapy and counseling (DMT) intern and the path I navigated as I sought to increase my confidence and directness as a leader in my new role while battling the monthly symptoms of premenstrual dysphoric disorder (PMDD). The challenges I faced were, in many ways, not unlike most other interns in the social services field. There was the constant wondering about whether I was truly cut out for this job. There was an utter lack of confidence in myself as a leader and someone who was supposed to be able to manage a group of behaviorally disordered children. There was the hesitancy I experienced when asked to step up and speak in a clear and concise manner with colleagues and superiors. There was the challenge of making self-care a priority in the midst of a slew of never ending external demands. And there were even bouts of ecstatic joy when everything just seemed to fall into place from time to time. But one part of my experience that set me apart from many other interns was my struggle with my monthly cycle. My hormonal fluctuations were always at the forefront of my mind as I went about my daily intern duties.

I often wondered whether I would be able to handle the noise or the activity level of the clients in a particular session without getting overwhelmed and having an outburst of my own. Would I make a snap decision in the heat of a moment of irritation that I might later regret? Would I ever write my session notes or would I feel lethargic and unmotivated forever? And was I really failing so miserably all the time or was my mind merely being taken over by my hormones that day? It was an experience of extreme highs and lows and always second guessing myself, wondering if I would ultimately be able to grow and become the kind of therapist I knew I wanted to be or if I should quit while I was ahead and forget the whole thing.

According to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), an estimated 75% of menstruating women experience some kind of small yet detectable change in their body or mood during the time leading up to their periods but only 3%-5% of women suffer from the type of symptoms that qualify for a diagnosis of PMDD. After consulting with a doctor, it has been determined that I am most likely one of those women who fall into the 3% -5%. Some of the criteria for the disorder, as identified in the DSM-IV, are as follows:

...1) feeling sad, hopeless, or self deprecating; 2) feeling tense, anxious, or “on edge”; 3) marked lability of mood interspersed with frequent tearfulness; 4) persistent irritability, anger, and increased interpersonal conflict; 5) decreased interest in usual activities, which may be associated with withdrawal from social relationships; 6) difficulty concentrating; 7) feeling fatigued, lethargic, or lacking energy; 8) marked changes in appetite...; 9) hypersomnia or insomnia; 10) a subjective feeling of being overwhelmed or out of control; and 11) physical symptoms... (American Psychiatric Association, 1994).

A cluster of just a few of those symptoms would likely be enough to make most people feel disabled or down on themselves to some degree. It was my experience as I was attempting to become a therapeutic leader that I often presented with as many as seven or eight of these symptoms for approximately half of each month. My ability to effectively help others was constantly in question in my own mind. How, I wondered, was I going to be able to get anyone grounded in their own body or feeling sound in their own mind if I myself was so often feeling like a lost ship in a stormy sea?

When I set out on this thesis journey it was not my intention to focus so heavily on the effects of my PMDD on my growth and progress as an inexperienced dance/movement therapist.

However, as the months passed I could not help but notice that my growth and progress as an emerging counselor was being overwhelmingly affected by my monthly cycle. It often felt as though every step I managed to take forward was erased by a hormone induced blunder and every victory or moment of self-congratulations was overshadowed by the dark looming cloud of my pre-menstrual time fast approaching.

For the nine months that I was engaged in my internship experience as a dance/movement therapy student, I was either actually experiencing my hormonal symptoms or I was dreading them. There was rarely a moment that I was not aware of my body's place in its menstrual cycle and how it might betray me in my work with my clients or in my relationships with my colleagues and supervisors. Yet I had goals for myself as a developing professional dance/movement therapist, I was aware of areas in which I needed to improve, and I was determined to push ahead in increasing my abilities and effectiveness despite my personal challenges.

This research is the culmination of that experience. It is my hope that sharing this information with others will result in an increased awareness of some of the effects, not only of hormonal and personal challenges in the internship experience, but also of this dance/movement therapist's unique and additional challenges while attempting to emerge in the social service field as a professional clinician. It is also my hope that the various modes and methods of self-care and coping skills that I explored for myself may be of use to those who are also trying to find a healthy and peaceful way to succeed in this field.

Literature Review

Clinician Distress

The experience of personal and professional distress among mental health professionals, such as clinical psychologists and master's level therapists, has been a topic of interest in the field for the last several decades. After a review of the literature on the topic, it appears that the impetus behind conducting these studies has been twofold. First, there is a genuine interest among some researchers in the experience of the therapist and what might be done to assist the struggling professional so that he or she might be better able to cope with their issues and/or regain personal health and well-being. Secondly, another set of authors seem to be more interested in the professional and ethical implications that arise when clinicians under extreme distress continue to see clients. The fear from both sides of the research, that therapists and psychologists are suffering and are therefore less effective in their jobs than they could or should be, stems from myriad findings that professionals who provide therapeutic services are categorically at a higher risk for experiencing personal distress, anxiety, and depression than other individuals (Barnett, Doll, Younggren, & Rubin, 2007; Deutsch, 1985; Gilroy, Carrol, & Murra, 2001, 2002; Guy, Poelstra, & Stark, 1989; Mahoney, 1997; McCann & Pearlman, 1990; O'Connor, 2001; Sherman & Thelen, 1998; and Turner, et al., 2005). And whether the reason for assisting mental health professionals in distress is an ethical matter and solely for the clients' benefit or a more holistic reason that includes concern for the professional as well, the need to do something to address taking care of the caregivers is evident. If the mental health field is to continue to grow and thrive, the people providing the care need to tend to themselves just as diligently as they tend to their clients and patients.

Before moving on, it is important to discuss what exactly is meant when talking about causes of distress, exhaustion, burnout, stressors, depression, and anxiety within the context of mental health and clinical professionals. It will also be helpful to identify what is meant by self-care and positive coping skills. The interest in this topic is fundamentally due to the irony that the professional in this field is required to exhibit a high level of mental and emotional health while at the same time being exposed to circumstances that create an environment which makes it exceedingly difficult to remain stable, healthy, and at ease. Turner et al. (2005) mention some stressors that new psychologists, therapists, and interns might experience, including things like adjustment to a full caseload or schedule, a new sense of identity as a professional, and worries about evaluations regarding their performance. Turner et al. (2005) also include some reasons for general mental health professional burnout such as this being an “other focused” field where one must constantly empathize with and attune to the needs of clients while pushing personal needs and desires aside throughout the work week. Mahoney’s 1997 survey summarizes the various consequences of engaging in this helping profession. Mahoney (1997) reports that the most common problems experienced personally by the mental health practitioners he surveyed were “exhaustion and fatigue...problems with interpersonal relationships and feelings of isolation, disillusionment about the profession, anxiety, and depression” (p.14).

All of those issues are cause for concern when associated with the helping professional because of what Barnett et al. (2007) refer to as “emotional competence” (p. 512). The authors make it clear that if a mental health professional is not aware of, and consequently not tending to, their own mental and emotional health then they run the risk of conducting therapy with a compromised level of clinical competence (Barnett et al.). As for the definition of “clinical competence”, Barnett et al. admit that there is still plenty of gray area when it comes to that and

it is up to each professional to constantly monitor his or her own state of being and efficacy while also consulting with peers, supervisors, and colleagues to maintain the highest levels of competence and to meet ethical standards. Deutsch (1985) summarizes it best, however, when she writes, “the therapist’s emotional and mental ill health, regardless of degree of severity, probably will have some negative impact on the client, making therapy less effective” (p. 305). In other words, the most basic reason therapists and other mental health professionals need to maintain their personal mental and emotional health is that, professionally, they are supposed to be a stable and clear resource for their clients and to be anything less than or other than that would be to practice poor ethics and exhibit substandard competence in their chosen field. So, with these details having been explored more in depth, we can move on to some more specific areas of practice that lend themselves to potentially higher risks for clinician distress.

Clinician Populations Experiencing Higher Distress Levels

We have discussed the general consensus in the field that being a mental health therapist of any kind can increase the likelihood of becoming overly stressed, anxious, or depressed. However, a few authors have focused on the difficulties which more specific groups of mental health clinicians face. For instance, female therapists, as compared to their male colleagues and to women who do not work in the mental health field, have been found to experience distress and depression at significantly higher rates (Gilroy, Carroll, & Murra, 2001). Another group that is at higher risk for depression and distress are therapists who hear and see particularly troubling material in their everyday work. McCann and Pearlman (1990) explain how therapists working with victims of either human cruelty or natural disasters can become what they call “vicariously traumatized” by being exposed to so much of others’ trauma (p. 136). The authors point out that as a result of repeatedly encountering clients who have experienced traumatic and uncontrollable

events, the therapist can eventually yet unconsciously begin to shift their own personal world view from a generally positive, trusting, and optimistic outlook to a rather frightened, negative, depressed, or even angry one (McCann & Pearlman). McCann and Pearlman found that this may in turn lead to a decreased efficacy in client/therapist interactions and difficulties for the therapist in his or her personal relationships as well.

Other special categories relevant to this research include both the inexperienced therapist (or intern), that we have briefly discussed, and the dance/movement therapist. Payne (2004) offers accounts from dance/movement therapy graduate students participating in her study that express a sense of uncertainty in how they should put the theories they learned in school into real life practice with their clients. They also expressed an initial lack of confidence when it came time to take ownership of and stand behind their own ways of practicing dance/movement therapy techniques. They had ups and downs throughout their schooling and internship experiences that led them to question their abilities and knowledge, which oftentimes added to their overall levels of stress. Turner, et al. (2005) offer similar findings with their own report that not only can counseling psychology interns feel insecure and uncertain, but they may also often feel a sense of falling abnormally short because they believe they need to be more confident and knowledgeable more quickly than they are humanly capable of being. According to the study, graduate students can also often feel alone in their experience because these feelings are not generally openly accepted or discussed, just as the topic of self-care can be neglected and pushed aside in graduate programs. This internalization of negative feelings adds to increased experience of personal distress, which, in turn can have negative effects on the quality of therapy the intern is then able to provide to clients (Turner, et al., 2005).

All of the information provided up to this point has conveyed that the experience of a dance/movement therapy and counseling intern who is female and who also works with traumatized clients is one that lends itself to great risk for self-doubt, anxiety, and other forms of personal and professional distress. All of these qualifiers do not necessarily point to automatic personal distress or anxiety or even a decreased effectiveness in client treatment for a therapist but, according to the literature, the more of these components the individual therapist has going against him or her, the more vigilant one needs to be about staying aware of their personal state of being and taking care to manage the stress of every day work in positive and healthy ways.

Premenstrual Dysphoric Disorder

Finally, there is one further factor that played a significant role in my own personal experience that must be included before moving on: my menstrual cycle and all of the hormonal ups and downs involved in it. As if the multitude of factors that have already been discussed were not quite enough, the one element that contributed most heavily to my own distress in becoming a dance/movement therapist was my experience of symptoms associated with PMDD.

Dell and Svec (2003) make it clear that not all women experience their menstrual cycles in the same or even similar ways. The effects of the normal monthly cycling of hormones in a woman's body can range from a feeling of bloating and other minor physical discomforts in the week or so leading up to menstruation all the way to severe moodiness and feelings of irritability that can cause a woman to irrationally lash out or cry at the slightest triggers in her environment. In most cases, women's premenstrual experiences are a slight inconvenience, if even bothersome at all. However, Dell and Svec (2003) say that somewhere between three and nine percent of women in their childbearing years experience symptoms so severe that they interfere with the

woman's familial relationships, her self-esteem, and may even lead a woman to question her sanity and ability to function normally.

In fact, the symptoms of PMDD mirror depression in many ways and Dell and Svec (2003) cite resources which point to drops in serotonin levels as correlating with premenstrual changes in mood. While they say that most studies have not found any differences in actual hormone levels between women with and without PMS or PMDD, it has been found that there are significantly reduced numbers of neurotransmitters that allow for stabilized mood in women diagnosed with PMDD. In other words, even if the levels of serotonin are normal in a woman with PMDD, the neurotransmitters available to receive the mood enhancing chemicals in her brain are in short supply and can lead to the same results in mood that low levels of serotonin would produce. These findings, along with research showing the effectiveness of serotonin reuptake inhibiting medications relieving the symptoms of PMDD, support the validity of PMDD and PMS as valid diagnoses as well as the need for these conditions to be taken seriously just as depression or bipolar disorder would be (Dell and Svec, 2003).

