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Maintaining Stability in the Face of Adversity: Self-care Practices of Human Trafficking Survivor-Traniners in India

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MAINTAINING STABILITY IN THE FACE OF ADVERSITY: SELF-CARE PRACTICES OF HUMAN TRAFFICKING SURVIVOR-TRAINERS IN INDIA

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Abstract

What are the lived experiences of self-care for human trafficking survivors in Kolkata, India who are working with other survivors? Within the human rights organization, Kolkata Sanved, survivors of human trafficking are implementing dance/movement therapy (DMT) based techniques to empower other survivors. These survivor-trainers are currently fulfilling the dual role of survivor and provider. Six women between the ages of 22 and 28 participated in this transcendental phenomenological study. Semi-structured interviews were the primary mode of data collection. Artistic methods were also included to engage participants in movement to further reflect on their experiences of self-care. To analyze the interviews, Moustakas' (1994) modification of the van Kaam method of analysis of phenomenological data was implemented.

Findings revealed common self-care practices among the participants which contributed to their stability. Themes of this self-care experience included self-reflecting, engaging in the creative process, demonstrating autonomy, finding connection through movement, using movement for emotional awareness and release, sharing within relationships, balancing life roles through dignity, working in Kolkata Sanved, and valuing the interview process. The discussion included how these self-care practices helped to minimize the participants' re-traumatization when working with other survivors, in addition to how DMT influenced their self-care. Implications of this study were illuminated regarding current dialogues on scope of practice within the DMT field. This study suggested the use of DMT and body-based practices for self-care within community-based organizations employing peer-provider models.

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Chapter One: Introduction

Human trafficking leaves few visible traces due to its clandestine nature. However, for individuals affected by this form of modern day slavery, the emotional ramifications endure. Today, human trafficking is a growing phenomenon that has extended to every corner of the world. The U.S. Department of State (2013) acknowledged that there could be at least 27 million survivors of *human trafficking* (see Appendix A) living around the world. Yet, only approximately 40,000 survivors have been identified internationally this past year (U.S. Department of State, 2013). Efforts to combat and prevent human trafficking have been initiated by international agencies, governments, and community-based organizations. In the United States, anti-trafficking awareness campaigns have appeared on public transportation and even in mainstream media outlets. Despite these efforts, human trafficking continues to plague women, children, and men in local and global communities.

My interest in raising awareness about human trafficking began a decade ago while interning at the United Nations. My work focused on the best practices of psychosocial rehabilitation programs for survivors within the European Union. As a lifelong dancer, I strived to find a way to integrate my love of movement with this humanitarian work. I was well aware of the power of dance—as movement brought me comfort, serenity, and agency in times of distress. In fact, it was the powerful role of dance in accessing implicit emotions that led me to learn more about *dance/movement therapy* (DMT, see Appendix A). Taking this path ultimately allowed me to be better equipped to work with traumatized individuals.

I was fortunate to find a way to bridge my anti-trafficking initiatives with dance through the organization, Kolkata Sanved. Formed in 2004 by Sohini Chakraborty in Kolkata, India, in collaboration with a group of human trafficking survivors, this organization was based on the

premise that dance can help to heal and empower survivors. Kolkata Sanved's mission was to help survivors to "transcend their trauma and become educators and activists employed by the organization to break the cycle of marginalization and violence, and in turn create and perpetuate a new cycle of empowerment and growth" (Child Recovery and Reintegration network, n.d.).

In March 2008, I first travelled to Kolkata, India to intern with Kolkata Sanved as part of the requirements for my Master's degree in Cultural Project Management. Over the course of eight months, I learned about the various community–based programs that Kolkata Sanved implemented in shelter homes, psychiatric wards, schools, and on railway platforms around the region. I began observing the resiliency of the *survivor-trainers* (see Appendix A) as they used dance to help heal the psychosocial wounds of other survivors of trafficking. I started to wonder what helped them to maintain this resiliency as they offered their services to other *trauma* (see Appendix A) survivors. Also, I pondered the coping mechanisms that could prevent *re-traumatization* (see Appendix A) when working in situations that would likely trigger memories of their own traumatic experiences.