Further backing for the reality of the experience of mental distress during the premenstrual phase for a select group of women comes from Fontana and Badawy's 1997 study on coping with stress and perceptions of stressful situations across the menstrual cycle. The researchers used a group of women who met the criteria for PMDD and a control group of women who did not experience any premenstrual distress. None of the women's hormones were altered by pregnancy, oral contraceptives, or hysterectomy at the time of the study. For a period of 35 days all of the participants completed the daily stress inventory (DSI), the daily rating form (DRF), and the daily coping scale (DCS). These three measures covered participants' experience of stressful events, general moods and emotions, and types of coping skills used on each day of

the study (Fontana and Badawy, 1997). Their responses, in combination with the phase each woman was at in her cycle, provided the statistical data needed to support the idea that women who suffer from PMS and PMDD have a more difficult time dealing with stressful life events in general, with a slight increase in difficulty during their premenstrual phase. Not only did the patients perceive life events as more stressful than the control group during the premenstrual phase, but they also reported reduced ability to cope with such situations. More simply put, the control group showed no change in how they perceived or coped with stressors throughout their cycle and were, in general, better able to cope with life's daily nuisances than women who were labeled with PMS and PMDD (Fontana and Badawy, 1997). The results, while surprisingly not confirming a negative experience solely during the premenstrual phase as expected, do suggest that women who suffer from PMS and PMDD may experience the effects of their disorder throughout the month with an increase in symptoms during the premenstrual phase. This could perhaps be a result of the women adopting the belief during their premenstrual phase that they simply cannot cope as well as other people. The authors suggest that perhaps, in instances where this might be true, women with PMS and PMDD could benefit from cognitive therapy to change their internalized beliefs and avoid taking medication (Fontana and Badawy, 1997).

Dell and Svec (2003) also support the use of cognitive behavioral therapy (CBT) for some cases of women experiencing premenstrual disorders. According to Dell and Svec, CBT focuses on rewriting one's thoughts surrounding an experience or issue. For instance, if a woman constantly feels out of control when her cycle hits the premenstrual phase, her therapist might ask her to replace the thoughts and fears of being out of control with positive and rational self-talk (Dell and Svec). And while it may be helpful for many women to recognize that their instinctual thoughts are less than rational during their premenstrual phase, it may not be

sufficiently successful for everyone suffering from PMS and PMDD. As mentioned earlier in this review, Dell and Svec have also reported that women with PMDD have fewer neurotransmitters in their brains to receive mood enhancing hormones. If that is the case then it would logically follow that these same women would have difficulties in coping with life stressors throughout their menstrual cycles and that, contrary to Fontana and Badawy's (1997) findings which were also discussed earlier, it is not simply a self-defeatist attitude at work in women's minds that causes their lack of ability to effectively cope with stressors, but rather a physical and chemical condition in the brain. While CBT might be a helpful part of a therapeutic regimen, the issue of serotonin levels and brain structure must also be addressed in order to fully understand and treat PMS and PMDD.

Coping with Distress

In an exciting report that addresses serotonin levels and the effects of DMT on depression, Jeong, et al. (2005) describe the symptoms of depression and they are nearly identical to the defining symptoms of PMDD that have already been discussed in this review. The study, conducted by Jeong et al. (2005), looked at the effects that 12 weeks worth of dance/movement therapy sessions had on the serotonin levels of depressed teenage girls living in Korea. There were two groups, a DMT group that participated in three 45-minute sessions of DMT per week for 12 weeks and a control group that received no treatment. The serotonin levels of the girls were recorded at the outset of the study and again at the end. The DMT sessions focused on the following themes:

Awareness of the body, the room, and the group; movement expressions and symbolic quality of movement; movement, feeling, images, and words; and differentiation and integration of feelings. Each of these themes included various sub-themes: setting limits

and outer, inner, and personal space; body language, the reflecting process, polarity, and inward and outward expression; playing, drawing, and verbalization; and the inner sense, quality of movement, and expression of feelings. (Jeong et al, 2005, p. 1715)

The authors found a statistically significant increase in serotonin levels of the DMT group after the 12 sessions had concluded and found that the levels in the control group had actually deteriorated over time (Jeong et al, 2005). These results can easily be translated to the world of PMDD due to the similarities between depression and PMDD. This study certainly ought to be replicated in order to confirm its reliability and validity because if increased serotonin levels equal increased functioning and improved life satisfaction in women who suffer from PMDD, but a number of those women don't necessarily want to take medications such as SSRI's, this could be revolutionary. And if these results can be reproduced it would mean that DMT really might be able to do the same job as antidepressant drugs but without any of the negative side effects.

In a similar vein, Lane, Hewston, Redding, and Whyte conducted a study that discusses the benefits of dance as related to mood in 2003. They studied the effects of two different styles of modern dance on the mood of the dancers who participated in the classes. Their participants were limited and none of them presented with significant mood disturbances such as depression or PMDD. However, the researchers did find that when the dancers completed a mood measure survey before and after classes there was a marked improvement in responses from before to after. The more free flowing style of Limon-based class showed an even greater mood increase than those participating in the Graham-based classes. However, ultimately, the effects of the dancing were only short term (Lane, Hewston, Redding, and Whyte, 2003).

Yet another study conducted by Netz and Lidor (2003) in Israel focused on the differences between mindful modes of exercise and plainly aerobic exercise in levels of mood improvement. The authors used multiple scales to assess the moods of their female participants both before and after the programs were completed. The groups were swimming, aerobic dance, yoga, computer class, and Feldenkrais movement. The results showed that aerobic dance did not improve mood significantly, the computer class participants did not improve their mood at all (as expected since this was the control group), and the swimming, yoga, and Feldenkrais groups did in fact show statistical increases in mood levels at post test (Netz and Lidor, 2003). These results imply that the mere act of physical activity is not enough to induce mood improvement. Swimming, yoga, and Feldenkrais are all methods of movement that involve concentration on breath and repetitive slow flowing movements. The authors attribute the experience of improved mood in the participants of the study to these elements. However, the authors openly admit that more research is required to make any conclusive statements on the subject (Netz and Lidor, 2003).

This all brings us back to the broader picture of how a DMT intern who is female, works with traumatized clients, and suffers from negative PMS symptoms might best find and use the coping and self-care skills necessary to function appropriately in the various life tasks she must perform as well as to ethically and effectively serve the clients she is responsible for. For a start, the Jeong et al. (2005) study provides an obvious route to try, which would be for the dance/movement therapist to engage as a client of dance/movement therapy. The various elements of DMT, such as physical movement, emotional expression, and being witnessed by or empathized with by other(s) are all elements that have years of support behind them as restorative and therapeutic modes of intervention. Payne's 2004 study of dance/movement

therapy students' experience of being engaged in a DMT group as clients themselves during their internship experience also gives support to the idea that being a client can be an extremely helpful and restorative experience for practitioners. Payne tracked one cohort of DMT graduate students over 2 years as they experienced their academic and internship responsibilities within the context of being engaged in a dance/movement therapy group as clients once per week. The participants all had varying experiences, of course, but the overall consensus from the DMT students/clients was that a) being clients helped them to understand how to be better leaders and facilitators and b) being part of a DMT group was therapeutic and helpful in reducing feelings of isolation and anxiety (Payne).

Along those lines, but with more general implications, is the inclusion of personal therapy as a coping skill and self-care activity that is mentioned in numerous studies (Barnett, Doll, Younggren, & Rubin, 2007; Deutsch, 1985; Gilroy, Carrol, & Murra, 2001, 2002; Guy, Poelstra, & Stark, 1989; Mahoney, 1997; McCann & Pearlman, 1990; O'Connor, 2001; Sherman & Thelen, 1998; and Turner, et al., 2005). These authors have all included items such as seeking personal therapy as an option on their various questionnaires as part of studies related to how mental health clinicians and interns can best take care of themselves. This common inclusion suggests that therapy is most certainly a tool that therapists themselves can utilize in order to maintain their own wellbeing while they are involved in the business of helping others. Whether it is talk therapy or dance/movement therapy, the idea of a therapist seeking therapy appears to be generally acknowledged as a healthy and common occurrence.

Other self-care strategies suggested by multiple researchers include engaging in physical activity, getting plenty of sleep, taking adequate breaks from work, enjoying pleasurable activities such as reading or hobbies, spending time with friends or relatives, participating in

clinical supervision with and getting feedback from colleagues and supervisors, maintaining an awareness of personal distress and triggers, writing in a journal, and utilizing spiritual practice and/or prayer and meditation (Case & McMinn, 2001; Gilroy, Carrol, & Murra, 2001, 2002; Guy, Poelstra, & Stark, 1989; Mahoney, 1997; McCann & Pearlman, 1990; O'Connor, 2001; Sherman & Thelen, 1998; and West, 1998).

Although all of the articles and suggestions listed above offer excellent resources for the struggling neophyte dance/movement therapist, one article that stood out from the pack as something noteworthy and different was one conducted by Sherman, Bunyan, Creswell, & Jaremka in 2009. The authors ran a study with college students under the assumption that the reason most human beings become so distressed in pressure filled situations is that they base their self-worth as a whole on the outcome of their performance in the individual tests and evaluations that they must engage in as part of being a student or employee. The theory, proposed by Sherman, et al. (2009), was that if a student had experienced failure on a test in the past or had generally low self-esteem prior to engaging in an important test of skills, then the student's stress hormones would reach significantly high levels prior to, during, and after the test for fear of being negatively evaluated. The results of the study showed that when the test group participants engaged in the exercise of writing positive self-affirmations prior to the stressful test event, the students not only experienced no change in stress hormone levels, but also were able to do better on the tests than when they were feeling stress (Sherman, et al.). The authors, based on previous studies as well as their present study, conclude that the benefits of writing about positive aspects of oneself can assist an individual in maintaining a positive self-image regardless of their performance on a specific test or task, which in turn assists the individual in feeling less stress leading up to evaluative experiences that have previously been extremely

distressing (Sherman, et al.). Sherman, et al. explain that when a person can understand their self-worth on the whole as being separate from individual instances of negative or positive evaluation, they will be less vulnerable to the stress that accompanies these evaluations because they realize that their internal qualities do not shift and change with every evaluation. This research is particularly interesting in relation to this thesis as the results can easily be translated to the internship experience, which is filled with constant evaluation and can lead a person to begin to internalize every negative comment or failure that occurs as they stumble through their introduction to the mental health profession.

Also of note in the field of mental health practitioner self-care is a book devoted to the topic by Babbette Rothschild (2006) entitled, *Help for the Helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma*. The book (Rothschild, 2006) covers everything from definitions of things like empathy, countertransference, and compassion fatigue, to ways in which therapists can utilize their bodies and their own awareness in order to protect themselves from the detrimental effects of working in a demanding caring and helping profession. This review is not the place to reflect upon each chapter and nuance of Rothschild's work, however the highlights will most certainly be mentioned. Firstly, while Rothschild may not be a dance/movement therapist she constantly refers to the body and how the physical aspect of being with clients is just as potent as the emotional and verbal elements. In one particular passage, the author discusses the power of postural mirroring and how this can deeply affect not only the client, but the practitioner as well. Rothschild recounts a session where she at first consciously took on the posture of an angry client in order to attune to his needs and get him to open up to her. The mirroring worked and the client was able to have a productive session, leaving with a sense of peace and calm. But Rothschild writes that she was left feeling extremely angry and

confused once the client left. After questioning herself and seeking the counsel of a friend, Rothschild came to the conclusion that her feelings of residual anger had come from her postural mirroring of her client. Something that had begun as an intentional and effective therapeutic tool became unintentional throughout the remainder of the session and the therapist had forgotten to undo, so to speak, the effects of taking on the client's expression of anger. Rothschild continually reminds her readers throughout the book that, as important as it is to attune to clients, it is equally important to be conscious of cleansing oneself of the clients' feelings, expressions, and state of being after the client leaves in order to protect oneself from becoming overly fatigued. Rothschild stresses that empathy is important, but carrying the weight of client's troubles long after the client has gone home feeling relieved is not healthy or helpful for anyone. According to Rothschild, the idea of cleansing after a session or a work day can be as simple as literally washing one's hands or changing out of work clothes to being as spiritual as lighting incense and opening a window to clear the air in the work space of the client's energy.

Rothschild (2006) also makes much of protecting oneself from compassion fatigue and vicarious traumatization before and during sessions. Rothschild suggests wearing clothing or jewelry that feels powerful or protective, averting one's gaze during particularly intense moments with clients, and monitoring levels of personal arousal and anxiety while working with clients. Throughout the book, Rothschild admits that there is a fine line between being effectively empathetic with clients and becoming traumatized by client's experiences due to overly empathizing with clients. And while Rothschild does not claim to have the end all answer to this balancing act, she does offer suggestions for attempting to control the extent to which visualizations of clients' trauma invade the therapist's mind, stating that it is not necessary to relive the trauma with the client in order to assist the client. Rothschild also recommends that

therapists ultimately focus on knowing themselves and their own life histories well enough to recognize potential triggers and stressors that may put them at risk for becoming overly fatigued or incapable of rationally and effectively practicing their trade and to then take extra care to restore themselves after working with clients who pull those triggers.

Spirituality as Coping Mechanism

One specific way to take care of oneself that Rothschild (2006) briefly touched upon is developing a spiritual or religious practice. Case and McMinn (2001) conducted a study regarding the ways in which some psychologists use spiritual practices as a defense against the distress that can set in as a result of being in the mental health field. The authors sent out questionnaires to 600 psychologists who were members of the American Psychological Association, with 400 of the questionnaires being returned and usable for the study. The questionnaire asked participants questions about work related distress, perceived impairment due to distress, and personal coping behaviors. The results showed that those who reported being less religious experienced about the same amount of distress as those who reported being more religious. The more religious group did experience different types of distress, however, such as more distress related to spiritual or religious issues than the less religious participants, but that is to be expected. For example, issues of feeling unaccepted or conflicted in professional secular settings were prevalent in those who reported being more religious. Also of note is that while prayer, meditation, and attending religious services have ranked consistently low as preferred coping skills amongst mental health professionals when measured in other studies, in this study it was revealed that amongst more religious respondents, prayer and attending religious services ranked as the highest preferred coping skills both in times of distress and in general. The authors point out that for religious people, God and spirituality are not necessarily emergency buoys used

only in times of crisis, but rather a constant frame of reference for all aspects of the person's life (Case and McMinn, 2001).

West (1998) confirms that spirituality is not merely a coping mechanism for many religious therapists, but a full time way of existing in the world. In the face of a largely secular profession, West points out that as much as being religious can be a benefit to mental health professionals, it can certainly also give rise to discomfort and inner turmoil when the professional feels a desire and calling to share the source of their comfort with clients or to explain personal beliefs to colleagues. West found that some spiritually inclined therapists reported feeling uncomfortable bringing certain issues to supervision for fear of being negatively judged and subsequently suffered the consequences of not receiving sufficient feedback. On the client-therapist relationship end, one participant in West's study expressed feeling that it would be professionally unethical for her to privately and silently pray for clients who had not specifically requested such intervention, despite her own spiritual beliefs in the power of prayer. However, even in the face of these examples and other drawbacks to holding personal spiritual beliefs in a secular profession, West's overall conclusion was that prayer and faith in God provided a deep sense of meaning and support for the individual mental health professionals who responded to the survey and that it was not ultimately important that they share the details of their faith with their clients as long as they themselves had private spiritual practices in place. West found that Quaker therapists involved in the study used prayer as spiritual preparation and inspiration for their work, even if they never mentioned their faith to their clients. Also important to note is that the feeling of support and the potential for distress reduction that spiritual and religious therapists found was reported to come from a feeling of "a session sometimes being taken beyond just what I could do" (West, 1998, p. 373). In other words,

believing in a God that can be called upon for guidance and intervention in one's work, especially when attempting to help others, can lead to feeling that one is not so completely alone and vulnerable in the responsibilities of being a therapist or counselor. This can in turn reduce the stress that can often accompany those responsibilities. In closing this section it would be helpful to point out that the Bible itself instructs Christians to, "not be anxious about anything, but in everything by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds..." (Philippians 4:6-7, New International Version).

Question

The most succinct question that was addressed by this research is: How can the importance of clinician self-care be more vibrantly understood and promoted in a more personally meaningful and relatable way? More specifically, how can dance/movement therapists, women, individuals experiencing emotional or mental distress in their personal lives, and those new to their professional roles utilize self-care as a means of improving self-confidence and ethical clinical practice? Other questions have been addressed regarding the various sub-categories that are explored in this study as well, but whether it is religion, PMDD, or working with traumatized clients, the thread throughout is clearly defined by the themes of self-care and increasing self-awareness of the professional in the mental health field.

Purpose

The purpose of this research is twofold. First, a deeply personal story has been revealed. The story is full of illustrations of the frustrations and perceived inadequacies of a fledgling dance/movement therapist and person experiencing PMDD. It is my hope that sharing this story will provide other fledgling dance/movement therapists (and women suffering from PMS and

PMDD) with a sense of universality and comfort in knowing that they are not alone in their struggles and fears. It has been widely reported that a common perception of interns is that they are alone, unique, and should not let anyone know about their feelings of distress for fear of being shamed or judged harshly by their peers and superiors. The same is true for women experiencing severe hormonal disruptions every month. It seems only reasonable, then, that the more information that can be shared about how very unhealthy (yet common) those feelings of isolation are, the less people there will be who will have to experience them.

The other purpose of this current thesis is to present a coherent collection of resources and information about how someone in either the position of working in the mental health field, or in the position of experiencing personal distress of any kind, might be able to find a sense of peace and comfort in their lives despite their daily challenges. I have included information on everything from the pleasures of taking circus classes to the power of prayer to the ritual of cleansing oneself after seeing difficult clients. I wouldn't argue that there is something here for *everyone*, but I do feel secure in stating that I tried a multitude of self-care and coping tactics for myself and that amongst them there may be helpful resources for those who read this research.

Methods

Methodology

This research is the result of nearly two years' worth of self-exploration and curiosity about the ways in which my own personal experiences might be universally linked to the experiences of others and, in turn, how that universality may increase and illuminate meaning for myself and others who will eventually read this research. What began as a neatly packaged question about how my PMDD symptoms were affecting my personal and academic life, and whether or not becoming a DMT client might modify my experience of the symptoms, eventually shifted into a much deeper and longer term exploration of not only how my PMDD and other stressors were affecting my life, but how these things specifically affected my process as an intern working with traumatized children and how all of the various self-care methods I chose to invoke were helping or hindering me as I went along and tried to become an effective and healthy dance/movement therapist.

At the outset of this process I was passionate about finding a way to capture the fullness and depth of my experiences and to make sense of them in a way that might be useful for others in the field, but I was at a loss for how exactly to do that and still produce a legitimate and academically approved product in the end. Fortunately, I was introduced to a process called heuristic inquiry, which provides exactly the framework I had been searching for but had not believed existed. In his 1990 book *Heuristic Research*, Moustakas described heuristic inquiry as, “a process that begins with a question or problem which the researcher seeks to illuminate or answer. The question is one that has been a personal challenge...” (p. 15). Further, heuristic inquiry is a process in which a researcher immerses oneself so fully into the study of an experience that it consumes them as they attempt to gain understanding of all facets of it (Braud

& Anderson, 1998). Thus, results come in the subjective form of in-depth and extensive personal insight into the phenomenon rather than objective statistics or theories.

According to Douglass and Moustakas (1985) there are three phases that are generally involved in heuristic research: 1. Immersion 2. Collection of data (Acquisition) 3. Synthesis of data (Realization). But the authors explain that these phases differ from more traditional and objective research methodologies in that they require understanding and experiencing of the subject matter on a personal feeling and sensing level where one is required to utilize their own “intuition”, “tacit knowing”, “inference”, and “self-disclosure” to collect, make sense of, and present their data (p. 43). Douglass and Moustakas also emphasize that the steps involved in conducting this kind of research tend to “unfold spontaneously, yet they are guided by a desire to illuminate the phenomenon. In the spirit of this flow, it is appropriate to change methods or procedures in midstream....” (p. 45).

This became quite true for me as I began my internship experience with one notion of how I would like to collect my data and for how long I would be collecting data, but I ended up with a much different attitude and practice by the time the data collection was completed nine months later. In the end, embracing the guiding idea of heuristic inquiry as my methodology allowed me to freely and profoundly delve into any facets of my lived experience I felt I needed or wanted to without the confines of attempting to discover or disprove a theorized answer to a predetermined question. Also, much like Etherington found in her 2004 study on heuristic researchers, I found myself becoming more self-aware both professionally and personally as I collected and analyzed my data.

Yet, while this open, intangible structure was freeing and allowed me to live my life with very few encumbrances, it certainly lent itself to many difficulties and challenges as well. A

1996 article by Patricia Fenner discusses in depth the felt lack of structure in the author's own heuristic research process. Fenner describes her heuristic experience with words such as "uncertainty", "exciting journey", and "elusive" (1996, p. 40). At times I could relate to Fenner's experience, as I felt that I had too many options and too many directions in which I could go as well. During the data collection phase, the question, "So what is your thesis about?" rarely had an easy answer and elicited anxiety whenever anyone asked it of me. There were times in the process when I was encouraged to try and narrow down my focus, which I would try to do, but I always ended up being drawn back to the fullness and the larger scope of my life experiences, not wanting to leave anything out because it all felt so rich and important.

When it came time to finally analyze and report on my data I often froze in frustration at not feeling able to sufficiently capture the true essence of my experience in a coherent way. But, as Douglass and Moustakas describe in their 1985 article, these challenges are all just part of the heuristic experience. Reading about it cannot fully prepare anyone for the intense highs and lows, the frustrations and eureka moments, or the struggles of desiring and needing to know more but feeling too physically and mentally full to be able to consume even one tiny morsel of additional information.

Participants

The sole participant being analyzed in this study is myself. And while other people in my life contributed to my research experience simply through the act of being in relationship with me, no one was formally interviewed or asked to fill out any type of survey or questionnaire, or to sign a waiver. When people such as my academic and on-site supervisors, personal dance/movement therapist, boyfriend, clients, colleagues, or peers are paraphrased or referenced in this present study, it is by anonymous pseudonyms and for the sole purpose of illustrating how

my personal experience played out in relation to them, not to in any way draw conclusions or create theories related to them. As such, I remain confident that ethically there were no human participants used in this study aside from myself.

Procedure

The skeleton of my heuristic procedure for this research is that I set out with a plan to write in a journal in order to record my master's level dance/movement therapy internship experience as well as my experience as a participant in individual DMT sessions. And while that is essentially what took place, the heuristic nature of this journey led to a slightly more complex and ever changing set of exact procedures that I will detail in this section.

My first step took place prior to the first day of my dance/movement therapy and counseling internship, which took place at an urban residential facility for children and adolescents that were, for a variety of emotional, behavioral, and legal reasons, unable to live in a home environment. I decided my primary method of data collection would be writing in a journal. I took my time in selecting a leather bound journal with lined paper that appealed to me not only aesthetically but also in weight, size, and feel. This component was important because I sensed that having an appealing journal would assist me in staying motivated to write more often and to write for longer periods of time than if I had purchased a notebook that was not visually appealing or that was uncomfortable to write in. Also prior to the beginning of my internship, I contacted a local licensed clinical professional counselor who was trained as a dance/movement therapist and she agreed to meet with me once per week for private individual sessions.

Next, I determined that the best times for me to commit myself to writing in my journal would be after sessions with my dance/movement therapist, after meeting with my on-site supervisor, and after group supervision with my academic supervisor and classmates. However,

I also determined that I would carry my journal with me daily in case I felt inspired to write at any other time.

My only initial parameters for what types of thoughts or experiences I intended to record were that I wanted to focus on a) my experience as a dance/movement therapy master's level intern at a residential facility that serves emotionally and behaviorally disordered children and b) my experiences as a dance/movement therapy client. I went into the process trusting that if themes began to develop I would recognize them as they arose and decide what to do with that information, if anything, either at that time or during the analysis phase. I went into this process with a complete openness to following the flow of whatever may or may not arise throughout the process. This was in true heuristic form (Douglass & Moustakas, 1985).

I also initially determined that I would collect data from September of 2008 through December of 2008, or, one academic semester. However, as my process began to take on a life of its own and as I became increasingly engulfed in examining my process as an intern and client, I began to sense that I would not feel complete or whole in the research if I stopped midway through my internship commitment. I sensed that I would not be able to begin writing retrospectively about my process if I was still experiencing new parts of it. It didn't make sense intuitively to stop what I was doing and pull myself out of the process simply for the sake of churning out my thesis more quickly. So in December of 2008 I met with my thesis advisors and made a commitment to continue writing about my experiences throughout the remainder of my internship, which ended in May of 2009.