An increasing number of community-based organizations, like Kolkata Sanved, are employing *peer-providers* (see Appendix A) to work in their institutions. Examples of such organizations include Heartland Alliance for Human Rights and Human Needs, and Peers: The Prostitutes' Empowerment, Education and Resource Society. There has also been a substantial presence of peer support programs within organizations providing prevention and recovery services for human trafficking survivors (e.g. Standing Against Global Exploitation Project and APNE AAP women worldwide). Employment within a human rights agency is a viable option for survivors who are on their path to recovery; survivors in such roles are able to receive continual support from the agency, prevent the common occurrence of re-trafficking, and find

empowerment in helping others who have undergone similar trauma (Hotaling, Burris, Johnsons, Bird & Melbye, 2003). However, according to Adame (2011), a major ethical issue regarding survivors working with other survivors of trauma is that there is the possibility for re-traumatization, *vicarious trauma* (see Appendix A), and other forms of *secondary trauma* (see Appendix A).

One way to prevent secondary trauma is through *self-care* (see Appendix A). As I have learned in my graduate dance/movement therapy (DMT) training, self-care is an essential part of a therapist's wellbeing. Research has demonstrated the negative consequences of forgoing self-care (Figley, 2002a; Newell & MacNeil, 2010). While observing my own self-care practices, I reflected back to my time in Kolkata and started to consider the role of self-care in preventing secondary trauma among the survivor-trainers. I observed that the survivor-trainers were regularly confronted with varying levels of trauma from their participants.

The purpose of this *transcendental phenomenological study* (see Appendix A) was to explore the self-care experiences of human trafficking survivor-trainers in India who were fulfilling the dual roles of survivor and provider. In particular, this study addresses ways in which these survivor-trainers helped to prevent or minimize their own re-traumatization when working with other survivors. I also investigated how participants integrated movement based and DMT techniques into their self-care practices.

A transcendental phenomenological approach complemented my human rights based approach as a clinician and researcher. In particular, I placed an emphasis on the importance of collaboration, as I viewed my clients as collaborators in their treatment. Likewise, this view translated to my role as researcher. To align with the phenomenological approach, which honors personal experience, it was integral to present the participants' experiences from their own lens.

The primary research question was thus as follows: What are the lived experiences of self-care for human trafficking survivor-trainers in Kolkata, India who are working with other survivors? To complement this overarching question, a sub-question was posed: How do the myriad life roles support and/or challenge their self-care practices?

The work of Kolkata Sanved has been documented in various publications (Chakraborty, 2010; Chakraborty, 2011) and in the American Dance Therapy Association's (ADTA) conference proceedings (Capello, 2006; Capello 2008). In addition, American dance/movement therapist, Bonnie Bernstein, who has implemented month-long workshops once a year with Kolkata Sanved since 2008, has also documented her work with this group (Bernstein, 2009; Bernstein, 2012). Despite these publications, the perspectives of survivor-trainers in the literature are scant. This research contributes to existing literature by specifically addressing the experiences of self-care for peer-providers who are working with other survivors. In particular, this study fills the gap in the research by illuminating the self-care experiences of human trafficking survivor-trainers, which have not been described in the literature to date.

Chapter Two: Literature Review

This review examines literature related to the self-care needs of peer providers, presenting a context for self-care experiences of human trafficking survivors in India. For the purpose of this study, I have identified two types of providers: survivor-therapists who have undergone formal graduate training in counseling or psychology, and peer-based providers such as substance abuse counselors who have obtained non-clinical training. Although this study is focused on the experiences of peer-providers, I have included literature on *survivor-therapists* (see Appendix A) due to the paucity of research on the self-care practices of peer-providers. Research showed similarities in the recommended self-care strategies for peer-providers and survivor-therapists, despite disparities in clinical and academic training.