During that same meeting with my thesis advisors, questions as to whether I had noticed any obvious themes or common threads arose. At that time I felt very unsure of what the end result of my heuristic process was going to look like and my uncertainty lent itself to an anxious

desire to want to begin to make sense of my data and to drive it down one road or another. My answer was that, yes, I had noticed a few themes, including feeling a lack of self-confidence both in general and in my role as a leader and also a lack of directness when interacting with others, which seemed to be hindering me from progressing as quickly as I had hoped. By the end of that meeting I had agreed to focus my future journal entries on those themes rather than continue to write about anything and everything I may experience in my life as an intern and client.

However, as the weeks went on I couldn't shake the overwhelming sense that I was doing myself a disservice by narrowing down my focus and perhaps cutting off other possibilities too soon. I did continue to stay mindful of the themes I had discussed with my advisors but I felt I was forcing out a wealth of important information regarding my self-care strategies, my return to church, and my struggles with my menstrual cycle that caused me great distress in the form of nearly disabling PMDD symptoms. I wanted to be able to produce a coherent final written product and so I was drawn to the idea of reining in my focus, but at the same time, my intuition was insisting that I not let go of the bigger picture. The bigger picture seemed like it was the point. The bigger picture was what I had grown so passionate about because that was where the meaning of it all was going to emerge. Douglass and Moustakas (1985) assert that, "without formal hypotheses to predispose the search, one is not only free but obliged to follow the path that holds the most promise for disclosing truth" (p. 49). So while I was still anxious about how I was going to condense my ever growing data when it came time for analysis, in February of 2009, I decided to resume the free flow method of recording every thought that seemed important and to do it in any format I was inclined to record it in. I knew I would have to deal with the consequences when it became necessary, but that wasn't the focus yet.

As a result of that decision, by the time my final days of being an intern arrived in May of 2009 I had roughly 9 months worth of hand written journal entries, typed computer journal entries, stick figure pen drawings, swirling cray pas drawings, crude paintings, hand made clay ornaments, to-do lists, various art therapy projects that I had made alongside my clients during my supervisor's group sessions, personal session notes, responses to session notes, and scribbled thought fragments in practically every notebook and textbook I owned.

Douglass and Moustakas (1985) say that heuristic inquiry involves “immersion [that] carries the sense of total involvement...in such a way that the whole world is centered in it for a while” (p. 47). For me, this became especially true towards the second half of my data collection phase. I was living my life in two parallel worlds whereby I was going about my daily life as usual yet I was also constantly wondering how each instance, interaction, and personal choice was fitting into this grand scheme of my experience of being a DMT intern and a DMT client. Nothing was ever just happening; everything was being catalogued in my brain as something new to write about later, something that was connected to an existing thread, or something I could possibly leave out.

Data Analysis

As mentioned earlier, I began to have concerns about how to analyze such a vast quantity of qualitative and personally significant data from the inception of this research process. The very things that excited me about wanting to engage in this type of data collection were the same that discouraged me when it came time to think about how one might possibly analyze that data. However, it came down to simply having to make choices about what absolutely needed to be included and to then not dwell on the massive amounts of data that must necessarily remain left out for sake of space, time, and cohesion.

The first task for me, as suggested by Moustakas (1990), was to take time away from the data to allow my mind and body to rest before returning to the information with a fresh view. I accomplished this as I took a two-week trip to Scotland immediately after my internship was completed. The change in place and pace allowed me to almost completely forget about my thesis and to shed my dual roles of participant and researcher for a short time. Upon returning home, and then throughout the analysis process, I continued to take time away from the material for hours, days, or even weeks at a time. While this is admittedly not the most efficient manner in which to complete data analysis, it felt necessary in order to avoid becoming too short sighted or overwhelmed.

The actual steps by which I analyzed the data were as follows:

- 1) I decided to only analyze data that was included in my hand written journals or on my computer saved under the “thesis journal” file. This was done as a way of attempting to simplify my process for the purposes of producing a thesis document in a timely manner and in no way implies that the art and other notes I made felt any less valuable or meaningful.
- 2) I read every written journal entry in its entirety and allowed myself to make notes in a separate notebook as I went as a way of making sense of the data.
- 3) I read every journal entry again, this time marking anything that seemed important with a yellow highlighter marker.
- 4) I went back over all of the highlighted excerpts and from those entries came up with five categories to which I assigned five other colors of highlighter marker:
 - a. Pink = Hormones/PMS symptoms/ Relationship to DMT
 - b. Blue = Confidence/Comfort in Role as Therapist

- c. Green = Directness
 - d. Purple = Self-Care Activities/Therapy Visits
 - e. Orange = Religious/ Spiritual
- 5) I then read the originally yellow highlighted entries and went on to re-highlight or otherwise mark off each segment with a new color according to the category or categories it seemed to best fit.

After this step I felt very familiar with the data and decided it was appropriate to begin choosing which excerpts would be most useful to include in my final results. I wasn't entirely sure how to go about this in a methodical or logical way because much of the data still seemed so relevant and important, but I knew it could not possibly all be included. This, then, led to my next course of action:

- 6) I had a meeting with my thesis advisor to assist me in deciding what the next steps might be for my process and also discussed how exactly to include everything I wanted to include without allowing the data to become overwhelming and difficult for a reader to sort through and make sense of.
- 7) With my thesis advisor, the idea of layering came up, with each part of my experience laying the foundation for the next, which gave me the visual image I needed to move ahead.
- 8) I created a blank Word document and typed out the five general categories I had intuitively begun using as my framework.
- 9) I discerned that I would simply read through the highlighted journal entries from start to finish one last time and choose only 5 to 10 excerpts to include under each category.

10) I proceeded to follow through with this plan until I had several entries typed under each of the category headings.

This is where my strictly internal process ended and my search into the external realm of information began. It was at this point that I had plenty of understanding about what I had personally gone through on my journey and I had chosen the highlights that would best illustrate the points I wanted to make, but I realized I needed to begin to put my experience within the context of what others had already found to be true in their own or their participants' experiences.

11) I went to PsycInfo's online database of psychology-related articles and typed in various key words that I felt pertained to my own data, such as "internal mental health", "psychologist mental health", and "dance/movement therapy intern." These initial searches led to a few of the types of articles I was looking for, which in turn gave me new ideas and led me to further articles that were even more relevant to my work.

12) I printed out (or ordered from the library) and read through each article that felt relevant to my own experiences.

13) I used the articles and other outside sources to inform my analysis of my own data.

14) After all of this had been accomplished, I was able to cohesively and coherently write the results of this study, which are presented in the following chapter.

Results

The findings of this exploration are multi-layered but contain the main themes of my experiences of increasing my self-awareness as an intern, as a sufferer of symptoms of PMDD, and as someone advancing towards and retreating away from integrating dance/movement therapy in my personal and professional life. Sub-themes abound but the most prevalent of them include: feelings of doubt, guilt, and inability to succeed in my new role; feelings of helplessness and deep concern regarding being able to cope with my waxing and waning PMDD symptoms; feelings of great enthusiasm, determination, and optimism at times of breakthrough and success; feelings of being unique and isolated in my extreme emotional ups and downs; and a constant search for and trying-on-of coping and self-care mechanisms that might see me through to a successful completion of my graduate program and propel me ahead into a thriving dance/movement therapy career.

Premenstrual Symptoms

“When I’m feeling like I want to jump out of my skin, what do I do? If I’m alone, I scream and punch; if I can, I want to be held and contained.”

-Journal entry from September 4, 2008

As I reviewed my journal entries the prevalence of my PMDD symptoms clearly emerged as an undercurrent of my experience throughout the nine months of my internship. While I did not always make explicit note of the role my hormones were playing on a given day, I found that when I went back and did an informal charting of my moods (as expressed in my journal) as they related to the day in my menstrual cycle, the two appeared to be correlated.

These mood swings, mental challenges, and physical symptoms made my self-confidence in my role as a dance/movement therapy intern plummet one day, only to soar the next, which left me confused and uncertain about my ability to consistently embody the qualities I believed were necessary to be successful in the mental health field. During times when my cyclical symptoms felt to be at their worst, I seriously questioned my sanity and wondered if I ought to be engaging in therapeutic practice at all. An entry from October 9, 2008, about one month into my internship, illustrates my experience of shame and doubt in relation to my co-intern:

I couldn't pull it together and get in a good mood again. I let J. pick up all my slack because I felt defeated and weak. Then I felt guilty. Then I felt like a failure. Who am I to be working with kids? She seems so good at it, so bubbly, so fresh and able. I feel like when I stand next to her I'm a drab and useless drudge. I'm not fun, I'm not always bubbly, I'm not confident and strict. I just sort of "am"...

This sentiment reflects findings from Jane Ussher's 2003 study that assert PMDD is not simply a disorder of the self, but one that has very real relational implications as well. Ussher found that the vast majority of the dissatisfaction women with PMDD experience is within the context of close relationships, because the woman feels she is somehow displeasing or inconveniencing other human beings as the result of her own hormone-induced words or actions.

The journal entry above also illustrates how drained and heavy I felt. The language I was using makes it sound as though I were sinking. This was a common feeling during the week and a half or so leading up to each new menstrual cycle beginning again. Yet it was contrasted by equally strong feelings of dreaminess or being spaced out. One moment I could be feeling the sinking, the heaviness, and the lethargy which made me just want to fall asleep but the next

moment the low energy would simply manifest itself in a total lack of focus and a light-headedness which made clear thought and focused attention seem impossible.

This entry from November 6, 2008 shows the extent to which my symptoms were becoming dangerous:

Also, I wish my period would start already because my hormones are contributing to my lack of focus and the lethargy as well. And that whole lack of sleep thing; I'm just fried. I rear-ended a car tonight because I just completely zoned out at a stoplight and let my foot off the brake. I need to snap together somehow because this feels unsafe, like I'm in a dream state...

And this was the second incident within a very short span of time where I had been so out of focus and so not present in the moment that I had done something careless (but minor) with my car. This incident really did snap me into action. This was the point at which I started to realize that I needed to begin to take a more active role in managing my symptoms. If this truly was PMDD I knew I was going to have to make some sort of plan to help myself decrease the negative impact that would predictably occur every few weeks. The process started more broadly with things like self-care, which will be addressed in a later section, but by February 22, 2009, I was writing entries like the following:

I partly feel like coming to church today was a waste. But mostly I think my hormones are getting the best of me and it's an opportunity to remember that I need to try and regain some control. I'm ready to snap. I want to be alone. I'm sensitive to everything. But I'm supposed to go help in the nursery soon. I need to take some time to hide, to be away, before I can be around people and small children.

And I'm worried about the rest of the day with C. I don't want to snap at him. I'm super happy with him right now. I just have to stay mindful and go slowly. And keep taking my Estroven to help calm me down!

A 2003 study by Ussher found that women with PMDD reported a tendency to retreat from others and isolate themselves in an attempt to avoid conflict during their premenstrual phase. Similar to my own experience, these women from Ussher's 2003 study would apparently rather have been alone during their luteal phase than risk upsetting relationships or social connections.

Personally, I had entered into a place where I generally tended to feel safe, comfortable, and at peace—my church. Yet my body was at its peak of sensitivity to everything from smells to sounds to changes in routine and I felt as if I would lose control of myself if I sat in the company of other people for a moment longer. I ended up leaving the big room filled with people and secluding myself in a quiet room with a television monitor to watch the rest of the church service by myself. I wrote the journal entry as I sat there. I was afraid that I was going to negatively affect other people. I was afraid that I was going to ruin an otherwise happy time in my relationship with my boyfriend. I was, in essence, afraid that I was going to lose control over my words and actions because of the overwhelming emotions and sensations I was feeling in my body. The only way to describe it is that I felt as if someone had taken a knob, attached it to my body, and cranked the intensity and sensitivity of my emotional and physical experience up to a nearly unbearable level without leaving any means of relief aside from the knowledge that it would only last for a few more days. But despite that extreme discomfort, I did have the presence of mind to attempt to formulate a plan.