The phenomena of peer-providers and survivor-therapists have not been exhaustively researched in any particular field, although literature on substance abuse programs (White, 2010) is prevalent. Therefore, I have drawn from several topic areas outside of human trafficking, such as eating disorders, sexual abuse, and the psychiatric survivor movement to address the benefits and risk factors of the survivor-provider identity.

Human Trafficking

The most commonly accepted definition for human trafficking was outlined by the United Nations Protocol adopted in 2000 (see Human Trafficking, Appendix A). For an event to constitute trafficking, it must involve: the act (the recruitment of individuals for trafficking), the means (the threat or deception), and the purpose (the form of exploitation) (United Nations Office on Drugs and Crime [UNODC], 2012). An event does not necessarily have to entail transportation for it to meet the definition of trafficking in persons (U.S. Department of State, 2013).

This Protocol was integral in helping to criminalize trafficking in nations around the world (UNODC, 2012). As of 2013, 140 countries had enacted laws to criminalize trafficking for both sexual exploitation and forced labor (U.S. Department of State, 2013). Although convictions of traffickers have increased, many governments are still unable to deal with the extent of the problem (UNODC, 2012).

Trafficking Survivors

While recruitment tactics may vary, common characteristics exist among trafficking survivors' experiences. Traffickers "constantly adapt their tactics to evade detection and operate in zones of impunity" (U.S. Department of State, 2013, p. 8). They use control tactics, including physical, sexual, and psychological violence; debt-bondage; threats against family members; lies and deceit; and emotional manipulation. Other tactics include maintaining victims in unpredictable or uncontrollable situations and withholding documents (International Organization for Migration [IOM], 2009. p. 9). Moreover, they target vulnerable individuals: children, adolescents, persons with disabilities, newly arrived immigrants ("would-be migrants"), refugees, and women (UNODC, 2012). Between 55 and 60 percent of survivors worldwide are women, particularly due to gender inequalities such as lack of access to education and employment (UNODC, 2012).

The search to ameliorate one's life situation, or that of a family member, is often at the root of human trafficking: victims are "easy targets for criminals [intending to exploit] individuals' hopes of a better life" (UNODC, 2012, p. 15). Related, trafficking survivors may be reluctant to approach authorities due to the fear of being prosecuted, arrested, or deported (U.S. Department of State, 2013). This can make it difficult to identify survivors (U.S. Department of State, 2013).

In terms of purpose, or the form of exploitation, women, men and children are not only trafficked for sexual exploitation, but also for forced labor, removal of organs, begging, forced marriage, illegal adoption, participation in armed conflict, and commission of crime (UNODC, 2012). The act, means, and purpose can vary according to country, but the psychological implications of human trafficking transcend nationality and borders.

Mental Health Effects of Trafficking

Reports on global trafficking have been published primarily by international non-governmental organizations such as the Human Rights Watch (2002), governmental departments such as the United States Department of State (2013), and international bodies such as the United Nations (2012). Despite the breadth of information in these reports, there is a substantial paucity in peer-reviewed literature, specifically with regards to the mental health issues survivors often encounter. And although international conventions recommend that the mental health effects of trafficking be explored, knowledge in this area remains limited (Tsutsumi, Izutsu, Poudyal, Kato & Marui, 2008).

Among the studies that have been conducted, however, researchers share a consensus with regards to the mental health effects in trafficking survivors. In particular, post-traumatic stress disorder (PTSD), anxiety, and depression have been found to be prevalent among trafficking survivors (Abas, Ostrovschi, Prince, Gorceag, Trigub & Oram, 2013; Farley, Cotton, Lynne, Zumbeck, Spiwak, Reyes & Alvarez, 2003; Houssain, Zimmerman, Abas, Light, & Watts, 2010; Tsutsumi et al., 2008). One study found survivors more likely to be diagnosed with PTSD if they had experienced violence and injuries while being trafficked (Houssain et al., 2010). Houssain et al. interviewed survivors of trafficking and sexual exploitation in Moldova, Ukraine, Belgium, Czech Republic, Italy, Bulgaria and the United Kingdom (n=204). Survivors

who had past histories of violence such as childhood sexual or physical abuse, rape during prostitution, or past physical assault in adulthood, were more likely to be diagnosed with PTSD (Farley et al, 2003). Abas et al. (2013) found similar results in their study addressing the risk factors for developing mental disorders in Moldovan women that have been trafficked (n=120). The authors employed a structured clinical interview for DSM-IV (SCID) to assess pre-trafficking and post-trafficking experiences between two and 12 months after the survivors' return to Moldova. Seventy-nine percent of the participants reported abuse in childhood and 54.2% were diagnosed with a mental disorder. The most common diagnoses were PTSD, depression, and other anxiety disorders.

Survivors share not only risk factors and diagnoses but also emotional symptoms. The experience of shame was one theme that surfaced in multiple studies. Freed (2003) discussed the disruption of normal development in prostitution survivors in Cambodia. For the survivors, not having children and not marrying resulted in feelings of shame. Shame, according to Freed, "is generated from internalized social attitudes" (p. 139). Chakraborty (2010) expanded on this sentiment to describe feelings of shame, which were experienced on a body level for survivors in India. These feelings resulted from having been trafficked and exposed to violence, as Chakraborty explained:

> Living in these circumstances often makes it difficult to relate to one's body, spirit and mind in a positive way. Instead, it becomes more common to see the body as a shameful means of labor and mechanical source of income-generation, or worse still as a commodity that does not belong to them but to the highest bidder. (p. 62)

Chakraborty added that the disempowerment, which results from being subjected to such circumstances, can create profound negative perceptions of both body and mind for survivors of

trafficking and prostitution.

Blame often accompanies shame in survivors. Multiple authors emphasized the necessity of addressing blame when working with trafficking survivors in a therapeutic setting (Freed, 2003; IOM, 2009). The International Organization for Migration's (IOM) handbook for caregivers of trafficking survivors specified that "[p]eople who have been trafficked need assurance that they are not to blame for what happened to them" (IOM, 2009, p. 12). Accompanying blame were the themes of lack of trust and betrayal, as Freed (2003) discussed in her study with survivors in Cambodia. These feelings were invoked in survivors as a result of being sold by family members or other people the survivors trusted. Additionally, many survivors in Freed's study experienced symptoms of grief when talking about their childhood with regards to their loss of virginity, freedom, and safety.

The psychological implications of trafficking demonstrate the importance of after-care programs for survivors such as mental health services, healthcare, housing, and legal services (IOM, 2009). To respond to survivors' varying needs, the IOM (2009) guidebook identified three stages of psychological recovery: restoring a sense of safety and personal control, addressing traumatic experiences and their impact on mental health, and providing support for survivors when entering their original or adopted communities (p.138). The guidebook's authors emphasized that there is no clear timeline for recovery and that survivors often fluctuate between stages. Survivors can also influence this timeframe if they decide to participate in prosecution proceedings for traffickers. In addition, trauma-informed care, as well as patient-centered care can empower survivors, enabling them to feel that they have input into and control over decision making, helping them to overcome unpredictability during the recovery process (IOM, 2009).

A common limitation appearing in several of these studies (Farley et al, 2003; Freed,

2003) is the exclusion of some of the most vulnerable survivors of trafficking and prostitution. Most often survivors are interviewed only if they have already been rescued by non-governmental organizations (NGOs). Also, survivors living in brothels that are cooperating with such NGOs are more likely to be interviewed (Freed, 2003). On the other hand, those who are more victimized or living under menacing brothel owners rarely participate in studies out of fear for retaliation by brothel owners. Therefore, as Freed (2003) posited, the results could be skewed. It thus remains difficult to gauge the full extent of the mental health effects of trafficking.