The Estroven was one of many things I tried over the course of the time I was engaged in this process of self-examination. Estroven is like an herbal tea, but in pill form. Its purpose is to lessen the severity of premenstrual symptoms. And in my case, it did help a bit. But the herbal teas and the homeopathic pills always seemed to be a last resort. In my weaker moments I would come home and have a cigarette and a glass of wine to calm my nerves and quiet my mind. In an entry from October 1, 2008, I wrote, "I'm going to have a glass of wine and go to bed. But I definitely want to track this...will I turn to wine or smoking? What's a better way?" I was still in the beginning stages of my internship, I was feeling worn out and frazzled from not only my PMDD symptoms, but also just from being a relatively new dance/movement therapy intern. And I was already questioning whether or not I would take the easy way out by drinking my cares away and returning to an old habit of smoking, or if I would be able to do the healthier thing and find more appropriate and progressive coping skills for myself. Fortunately, by April of 2009, my tactics had improved:

So this month I'm taking my Estroven, I'm trying to rest, I'm not listening to anything but Christian music, and I'm attempting to stay in communication with God and stay aware of my body and brain as much as possible. So far, so good. Not perfect, but certainly better than previous months. I feel present and connected. I feel alive. I don't feel lost.

By this time I was turning to my spirituality and other self-soothing techniques to calm myself down rather than giving in to my intense emotions and lashing out at those around me. However, just a few days later here is what I wrote:

Intense guilt. About everything. I'm fairly certain that it's because of my hormones and not because I'm actually losing my mind. But all the same, it sucks. The knotted

stomach, the racing tumbling thoughts, I just want it to stop. And it will. It always does. I'm trying very hard to practice patience and calm and to rest and to eat better. I'm so scared I'll be crazy when I go to Scotland.

So far, outwardly I'm doing way better than usual. But on the inside it's still a struggle. But overall I guess it's better and I know I'll be able to handle it.

So by the end of the research period I had achieved an extreme awareness of my body, my cycle, what each day might bring, and even ways to shield others from my negative moods by controlling my external behaviors and words as best I could. However, on the inside the overwhelming battle between good and evil continued to rage. It was as though I was now living two lives at once, the conscious and self-aware version of myself, and then the irate, dramatic, uncomfortable and depressed self that was dragging my better self down.

Finding Footing and Growing as Dance/Movement Therapy Intern

Just as I was struggling with the challenges of my PMDD symptoms over the course of the research period, I was also engaged in the typical ups and downs of life as a novice therapist. As I entered the experience, my graduate program instructors tried to give all of the students a warning of what was to come, even handing out sheets of paper entitled *The Lifecycle of an Intern* (See Appendix B). But while it all made logical sense that other people would go through those feelings and experiences, I was convinced that it would be unique and different for me. And, after reading through my journals and then comparing them to that original sheet of intern stages, I realized I was not entirely mistaken but I was also somewhat foolish to think of myself as completely unique and immune.

The beginning of my internship was filled with just trying to comprehend the basics. How should I prepare for an individual session? How should I plan for groups when I'm

supposed to co-lead and my fellow intern is the complete opposite of me in style and personality? How could I let kids with behavioral problems dance without completely losing control? How strict would I need to be and how lenient would be too lenient? My mind was constantly swimming with questions and the fear of being wrong. So when my supervisor at school offered an affirmation that my instincts were right on track, I was ecstatic. In September of 2008, my first month of being an intern, I wrote, "It felt good, no, amazing to know that my initial instinct was a good one." This constant need for validation from people with more experience than me would continue throughout the learning process up through my last day.

I was terrified that my supervisors and instructors were secretly judging me and were not giving me the type of feedback I should really be getting in order to progress. I appreciated the positive comments I often received, but when they consistently came from my art therapist on-site supervisor who never had time to come and watch me lead my dance/movement therapy groups, the compliments seemed unfounded. I lapped up validation from other therapists on site as often as possible, like on March 20, 2009 after a meeting with a unit therapist and a senior staff member who had been in the field for over 30 years:

P. and M. confirmed a lot of my concerns about the staff's extreme rigidity and their fear of letting the kids do anything even remotely exciting or energetic. It felt good to be heard and validated by two professionals that I respect. But then I went and talked to the unit supervisor and it was a little awkward. I did stand my ground though. I stayed calm and explained my points and requests.

Overall it felt good to just get these things out in the open with the right people and to feel confident enough to stand up for what feels right for myself and for the kids. I was

really clear and able to give specific examples and I feel like I'm starting to come into my own as a peer rather than "just the intern."

If I hadn't just had a meeting with two people who backed me up in my concerns, I don't believe I would have had the courage to go and have a frank discussion with the unit supervisor whose staff I was having trouble with, at least not at that point in my process. It wasn't until May, 2009, the last month of my internship, after a lackluster supervision session with my academic supervisor, that I wrote, "Maybe it's up to me to decide if what I'm doing is good enough or not. Maybe my job now is to really start determining my self-worth by how I feel and what I believe to be true rather than looking in everyone else's eyes for hints of disdain or approval."

In addition to my attempts at feeling confident in my role as a professional with my colleagues and superiors, another major theme was my journey to begin to feel comfortable in my role as a leader and a therapist who was able to contain a safe space for my clients. Whether it was leading groups or seeing children in individual sessions, my journals reveal that trying to figure out how to be an effective leader was constantly on my mind. My fears are illustrated in an October, 2008 entry where I referred to my feelings surrounding leading a group of resistant adolescent girls, "I took the role and owned it as much as I could. It was almost like a do or die sort of situation though, like, if I was going to lead, I had damned well better *lead*. And I did." Later that month I had a visit from my first semester academic supervisor and she credited me with being able to hold a safe space quite well, which as I wrote in my journal, "was so nice to hear because my greatest fear since my original field placement back in 2006 has been that I would be totally incapable of holding a room together." This fear was something that had initially caused me to quit my DMT program for a year. I had convinced myself after spending a

summer with an adult population that experienced substance abuse and various mental illnesses that I was fundamentally unqualified for this line of work and I ought to get out while I could. So to have affirmation at this last internship that I might be okay as a leader after all was an emotional boost for me.

The ups and downs certainly didn't end there, though. By December 2008, I was feeling pretty good about myself and writing entries like,

I feel so much more confident with groups. I just want to lead groups all the time now. I definitely have more growing to do but at least now I feel like I have a few successes under my belt and like I really do know what I'm doing (to some extent).

And,

"I'm the therapist and I get to choose what we need to do here." It felt good to say that.

Even though the whole session felt like a disaster, at least I felt like I was in charge. This is a new feeling for me.

The groups have been going that way for me too, I feel 'in charge'. My supervisor told me last week that it was the first time she's seen me look so grounded and settled in my role as a therapist.

But in January, it seemed like everything shifted. As I trudged through a long winter hiatus from supervision at school and was left to deal with my inner demons alone it seemed that I started to lose my grip on the positive qualities I had started out with and traded them in for a focus on wanting more control and power as a leader. I stopped seeing the kids in my groups as an inspiration and as co-leaders whose ideas I could use and modulate into therapeutic experiences and I started to see them as everyone else seemed to see them; they were things to be controlled, broken, and re-shaped into something better. But this shift was relatively short lived

because I saw immediate negative results. The new year brought with it the following experience with my group of pre-adolescent boys,

The therapy room with my nice little tape marks on the floor and my pre-selected music and my notes had been locked by the cleaning lady, so that threw me. But we pushed on and went to the gym. Immediately the boys were asking me if we could do this or play that or get the basketballs out. We barely got through the introductions before the whole session fell apart. I had lost control before we even began and I honestly never regained it. I tried being a hard-ass and threatened to end group early so they would lose all their points, but they just kept talking over me. I remember raising my voice and saying, “you have two choices: we do what I’m asking you to do or we’re going back to the unit.” I’ve never seen more disappointment or resentment from them, I had betrayed them and changed my rules without warning and we all knew it.

I felt embarrassed in front of the staff. I felt like they must be judging me, thinking I’m incapable of handling these kids. But I know I’m not totally inept. I have had successes in the past and I’ve seen these kids act up and defy almost everyone who works with them so it’s not just me. But all the same, I still feel a sense of responsibility to step back and see what I can do differently to provide better experiences for these clients because lecturing and strong-arming them clearly isn’t working.

This realization of what I was doing wrong led to an effort to be more mindful of my intentions when working with my clients. A few days after the incident above I was set to have another group session with a different set of boys. Before that session I wrote out what my intentions were for the qualities I wanted to embody as a leader and what I wanted the kids to get out of our sessions together and this is what resulted:

...I was also able to listen to the kids, to hear their ideas and decide on how we could act on them safely and therapeutically together...That went so much better than the previous group where I just kept saying 'no' to anything that wasn't on my agenda.

Setting intentions and goals for myself and my clients was always a part of my training and experience, but for some reason those elements of my process had begun to slide as I felt myself getting more self-confident in my abilities as a group leader. It was a two steps forward and one step back feeling, where I would be proud to make progress in one area, but then realize I had begun to backslide in another. It often felt like a juggling act, trying to keep so many elements of "being therapeutic" in the forefront of my mind at once and making sure they all got equal attention. Towards the end of January 2009, I wrote:

I'm exhausted. I just feel like I'm failing all over again. It's such a roller coaster all the time. Wednesday I'm not good enough, Thursday I get a new client and I feel confident and inspired, Friday I'm back on the self-doubt train. It's so crazy. I know this is what being an intern is probably supposed to feel like, but right now it's beginning to seem imperative that I get my act together. I'm feeling like experience and wisdom can't come fast enough. I'm impatient, I just want to do it right already. I'm trying but sometimes it feels like I'm not getting anywhere.

This feeling of craziness and struggle to get myself together and succeed came and went in waves for much of the internship process. The mid point was when it felt strongest though. That was a time when I was without consistent supervision and was lacking the support system I had grown to depend on in the first semester. Once the second semester began and I had a new academic supervisor to push and challenge me, I began to feel I was progressing in a more consistent direction again. I began to focus more on attempting to internalize my role as a

therapist and leader and to examine ways I could build my skills and confidence even more. The initial shock, the getting used to a routine and showing up, was over. In the second half of my internship it was clearly time to start honing my craft, to step up to accept more responsibility, and to voluntarily face tougher challenges. I was wondering about the reasons for my previous shyness and discomfort with being called a therapist or leader. In a journal entry I wrote:

I really don't think I believed I deserved respect and obedience from these kids. I wanted it, but I felt so awkward and new and insecure that I honestly didn't expect anyone to hold me in high esteem...

Adjusting my vision of what being a leader or being a therapist is will probably be the key to my success rather than trying to mold myself into this lofty ideal that doesn't match who I am as a person. I'm not there to be the 'boss' or the one who's in charge of my clients' experience. I'm there to be a guide and they're my co-creators. The sooner I relax into that way of thinking the sooner I think I'll be comfortable with even being called 'leader' or 'therapist' because it's so much more natural.

I had entered into the internship experience as someone who didn't want to be noticed or looked at or asked any questions. I had experienced many relational traumas in the years leading up to becoming a dance/movement therapist and those experiences had caused me to turn inside and avoid standing out at all costs. I didn't even want my therapist to look at me because I felt exposed. The first half of my internship was spent testing the waters of what leading groups and holding a safe space for clients could be like and also knowing in my mind that I needed to build confidence and practice speaking more directly with people. The second half of my internship became a time where I had built a strong foundation and was able to finally begin the process of integrating all of the skills I had been practicing. I was still facing challenges and experiencing

ups and downs, but I was making more bold and courageous steps towards my goal of becoming a theoretically competent and emotionally capable dance/movement therapist.

In a journal entry from March 5th, 2009 I was starting to feel out my authority and my therapeutic intentions at my internship site.

Today in my drum group with the boys I looked at them when they stopped following my directive, I stopped them, and I said, 'hey, I really want us to do the thing I showed you. Let's go back and try again'. And they did. In the past I either just let it slide and by the half way mark, the group was a total chaotic mess, or I was demanding that they listen to me but it was about my power and control rather than what I believed was truly therapeutic and best for them. But this time, by knowing what I wanted for them and by being really clear and calm about it, I got it. I was able to convey through my tone and my words that as the therapist, I had a bigger vision for them than what they thought they wanted to do in that moment and I was confident that we should focus on what I had asked of them. I do know better than they do in some ways and that's why I'm here to help facilitate their process. It's ok for me to ask things of them and get what I want out of them during a session. It's my job. I just wasn't very comfortable with that until now.