Shared Trauma

The construct of *shared trauma* may be especially useful in illuminating the challenges of agencies working to overcome the deleterious impact of human trafficking. Shared trauma, or the shared traumatic reality, (Saakvitne, 2002; Tosone, Bialkin, Campbell, Charters, Gierei, Gross, & Grounds, 2003) provides a theoretical framework for the experiences of professionals in the helping field. Specifically, it addresses the double exposure of being a provider as well as a member of an affected community. Shared trauma is also an alternative to other secondary trauma constructs such as vicarious trauma, *compassion fatigue* (see Appendix A), *burnout* (see Appendix A), and *secondary traumatic stress* (see Appendix A) (Baum, 2012).

Conceptualized after September 11, 2001, shared trauma has been defined as "the affective, behavioral, cognitive, spiritual, and multi-modal responses that clinicians experience as a result of dual exposure to the same collective trauma as their clients" (Tosone, Nuttman-Swartz & Stephens, 2012, p. 233). Early literature (Saakvitne, 2002; Tosone et al 2003) focused primarily on the experiences of therapists; however, the term is now more widely applied to other helping professionals working in the shared traumatic reality (Baum, 2012). Despite having

experienced the same trauma, it is important to note that clients and therapists do not necessarily experience trauma in the same way (Tosone et al, 2012). There are thus variances in how each therapist confronts his/her own traumatic experience and that of his/her clients.

Shared trauma can be the result of a natural disaster, as well as events such as war and mass shootings (Baum, 2012). Tosone et al (2003) chronicled social work students' reactions that were working in New York City following September 11th. The authors found that the following effects of the attacks influenced their work with clients: increased desensitization and lack of empathy toward patients; difficulties in helping others when preoccupied with personal feelings; and increased feelings of insecurity, uselessness, and helplessness with respect to clinical abilities (p. 59). Another important ramification, specific to the shared trauma context, was the reactivation of previous traumas that could occur when working with clients. Experiencing a new trauma could prompt previous experiences of loss and bring "to the surface all the personal issues and feelings that made them who they are" (p. 64). On the other hand, positive results included increased feelings of empathy and connection to patients, a greater need to feel involved and to communicate, and a newfound sense of confidence in professional competence (p. 59).

Baum (2012) expanded upon the emotional distress that can result from shared trauma. As Baum pointed out, empathy, or a lack thereof, can contribute to the distress resulting from the dual exposure of shared trauma. Baum posited that emotional distress is often due to certain defenses to distance oneself from the person being helped, as well as the need to increase self-esteem. According to Baum, these defenses are used to counteract an increased death anxiety that is a result of the communal experience of the shared trauma. While trying to cope with this death anxiety, she asserted that it is difficult to empathize with clients. Despite the growing body of

literature on shared trauma, the research continues to focus on the experiences of therapists, instead of other providers working in the helping field.

Survivor-therapists and Peer-providers: Risks and Benefits

Shared trauma among survivor-therapists, peer-providers, and their clients incites unique challenges and opportunities. Several studies explored the simultaneous benefits and risks of the survivor-provider identity for therapists (Adame, 2011; Brothers, 2009; Rance, Moller & Douglas, 2010; Saakvitne, 2002; Tosone et al, 2012) and for peer-providers (Goodwin & Patton, 2008; Hotaling, Burris, Johnsons, Bird & Melbye, 2003; White, 2010). A study by Rance et al. (2010) recounted the experiences of seven counselors who previously suffered from eating disorders and were currently working in the eating disorder field. The results revealed a "double-edged history" (p. 382) in which the participants had insider knowledge that could further the therapeutic relationship. However, the participants also recognized that there were substantial risks in working with clients with whom they shared such a background. The therapists reported experiencing over-identification, projection, and enmeshment with their clients.