As I began to work more confidently and therapeutically with my groups, I also found the strength to start challenging some of my individual clients as well. I had been a complete pushover with all of my individual kids, and I remained so with some of them until my last day with them, letting them choose the activities and going on walks to the park or corner store or making visual art projects instead of pushing for an idyllic DMT session. But with others, I was able to forgo my own comfort in order to push and challenge them, which hadn't happened at all in the first half of our therapeutic relationships. At the beginning I was shy and completely

uncomfortable naming the obvious challenges of my clients or what we might do to work towards healthy goals together. But, by the end, I was able to look at a child and calmly explain that we needed to move together (instead of knitting or baking or making origami) in our sessions because he was obese, impulsive, manipulative, and lethargic and he had been referred to me in order to assist in overcoming those issues through movement.

The end of my internship experience didn't leave me feeling accomplished or as though I had necessarily arrived at my destination as a fully emerged therapist. But I also did not leave feeling incomplete or lacking the necessary skills to be a competent professional. I left the cocoon of being just an intern feeling as though I had gained an incredible amount of guidance and experience, but that this was merely the beginning of a career's worth of learning and improving and finding better ways of working with clients and myself all along the way.

Self-Care and Coping Skills

As I made my way through the experiences of being an intern and having PMDD symptoms over the course of nine months, I realized quickly that I would need to find ways of managing the stress and other challenges that continually came up. My original plan was to simply become a dance/movement therapy client and rely on my therapist to be my main source of respite and help. After a few successful sessions I realized that while the relationship was going to become important, I would also need other ways of enhancing and improving my experience. I chose to take up aerial and circus arts classes as a physical, creative, and mental escape. I actively sought out learning experiences that would help me with the skills I was weaker in. And finally, I unexpectedly found solace in returning to my faith in God and the supportive community of a new church.

My relationship with my dance/movement therapist, S, was something that I viewed in several different lights throughout my internship process. I had initially intended to see S purely for thesis related reasons, as a way to officially tie in DMT to my topic, but my time with her turned out to be an extremely important part of my development as a growing dance/movement therapist and as a human being. She challenged me on personal and professional levels, provided opportunities for me to practice and observe therapeutic skills, and gave me a space in which I could explore setting my own personal boundaries without fear of negative social consequences. One particular area she was of most help is that of being a safe container for me no matter what my mood or troubles. I elaborated in the following journal entry from October 2, 2008:

The talking in a safe space is good too. I know S is holding my story and providing her outside opinion. And because I don't always agree with her, it gives me an opportunity to really fully examine who I am and what's most important to me. And I don't have to feel guilty for talking on and on because I'm paying her. I was really struggling with that before because I was using friends and co-workers as my sounding board and it felt yucky. I knew I was always saying too much to the wrong people but I couldn't help myself, I didn't have anywhere else to put all that stuff or anyone to just put the questions back on me. It's amazing how this process and this personal work has changed that for me.

I found it phenomenally helpful to be able to see S at my worst moments and to challenge her without the fear of being rebuked or shamed. It took a long time to trust that though. At the beginning I was still struggling with not wanting to hurt our relationship and so I would often keep things to myself, even if I was feeling very bothered. But this became part of

our work together because this was a tendency that was holding me back in other areas and other relationships in my life as well, especially with my clients. A clash we had in April 2009, illustrates how I was able to move past my own fears of disappointing S and communicate clearly and honestly with her:

I felt like I wasn't open enough, like it would appear that I was avoiding working on some deep issue, or like I would be a 'bad' client or student if I told the truth. I don't want to be viewed as lazy or uncooperative so I often try to appease S by going through the motions, but it always left me seething and wanting to end the relationship...It feels good to know that through honest and forthcoming discussion we can repair and improve the relationship instead of severing it.

Previous to this point in my life I had held on to a fear of disappointing anyone and I believed that if I caused an upset or spoke my true feelings in a relationship that it could easily lead to a premature end. But working with S was different. We were working on multiple levels at once. Our therapeutic relationship was often a great model for using the present moment as a catalyst for change in other areas of the client's life. S was like my practice relationship where it felt safer to take risks and speak my mind because I was the one in charge of whether the relationship should continue or end. And this new boldness, found in the safe space my therapist provided, truly did open the door to other adventures that helped me to feel more secure in myself and provided new tools for taking better care of myself over all.

One of the ways I consciously decided to take care of myself was through engaging in some creative and new activities outside the realm of my schooling or training. I wanted to have time and space for myself that would allow me to have fun, not think about my stresses, and to learn new things that could help me become a more well-rounded person. I had always been a

dancer and taking ballet classes had been my physical and mental release throughout most of my life. Unfortunately, as I started my graduate program, taking dance classes became less of a priority and fell by the wayside. After starting my internship I contemplated using ballet as a self-care outlet but, because of the high demands I put on myself to be perfect in the dance studio, I decided I needed something I would be new at, something I couldn't reasonably expect myself to be good at right away. I chose several things, including circus arts and aerial arts classes, dog training, volunteering in the nursery at my church, and engaging in a women's Bible study that was focusing on improving communication skills. In November 2008, I wrote an entry that explains what I perceived to be the benefits of some of these self-care activities:

I think my personal work for now is definitely about building back my own core, my strength, my stability, my calm, and my directness. Fortunately, I have a lot of resources right now. Aerial classes will help with the strength and core. Training my dog will help with my calm and directness. And I have my academic supervisor, my therapist, my boyfriend, and my best friend to keep me stable. Eventually I'll internalize these qualities and embody them for myself but for now I have to remember that these are baby steps.

I had a clear vision of where I felt I was lacking in embodying my idealized therapeutic qualities and I was getting meaning related to working on those qualities from each of my extra curricular endeavors. However, after several months of being fully engaged in so many different self-care oriented activities, I began to feel that my schedule was more than slightly overloaded. I was still gaining valuable experiences, but it was becoming clear by February 2009, that what had begun as a self-care regimen was turning into added stress instead:

For the first time in years, I'm doing a ton of self-care. It's all scheduled into my week. But now, as the full effect of being involved in all these activities is hitting me, I do wonder if it's really all self-care or if it's adding to my sensation of being scattered and pulled in too many directions.

A month or two after the previous journal entry, my constant busyness had begun to affect not only my life as an intern, but also my personal relationships. The very things that had been intended to help me de-stress and calm my frayed nerves were causing more problems than they were solving and I was exhausted. I finally brought this up with my therapist and she helped me to visualize everything I was doing in my life all spread out and to then use my instincts to pull the most useful and important things towards myself, leaving the less important things in the background. It worked brilliantly and made the decision to quit certain things much easier than I had imagined it would be. It turned out that self-care was an extremely important aspect of keeping myself relatively sane during my internship process but that it was also something to monitor and not go overboard with. Finding a balance between active self-care and some more passive self-care, like saying "no" to certain activities and just staying home, was what eventually felt right and healthy for me.

Another thing that felt healthy for me was to be an advocate for myself when I felt that I didn't have all the information or tools that I needed to be successful at my internship site. This was an act of self-care and a coping mechanism because the more I tried to do my job as a therapist while I was feeling unprepared or vulnerable, the more stressed I became and the less confident I felt that I could be successful. So I took care of myself by seeking out learning opportunities and grabbing them as often as I could. The best example of this was when I began having nightmares about not being able to properly defend myself against my clients. I went to

the therapeutic crisis intervention (TCI) trainer and asked if I could sit in on the next course. There had been an unusually high number of physical client restraints in the weeks leading up to my nightmares and while I logically understood that this was for the clients' own safety, it was still slightly traumatizing to see two or three grown people holding a screaming and thrashing child down on the ground for any length of time. In March 2009, I was able to attend the TCI training. The following are two entries, one from before I began and one from after I had completed the course:

And while I'm not really afraid of any of the kids, I really feel like any extra resources I can have to make myself feel stronger and more prepared would be great. I really want a better understanding of what's going on, both on the kids' side and the staff's side.

Because right now, the restraints and conversations I hear just seem like madness to me a lot of the time.

And:

I am ecstatic! TCI training has been amazing. I love the methods and I've gotten some great feedback from the instructors on my skills and talents. I'm so glad I did this, I think it's going to help me when I get back to my sessions with the kids to understand how to better approach them.

This experience was also truly something that stemmed from my work with my own dance/movement therapist. The work we had done together on helping me to speak up for myself and be direct with the people around me allowed me to be bold enough to ask to participate in a training experience that I hadn't been invited to. In the past I would have simply continued to have nightmares and sat back to wait for a supervisor to suggest that I take the TCI training. But as part of my active quest for finding experiences that would help me to better cope

with my fears and anxieties, I was able to go out and pursue what I felt I needed without hesitation or shame.

Aligned with the theme of hesitation and shame, the final component of my self-care and coping skills experience is something that I wasn't sure I would be able to expose in an academic paper. While I went into this research with openness to sharing the personal aspects of my experience, I hadn't anticipated that anything quite so professionally and socially controversial as God and Christian faith might come up.

When I began my internship in September, I had been away from church for over 8 years with no intentions of ever going back. But in November, I attended a church service with my mother because she was visiting me. Within minutes of walking into the sanctuary, I found myself weeping openly in the midst of a huddle of strangers who were touching my shoulders and back and praying for God to help me through my difficult time. If I had been praying prior to that moment, that experience is just what I would have asked for. In a journal entry written only days before my spiritual reawakening, I addressed the following aspects of my personal and professional discomfort:

My academic supervisor said the only way for this all to not totally overwhelm me is if I can just accept this experience as it is, accept myself as I am today, not how I wish I was. I have to fall apart and sit in that. But when do I have time for that? I'm hiding, I'm numbing out. I'm scared that I've built up a perfection to aspire to that I don't even want anymore. It's time to be brave and face all that.

I had been in need of something bigger than myself to hold me and allow me the safety to fall apart. I was trying so desperately to hold myself together despite my stress, my fears of being a new intern, and being rattled with my hormonal ups and downs. I did not want to show any

weakness to anyone around me and I was actually quite afraid of the depths of my fears and sadness about not meeting my own high expectations. I was suffering dearly for my attempted stoicism. But after I attended church that first Sunday my tone changed:

I went to church and I just broke down. It was exactly what I needed. *That* church is exactly what I need. I've been trying to figure out how it'll be safe for me to really be vulnerable and break down. I couldn't work out how to do it on my own and still feel safe; or even with my therapist. But there in church, I did. It started. I gave in to God, as weird as that sounds. But I realized that's the only way this is going to work for me. I can't rely on myself because I'm not feeling strong enough. But God can hold me.

That singular experience began a journey that merged with the rest of my internship experience and shaped the ways I began to handle fear, stress, and my PMDD symptoms. My relationship to my perfectionist side softened a bit and I started to understand that I truly couldn't expect myself to accomplish my lofty goals of my own volition; I needed help. And as I accepted God back into my life I knew I was no longer alone in my process, but rather, I had someone who I believed to be infinitely wiser and more powerful than myself acting as my guide and confidant. It was akin to having a super hero as a best friend. Maybe every battle wouldn't be won, but at least I could rest in knowing that someone was on my side no matter what.

As time went on, my reliance on God became even deeper. In December of 2008 I wrote:

I will not be patient or loving or creative or kind without God's help. It's really unreasonable for me to expect to be able to do any of those things that I want to do if I rely only on myself; dependence on God is not a weakness, but rather, it gives us strength.

Many of the therapeutic qualities I had been striving to embody on my own were now something that I could ask God to help me achieve. I wasn't giving up on having to put my own effort into striving towards excellence, but it felt much easier to do the necessary work when I knew God was my power source.

Saying a prayer before each session I led and before each big meeting with my supervisors became second nature and it allowed me to not only feel the comfort of communicating with my higher power, but also presented an opportunity that dance/movement therapy practitioners talk about all time, which is intention setting and grounding for oneself before attempting to facilitate a therapeutic experience for others. On the inside, it felt wonderful. Numerous journal entries touch on my feelings of being grateful and joyful for having found such a simple and powerful ritual for myself. The only problem was, I didn't feel comfortable sharing the source of my joy and enthusiasm with my peers and superiors. The solace I found in inviting God back into my life was often overshadowed by the confusion and embarrassment that arose when it came time to own my Christianity when talking with others. I knew for certain that I wasn't allowed to bring up religion with my clients unless they initiated the conversation, but what about the professionals and academics around me? I was supposed to be honest and transparent with my classmates and supervisors but it felt so awkward. I felt tormented by the fear of judgment and criticism. While it seemed cool to be a Buddhist or to be spiritual in a more general sense, I wasn't quite sure what my peers and colleagues would make of my belief in the Christian God.

These feelings and experiences continued on throughout my internship, with multiple journal entries devoted to sermons at church, my ups and downs in re-entering the world of Christianity, and how my personal prayer life and relationship with God was helping me through

my rough spots as I grew into my role as a dance/movement therapist. And despite my discomfort in sharing my faith with others, I did muddle through and start to reveal that part of myself slowly, challenging my supervisors and peers to be the ones to deal with remaining open to my choices. After several months I was still feeling uncertain about how much to share and how much to keep to myself in my secular professional and academic settings, but I began to care less about what others would think and more about how I was personally relating to God. In April 2009, I wrote:

I'm not empty anymore, that's what God brings to my life. I finally feel grounded and like I have a place of meaning. I have a place and a community that will catch me and hold me if I need it. I'm not floating aimlessly. I have an anchor.

Those sentiments eventually became the overriding ones and I was able to enjoy the benefits I was receiving from being in relation to God in my life. And while, as I mentioned before, I was never able to fully overcome my discomfort in sharing my faith with those who I knew were in direct opposition to my beliefs in that regard, I did grow to accept that this may always be a challenge for me but that the rewards far outweighed the struggles.

Relationship to Dance/Movement Therapy

“This stuff works. Now I just need to work on my planning skills and leadership skills and it'll be great. But that's what an internship is for...”

-Journal entry from September 25, 2008

As one might imagine, throughout my time in Columbia College's dance/movement therapy master's program I had my fair share of both triumphs and doubts. As mentioned earlier, after my first year and my first summer field placement I had become so self-conscious and uncertain of my capabilities as a potential dance/movement therapist that I dropped out

altogether. That was what could be called the pinnacle of my tendency to retreat from DMT when difficulties arose. But after a year away from being a master's student I felt called to return for a second attempt at gaining new understanding and becoming a practitioner of dance/movement therapy. My return to the program began my determination to advance towards DMT and embrace all that it had to offer as wholly and fully as possible. Yet throughout my internship this feeling of advancing towards and retreating away from claiming my knowledge and identity as a dance/movement therapist continued to ebb and flow along with the other cycles and events of my life.

While I certainly did believe from the beginning of my internship journey that this stuff works, what I wasn't so sure of was whether or not *I* was going to work. I would see and hear my classmates when they were relating their excitement about the movement work they were doing with their clients at their internship sites and I couldn't help but feel left out. I wanted to be excited too, but I was too busy being hard on myself and wondering if I would ever be good enough to do this work effectively.

Much of my discomfort and self-consciousness came from my struggle to understand the world of Laban and the various other modes of assessing and defining movement that were obviously such a key component to dance/movement therapy. I found myself at odds with the complex languages that were created and used in lieu of what I felt to be common sense and basic awareness for anyone accustomed to using their own body. As I sat through lecture after lecture and discussion after discussion on the minutiae of movement observations I began to zone out and reject the topic as something that was being shoved down my throat for no sensible reason. However, once I got to my internship site, I felt myself grasping for the information and

desperately wishing I had paid better attention when I had had the chance. In October 2008, I wrote about the following experience in my academic supervision class:

The battle against Laban might be over. Our supervisor forced us into some Laban review in class on Tuesday and while I started out just as resistant as ever, I ended up feeling a sense of accomplishment by the end. She took all of the pressure and urgency out of the ordeal and was calm about it. Anyway, the point is, I *do* know some things and I *can* “read” movement... And with my newfound relaxed approach and confidence boost, I’m watching people’s bodies and movement differently. I’m getting curious again. And just for myself, not because I have to.

And that was just it, really. I needed to see and feel the relevance of the information in order to embrace it. Whereas before, I was getting overwhelmed by the complexity of the language of Laban, once I was in an internship and I needed to be able to describe my clients’ movements to other movement therapists, I began to accept that this was worthwhile if I was truly going to enter into this field of practice. A few months later I even used one of my elective class credits to take a refresher course on the fundamentals of Laban and it turned out to be an excellent boost in my internship process. Of most value to me was that the instructor facilitated my new understanding that there is no grand goal of embodying one state or way of being/moving all the time just because it is something that is valued among colleagues. I also extrapolated that out to feeling better about not knowing everything right away, giving myself permission to stop being so harsh, and to stay open to learning all along the way.

But of course, that mini eureka moment didn’t stop me from desiring immediate perfection or rejecting things I felt I could not easily accomplish perfectly. And it didn’t stop me from feeling insecure and like I wasn’t being everything I should or could be. I went through a

period of time where I didn't feel like a movement therapist at all, especially with my individual clients. I still planned and executed movement-based games and activities for the groups that I led, but when I had individual clients it got to a point where we didn't even pretend that we might move together anymore. For a while I even began to embrace the idea that maybe I would have a future as a creative arts therapist or an expressive therapist where I could use other mediums I had learned from my on-site supervisors such as music and story books and visual art projects to facilitate therapy in addition to, or even in lieu of, my dance therapy. I felt a sense of pride in having been exposed to so many different modalities of therapeutic intervention and I began to drift further and further away from my DMT roots. But in May 2009, when my internship was about to come to an end, I began to panic. I had gotten hired on as an expressive therapist at another child psychiatric facility and I was starting to feel like perhaps I hadn't done enough in the way of embracing DMT. I feared that my new employers would expect me to be a more traditional dance/movement therapist. I started grasping for information:

I feel like I don't do "real DMT." But it doesn't feel very good being a rebel all the time. This past week I've felt myself drifting back towards DMT land. I've been longing for it. Yesterday I was prepping for a group and I just started dancing and dancing and dancing until I had to go get the kids. I felt an incredible high. I wanted to share that feeling with them. I wanted them to move and jump and slide and roll and spin and be free in their bodies just like I had felt free in my body. I remembered why I got into this in the first place. I remembered how much I missed dancing and moving and relating to music and the space around me. And all these DMT techniques keep edging around the sidelines of my brain, trying to materialize in full form. I want to remember how to do the kinds of sessions I want to be doing; I want to give it another try.

And a few days later, as the end of my internship was looming even closer, I wrote a similar yet more insecure entry:

As my time as an intern is ending I'm wondering how I morphed into a therapist who's afraid of movement, afraid of dancing, and who doesn't trust herself to lead a positive and safe experience with a group of kids. I feel frozen and stuck. I feel like I haven't done a 'proper DMT group' in months. For a while I was claiming my non-DMT identity with pride. I was convincing myself that I didn't need DMT and DMT didn't want me anyway. I was telling myself I'd forgotten everything I learned over the last few years and that I shouldn't even try because I would fall flat on my face. But yesterday I was in supervision and I wanted to know DMT. And it's not too late for me to go back and learn how to be more effective, how different techniques are appropriate for different clients...

From these entries it is clear that I felt a sense of yearning to go back and be allowed to do this whole thing over again. I was having remorse over the way I had handled myself when it came to not taking full advantage of the knowledge and wisdom that had been presented to me throughout my years as a graduate student in the dance/movement therapy and counseling program. And while I think a part of me realized that a lot of my emotions and fears had to do with the end of such a significant experience and chapter in my life and the beginning of the unknown world of becoming a professional, I was still struggling to see where my safety net was going to come from next. I had felt a sense of security in my title of intern. I felt that as an intern I would be expected to make mistakes and to falter along the way. After all, I was still learning the trade. And so I was deathly afraid that once I left my role as a student and intern

and had to own my title of practicing dance/movement therapist I would suddenly be expected to be perfect and all knowing.

But fortunately, in the last journal entry above, I was starting to come around to the idea that it was not, in fact, too late for me to keep learning more. And after having read through the sum of my experience over the course of the nine months that I was collecting data, I did see that I was always striving to learn more, to get better information, and to ask the questions I needed to ask in order to move ahead in my journey. I may not have always been walking the straight and narrow path of pure DMT theory and methodology, but I was always tethered to it and kept coming back to the body when the going got tough and I knew I needed something that would work. And, by the end of my internship I realized that while DMT is always going to be my home base I may have to come to terms with the idea that I will always dabble in other techniques and methods that work as well. It's nothing to feel guilty about, but rather something to remain aware of and open to as I continue to grow into my professional therapist self.

Discussion

Throughout this thesis, a multitude of experiences have been shared and many questions have been explored, but there were two concrete themes that consistently repeated themselves. The first theme was that of emphasizing the importance of clinician self-care and attempting to increase the reader's understanding of what clinician self-care means. This first theme also included attempting to capture the essence of what types of distressing situations or elements might contribute to a clinician's need for self-care. The second theme then built upon the understanding of what self-care can mean by attempting to expand the reader's vision of what types of self-care practices may improve a clinician's professional and personal qualities of life. Both themes were explored through a combination of this writer's personal experiences and a look at the current data that has been compiled by other researchers in the field.

When looking at these themes and how they emerged, the overarching question being asked was simply, "How did this experience go for me?" I wanted to explore the DMT internship experience in a natural way, without the borders or guidelines of an initial research question. The concept of self-care did not come about until much later in the process. All I knew for certain was that I was going to diligently journal about my day-to-day internship experience, how my sessions with my own dance/movement therapist went, and how my classroom experiences with my supervisors progressed along the way. That was it. I merely wanted to document my experience and then share that information with others in the hopes of providing some insight into the world of the DMT graduate level intern. I also felt it would be useful to the field of DMT specifically to provide a detailed and personal documentation of how being a DMT intern might be different from the experience that those in other areas of the mental health counseling field might have.

In response to that first broad question, I feel that my research did produce the results I had set out to achieve in several ways. I selected excerpts from my personal journals that ranged from the first week of my internship all the way through to the last week, which showed the range of emotions and personal growth that occurred throughout the full internship experience. I have also included insights into the various aspects of being a dance/movement therapy intern, being a client of a dance/movement therapist, and being engaged in academic supervision throughout the internship. So those areas of interest have been covered. But in the way of attempting to give outsiders a glimpse into the intricacies of what dance/movement therapy truly is and what makes it so different from traditional therapy and counseling, I believe I fell short. As much as I focus throughout this paper on the difficulties that I experienced exclusively because I was attempting to learn how to be a dance/movement therapist, I recognize that I was not able to provide a clear and detailed depiction of what the unique components of DMT really are and how they are different than, say, art therapy or talk therapy. This was not, however, due to a lack of trying on my part, but rather due to a lack of experiencing a clear encounter with being a dance/movement therapist. Because my on site supervision was with an art therapist, and because my theoretical framework in general was a bit hazy from lack of diligent studying, my experience as a DMT intern was not as strictly guided as I had originally envisioned it being. I ended up becoming more of an eclectic expressive or creative arts therapist than a traditional dance/movement therapist and so in that way, my original intention of sharing the true essence of the DMT world with readers could not possibly have been appropriately answered.

The next questions arose after my research had already begun. As is commonly understood to be the case with heuristic studies, these questions came about organically and as I was living the experience. I began to realize two things, one was that my PMDD symptoms

were starting to infringe upon my ability to stay clear headed and in control of myself and, secondly, that I was in desperate need of additional self-care mechanisms and coping skills if I was going to make it through the internship experience emotionally, relationally, and mentally intact. The question, then, became how should someone in my position best handle the stresses of not only an internship, working therapeutically with traumatized clients, but also of personal distress as well? If self-care is the answer, then what kind of self-care or coping skills might be useful for me? How much time ought I devote to these things? And, how will my own findings in this area be of use to others in similar positions?

The answers to these questions came in waves throughout my research period and this is where I clearly focused much of my attention in the literature review. I felt strongly that this would be the area in which I could be of most use to the field through sharing my insights on self-care as related not only to traditional methods and practices, but also more specifically geared toward the dance/movement therapy intern and the woman suffering from hormonal fluctuations. I was able to get into the details of my PMDD symptoms and the havoc they wreaked on my progress in my internship. And this section is also where I was able to discuss my relationship with my own dance/movement therapist as a resource, my experience with dance and creative physical movement in my own personal life, and my relationship with my supervisors and other mentors as a support system. I was able to accurately and honestly share my personal highs and lows throughout these results and to then touch on all of the ways in which I sought support and cared for myself in order to regain a sense of stability in both my professional and personal life.

Finally, I was able to address the question of what role my personal spiritual practice played in my internship experience. This was included as part of the self-care and coping

mechanisms portion of the results but spirituality also merited its own separate section due to the profound impact it ended up having on me. I was able to share about not only how cultivating a relationship with God and with my church community was a positive resource for me in my difficult times, but also how returning to church and to God caused some discomfort and awkwardness as well.