Risks. This "blurring of boundaries" can impact the therapeutic relationship for survivor therapists (Tosone et al., 2012, p. 235). Tosone et al. (2012) described a therapist-client role reversal in their case study of a social worker in Israel: The therapist's client began assuming the role of the therapist by caring for her and asking her questions. However, the therapist soon gained awareness of her countertransference during supervision as she admitted that she needed a protective figure in her life. This awareness subsequently helped her return to her role as clinician. Ultimately, the shared trauma enabled her to develop a greater empathic relationship with her client as she acknowledged that they were "in the same boat" (p. 237). In addition, the clinicians in the Tosone et al. (2012) study were aware that their responses to trauma altered the

relationship. They acknowledged the importance of reestablishing the boundaries and increasing self-care, while also addressing the needs of the client.

In addition to boundary issues, the vulnerability present in shared trauma can invoke feelings of shame and guilt in therapists (Brothers, 2009; Saakvitne, 2002). Saakvitne (2002) in particular explored the vulnerability therapists experience when working with clients who have experienced the same trauma. Saakvitne specifically discussed the internal conflicts around self-expectations when working in a shared trauma relationship:

> What works against us is our tendency to emphasize the intellectual over the emotional and spiritual in our own process. Further, our unrealistic expectations for ourselves and each other about professional detachment and "neutrality" can create a barrier of shame that prevents the honest disclosure of the pain and anxiety of the work. (Saakvitne, 2002, p. 446)

The theme of shame was also mentioned in Brothers' (2009) self-reflection. She recounted a therapeutic moment in which her own re-traumatization prevented her from empathizing with a client: "When I later realize that some lapse in my empathic responsiveness has brought suffering to someone entrusted to my care, I fall victim to dark feelings of shame and guilt" (p. 506). Brothers' (2009) is one of the few authors to address re-traumatization in shared trauma, which would appear to be a great risk for therapists working with clients who have faced similar trauma.

Similar findings regarding boundaries appeared in the literature on peer-providers (Moultrie, 2004; White, 2010). White's (2010) overview of peer-based recovery support services (P-BRSS) in the field of substance abuse highlighted problems of boundaries that existed between the peer-leaders and the receivers of services. To counteract this phenomenon, some

peer-based programs provided trainings for the peer leaders (Moultrie, 2004), which helped peers learn boundary-setting skills and develop self-reflection and self-awareness to deal with their unresolved childhood traumas (Moultrie, 2004).

The idea that shared trauma can affect the self-perceived identity of providers was another common theme in the literature on peer-providers (Freed, 2003; Rabinovitch 2003). Rabinovitch (2003) explored some of the negative implications of the effects of peer-based programs on the formation of identity. She found that a negative primary identity emerged for peer leaders who were survivors of prostitution and disclosed stories of their trauma: "…the effect of regular public speaking about one's traumatic history in prostitution can become one's primary identity, eclipsing other facets of personality and life experience" (p. 249). Freed (2003) similarly discussed the negative aspects of a new survivor identity. She found that "layers of truth" (p. 137) surfaced when survivors of prostitution in Cambodia recounted their stories. Freed described that brothel owners often constructed new identities for survivors to impose more control. This phenomenon led to a distortion of the survivors' stories to protect the survivors psychologically. The literature thus uncovered the significance of these emerging identities; it can help or hinder re-traumatization from taking place in these survivors. However, the literature failed to include ways to counteract the negative implications of the survivor identity.

Benefits. Despite these risks, the peer-providing phenomenon has existed for centuries (White, 2010). Notable programs include Alcoholics Anonymous, formed in the 1930's (Goodwin & Patton, 2008). Recent literature on peer-provider programs has expanded to address programming around sexual abuse (Goodwin & Patton, 2008) and prostitution (Hotaling et al. 2003; Rabinovitch, 2003). Survivor-therapist literature included eating disorders (Rance, Moller

& Douglas, 2010) and the psychiatric survivor movement (Adame, 2011). Much of this literature mentioned the benefits of survivor-therapist and peer-provider models. Rance et al (2010) found that survivor-therapists in the eating disorder field were able to provide motivation in their clients' recovery process. By referencing their own stories of recovery, they offered evidence that one can overcome eating disorders. The participants in this study also felt that they were better able to understand the challenges that their clients were facing, unlike in their own experiences in therapy during which they felt little empathy from their psychiatrists. Adame (2011) echoed how the survivor identity in psychiatric survivor-therapists can positively influence the therapeutic relationship. The participants in her study indicated that they were in a better position to help their clients due to having experienced treatment in the past. For example, the survivor-therapists in this study were able to draw on their own experiences of suffering to foster genuine and empathic relationships with their clients.

Research conducted with peer-support groups for survivors of youth sexual violence supported these findings (Goodwin & Patton, 2008). Goodwin and Patton found that peer-providers were able to provide emotional support for their peers, share advice and experiential knowledge, and increase their social networks due to their identity. Likewise, Hotaling et al. (2003) discussed the various ways in which the peer providers related to their peers. In their overview of a survivor-centered model implemented by the Standing Against Global Exploitation (SAGE) peer leadership program in San Francisco, the authors found that survivors were often able to develop greater trusting relationships with other survivors due to the extreme social stigma that prostitution holds in society. Hotaling et al. added that counselors were familiar with many of the obstacles survivors faced, such as re-entry into prostitution, and were therefore able to serve as role models for their peers.

DMT and Trauma

The aforementioned benefits and risks manifest differently within the context of DMT, which addresses trauma through the body-mind connection. A number of dance/movement therapists have written about the use of DMT with trauma survivors, specifically with sexual abuse (Bernstein, 1995; Mills & Daniluk 2002; Valentine, 2007) survivors of torture (Gray, 2001; Harris, 2007a), refugees (Singer, 2006; Koch, 2009) and former child soldiers (Harris, 2007b), among others.

DMT can help to address perceptions of fragmentation in the body when working with trauma survivors. This is done through fostering emotional and body awareness among individuals with trauma (Gray, 2001; Moore, 2006). Gray (2001) described how her client who was a torture survivor felt that her body parts were disconnected to the whole. Her client was not able to make the connection between the physical experience of torture and emotional pain. Gray worked with her client on awareness of sensations in certain areas of the body "to begin to re-establish the sequential organization of her experience that was violently disrupted by torture" (p. 41). As Gray stated, focusing on the sensation of the whole body could elicit flooding and hyperarousal. Instead it was necessary to focus on small sections of the body.

Likewise, Moore's (2006) study on women, children, and adolescents who experienced domestic violence reflected similar perceptions of body fragmentation. During therapy, the research participants explored issues such as fragmented body image and body sensations, low self-esteem, fear, anger, grief, and conflicts with partners. Participants reported having greater emotional and body awareness, feeling more confident in the body, and having more awareness of boundaries and body language after participating in DMT. Awareness of fragmentation helped participants "to find ways of non-threatening integration" (p. 114). Moore emphasized the

importance of helping clients recognize body sensations and reactions to these sensations to eliminate fragmentation.

The use of DMT to work through trauma and help survivors confront their pasts appeared in several studies (Bernstein, 1995; Harris, 2007a; Lumsden, 2006). With reference to his work with former child soldiers in Sierra Leone, Harris (2007a) observed:

> The embodiment of personal experiences and attitudes through active participation in contained thematic exercises helped these teenage ex-fighters come to terms with the past in a way that enhanced longer term prospects for survival, and provided a model for reconciling to a community still torn apart by years of brutal war. (p. 154)

Bernstein (1995) described her use of DMT with survivors of sexual abuse, which included tracking memories of the trauma that surfaced through movement. She found that this was integral for trauma resolution as "catharsis through dance released unexpressed feeling and memories" (p. 54). Lumsden (2006) additionally described the power of dance and improvisation when working through emotional trauma. Her study on theoretical perspectives in developmental neuroscience and traumatology focused on the affective self and affective regulation that support the use of DMT with complex trauma. She described how DMT can be both poetic—"the playful, creative exploration of new modes of being, enabling growth of the self"—and cathartic (p. 37). Supporting and empowering traumatized individuals through the use of DMT proved to be integral to promoting future self-growth.