When it came time to choose the literature that would relate to this research, narrowing the scope was extremely difficult. So many directions could have easily been taken. For quite some time I was headed towards focusing on discussing my experience of directness, confidence, and leadership in relation to my experience as a dance/movement therapy intern. And those facets would have all proved to be rich areas of exploration due to the immense struggle I had in cultivating those qualities over the time I spent working on doing just that. However, when it came down to choosing where to focus my attention, it felt right to consider the topic of self-care and coping mechanisms as having been the true underlying thread that tied my nine months of data collection together. All along the way, as I was attempting to become more confident in my role as a therapist and more direct in my communication with others, I was ultimately seeking support, rest, and emotional health in order to achieve my goals. My ability to ethically and appropriately do my work depended entirely upon my ability to properly take care of myself as well as my ability to allow others to help me along the way. So it made perfect sense, then, to seek out the wealth of information that is available on clinician self-care and coping skills.

The question, both in my own research and in the literature at large, was never whether or not mental health clinicians were suffering from the effects of their work, but rather, how to help them to maintain their own mental health precisely because the work that they do is unquestionably so demanding and draining. I was able to find for myself, through trial and error,

that what worked best for me was to attempt to achieve a balance between work and leisure. That when I over did it with the extra-curricular activities I became overwhelmed and exhausted but when I did not do enough self-care and merely focused on work and sleep, I also became frazzled and on edge. The key was to find what was most helpful for me and to continue to engage actively in the pursuit of my personal mental health for not only my own benefit, but also for the well being of my clients. The literature supports that finding fully and Barnett, et al. (2007) share that therapists who do not tend to their own mental health can become “emotionally incompetent” and therefore ineffective in their jobs (p. 512).

Additionally, in my own research I was focusing on myself specifically, a woman who is a DMT intern who also experiences PMDD symptoms and works with clients who have experienced trauma. The literature supports the idea that individuals in each of these categories are at an increased risk for becoming distressed and impaired while working in the mental health field. Gilroy, Carroll, and Murra (2001) point out that women appear to be more affected by working as clinicians than men, McCann and Pearlman (1990) share that therapists working with trauma victims are at an increased risk for “vicarious traumatization” (p. 131), Turner, et al. (2005) reveal that counseling psychology interns report higher levels of stress than their more experienced counterparts, and Payne (2004) shares that dance/movement therapy graduate students in her study often found themselves feeling confused or unsure of themselves due to a lack of concrete guidelines for how to properly practice their unique techniques and methodologies. Also, Dell and Svec (2003) wrote an entire book about how women who experience symptoms of PMS and PMDD are at greater risk for feeling isolated, frustrated, and depressed. These experiences from the literature were all mirrored in my personal data, almost to the letter, which is why I chose to research all aspects of my causes for distress. I felt that

showing how each of the elements contributed to distress would underscore the intensity of my own experience because all of those elements were compounded in my personal data. This was also one compelling way to assist the reader in understanding the full range of potential causes of clinician distress in a personalized context.

After guiding the reader through the causes of distress, the solution to the distress needed to be addressed. The benefits of DMT were discussed in the literature as well as the benefits of seeing a therapist, engaging in dance or physical activity, seeking professional supervision, and making a point of maintaining a healthy balance of work and leisure activities in general. I included all of these in both my own data as well as in the literature review because these methods are the widely agreed upon answers to the question of, “how do I stay stable and in tact when I work with the mentally ill?” I found self-care to be immensely helpful in my own experience and there is evidence of that in the results. I constantly searched for what was right for me personally and tried a multitude of things before I found the balance that was appropriate and healthy for myself. The literature also suggests that this is a necessary step for any mental health clinician to take. It is important to become aware of one’s own shortcomings, triggers, and limitations and to then seek out ways to counteract those qualities in order to maintain optimal personal and professional health (Rothschild, 2006).

Finally, my own experience with returning to my faith in God and relying on my spiritual practice in order to find solace was touched upon in the data. I expressed varying feelings on the topic ranging from being uncertain about how to express my faith and feeling like an outsider in a secular profession to feeling immense relief in knowing that I had a stronger and more powerful being than myself working with me. West (1998) conducted a study with Quakers who were also therapists and his results echoed my own feelings of being uncertain about how to

appropriately mingle faith with work, feelings of discomfort in sharing faith with colleagues and clients, as well as my experience with using prayer as a grounding ritual before and after sessions. West (1998) then goes even further and mirrors my own reported feelings that for many spiritual clinicians, prayer is not simply a crutch that is leaned on in difficult times but is rather a way of life and a meaningful preparation and inspiration that informs one's clinical work in inexplicable ways, often even beyond the clinician's own understanding. Case and McMinn (2001) also discuss prayer and spirituality amongst psychologists and found that rather than using spiritual practice as a back up or a last resort, many clinicians use prayer as a first line of defense against distress and rely heavily on their relationship with God and their church community as methods of self-care and coping.

In summary, my results may seem to be far reaching and perhaps even somewhat scattered as I cover everything from PMDD to God to aerial arts and many things in between, but what I have found to be true for myself can most certainly be of value to others who may come across this thesis.

What began as a simple documentation of my life as a dance/movement therapy intern morphed into a twisting and turning exploration of what it meant to be healthy, ethical, and self-aware in the mental health field. I found that my own challenges and stressors outside of my clinical life became compounding factors that forced me to step back and assess my own abilities and priorities. I also discovered that being honest with myself about how much self-care I really needed and what types of coping mechanisms I was using was the first step to being successful in my clinical placement. And finally, I came to the conclusion that relying on others for support, such as supervisors, therapists, friends, and even God, was not a sign of weakness at all,

but rather an exceptionally useful resource that all mental health clinicians would do well to recognize and implement.

At this juncture, after having discussed how my experience related to the literature and what my goals are in having asked the questions I have, it is appropriate to discuss the limitations of this present study. First and foremost, as with any heuristic or case-study undertaking, the results presented here are going to be quite limited in their scope and cannot in any way be generalized. Discussing my personal experiences and touting what has worked for me in my internship or in my struggle with PMDD as being significant is clearly not quantifiable or statistically significant. However, as qualitative data, this study does maintain its merit. By coupling my own experience with literature that has been previously published, I have presented meaningful data that can stand as an addition to the current knowledge on clinician self-care in the field. A second limitation of this research is the far reaching and winding nature of the topics covered. While clinician self-care may be the overarching theme, the various detours and alternate routes taken to get to that theme may serve as a distraction or deterrent for many readers who may be seeking a more succinct way to gain understanding about the topic.

As far as the implications of this current study, they are exactly as I had intended from the outset of my data collection phase. I set out to create a deeply personal document that would chronicle the lifecycle of this intern as a means of divulging the inner workings and nuances of how one might navigate through the experience of being a DMT intern in a residential treatment center for behaviorally disordered children and adolescents. I believe I have accomplished that and much more. I felt, and continue to feel, that it is extremely important for others in the position of being interns themselves to have a sort of survival guide in hand before they dive, face first, into the choppy waters of DMT. Perhaps this thesis could serve as something like that

for anyone who picks it up and takes a look. And as far as expanding the knowledge in the field, I believe there can never be too much information available on the topic of clinician distress and self-care.

The world of mental health is full of pitfalls and emotional curve balls, especially when one is attempting to engage clients on such a holistic level that engages the body and the mind. Therefore any additional insight into ways in which practitioners can better care for and protect themselves must have at least some merit. Having said that, the additional steps for research along these lines could most evidently go in two directions. The first would be to follow somewhat in the steps of Payne (2004) and to track a cohort of dance/movement therapy students/interns and formally assess their self-care and coping skill habits throughout their experience. This would provide a broader scope of information and produce some viable statistical information as well as additional insight into the individual habits of various DMT interns who would all come to the table with their own unique sets of personal challenges and concerns. The other route that could be taken on this topic would be to have other DMT interns follow similar methods to this study and to simply journal their internship experiences with self-care and coping skills in mind as the only guideline. This would, no doubt, produce a wide variety of deeply personal perspectives on how and why self-care is used in the lives of these unique practitioners. Also, revisiting and expanding research on using DMT as a tool to help ease symptoms of PMDD, depression, stress, etc., would be of great value to the field in future studies. And finally, it would be fascinating to gain more insight into how spirituality, and especially Christian faith, is used as a coping skill and self-care mechanism in the lives of spiritually inclined therapists and counselors, including, of course, dance/movement therapists.

From what is currently available in the literature, it appears that this is an area lacking in resources but one that has the potential for being rich in meaning and discovery.

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Appendix A

Definition of Terms

Grounded

“To say that someone is ‘grounded’ implies that the person has a stable sense of him/herself” (Hackney, 2002, p.41).

Laban Movement Analysis

In briefest terms, when referring to *Laban* in this text, this is what is meant:

“A field which values a full exploration of the elements of movement...and encourages their use in connective patterns, phrased to create a whole” (Hackney, 2002, p. 212).

Premenstrual Dysphoric Disorder

According to the DSM-IV:

A. In most menstrual cycles during the past year, five (or more) of the following symptoms were present for most of the time during the last week of the luteal phase, began to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least one of the symptoms being either (1), (2), (3), or (4):

- Markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts
- Marked anxiety, tension, feelings of being “keyed up” or “on edge”
- Marked affective lability (e.g., feeling suddenly sad or tearful or increased sensitivity to rejection)
- Persistent and marked anger or irritability or increased interpersonal conflicts
- Decreased interest in usual activities (e.g., work, school, friends, hobbies)
- Subjective sense of difficulty in concentrating
- Lethargy, easy fatigability, or marked lack of energy
- Marked change in appetite, overeating, or specific food cravings
- Hypersomnia or insomnia
- A subjective sense of being overwhelmed or out of control
- Other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of “bloating,” or weight gain

B. The disturbance markedly interferes with work or school or with usual social activities and relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work or school).

C. The disturbance is not merely an exacerbation of the symptoms of another disorder,

such as major depressive disorder, panic disorder, dysthymic disorder, or a personality disorder (although it may be superimposed on any of these disorders).

D. Criteria A, B, and C must be confirmed by prospective daily ratings during at least two consecutive symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation.)

NOTE: In menstruating females, the luteal phase corresponds to the period between ovulation and the onset of menses, and the follicular phase begins with menses. In nonmenstruating females (e.g., those who have had a hysterectomy), the timing of luteal and follicular phases may require measurement of circulating reproductive hormones (American Psychiatric Association, 1994).

Self-Care

Throughout the text, “clinician self-care” is referred to and is generally addressed, however a slightly more detailed explanation could be of some use to the reader. According to authors such as Rothschild (2006), self-care means taking care of one self in every area possible for two purposes. The first is to maintain a healthy state of being simply for the sake of the self. The second is to maintain a healthy state of being in order to retain an ethical level of efficacy as a professional counselor or therapist (Rothschild). Rothschild’s book, *Help for the Healer*, details a multitude of techniques that can assist healers in staying mentally and emotionally healthy. Examples include remaining conscious of how one is interacting posturally and emotionally with a client during a session (i.e. how much is the clinician letting the client in), creating and engaging in rituals that feel cleansing after meeting with clients, and maintaining a lifestyle outside of work that includes ample time alone, with loved ones, and engaging in activities that are personally restorative and enjoyable.

Appendix B

Life Cycle of an Intern

1. “Where am I and what am I doing here?”
2. “Who am I? Participant? Observer? Patient?”
“How far do I go into my own process while in groups?”
3. I can’t stand the institution! or How do I (and patients) fit into it?
4. “Hey! I have some ideas too!”
Beginning to contribute ideas and beginning to see the patients.
5. To site supervisor, “You don’t live up to my expectations. I don’t agree with everything you’re doing or saying.”
Beginning to feel strength of leadership
6. “It should have/could have been this way.” Co-leading has its problems.
7. “Why do I threaten you?” or “I am threatened by you.”
8. “What the hell is Chace technique and why didn’t Columbia prepare me for this?”
9. “My own group, oh God!” “I don’t know anything!”
Regression/depression: “Where is my mommy and why isn’t she here?”
10. “I’m okay after all, in fact...I know more about what I’m doing than you do!”
11. To site supervisor, “Let go.” Power struggles
12. Let it all hang out...on both sides.
“I need positive feedback.” Intern
“So do I.” Site supervisor
13. “I’ve made it!” A time of growth and confidence.
14. “It’s time to leave.” A time of sadness
15. “HELP...The Big World...I’m just beginning!”