A final theme in the literature involved the *therapeutic movement relationship* (see Appendix A). Establishing therapeutic relationships is a major goal when working with clients who have undergone trauma, specifically as "[w]ithdrawal from intimacy in personal relationships is one of the more enduring effects of trauma" (Turner, Mcfarlane & van der Kolk,

1996, p. 538). Accordingly, the benefits of DMT in helping to establish the therapeutic relationship with trauma survivors were well represented in the literature (Bernstein, 1995; Gray, 2001; Gray 2008). Gray's (2001) case study of a 38-year-old African torture survivor described the therapeutic movement relationship as "the one that initiates the healing process…" (p. 42), in particular in cases of relational trauma.

DMT with Trafficking Survivors

Research on the use of DMT with human trafficking survivors has only recently developed. At the time of this writing, there were only a few peer-reviewed studies on this topic. Two of these studies were published by the director of Kolkata Sanved on her program, which incorporated aspects of Western DMT practices in India (Chakraborty, 2010; Chakraborty, 2011). In addition, dance/movement therapist Bonnie Bernstein (2009) provided insight into her own work implementing DMT with survivors of trafficking in Kolkata. While not explicitly focusing on human trafficking survivors, the studies conducted by dance/movement therapist David Alan Harris on African torture survivors (Harris, 2007a) and child soldiers (2007b) were also relevant to this issue. In addition, there were a few unpublished masters theses in development on this topic.

Chakraborty (2011) provided a detailed explanation of the *Sampoornata* (fulfillment) curriculum, which is implemented with survivors of human trafficking, and abused and marginalized populations in Kolkata. Chakraborty described the *Sampoornata* Process as

> a curriculum of dance and movement therapy that is used to equip women and children with the skills, support, and motivation to combat oppression and create new lives for themselves. This specialized methodology works by allowing all of its participants to re-

imagine their worlds and self-identities–all by engaging the body and mind with rhythm. (p. 222)

Chakraborty (2011) discussed the need for alternative forms of therapy for marginalized populations, such as survivors of trafficking. She stated that it was not a reality for many people to attend "clinic-based therapy" in India due to cultural norms, the stigma of therapy, and financial barriers. Additionally, Chakraborty elucidated the importance of not only providing therapeutic services for the participants, but also implementing a multidisciplinary approach that included preparing survivors of trafficking and abuse "for sustainable alternative livelihoods… equipped with the necessary skills to negotiate healthy living environments in mainstream society" (Chakraborty, 2011, p. 229). One of the major goals of DMT within her program was "educating and developing awareness of body and self to rebuild confidence, self-esteem, and an understanding of dance and movement which helps grasp one's inner strength and the power of the individual" (p.230).

Another unique aspect of the program, and one central to this thesis, was the progression of some participants to become DMT trainers after two years of intense training. Barriers between facilitator and participants were broken as former survivors facilitated the sessions, thus promoting an elimination of hierarchy between facilitator and participant. Other benefits of the program included providing employment opportunities for the trainers. Chakraborty (2011) explained that it was empowering for the women to use "dance also as a vocational skill through which they can secure a profession of dignity that is sustainable, creative, expressive, and proactive" (p. 232).

In another article written by Chakraborty (2010), she discussed the importance of promoting a safe, non-judgmental environment with survivors as well as using a strengths-based

approach. She further described the emergence of the program and its uniqueness in drawing from traditional Indian dance forms. Chakraborty described that the use of footsteps from the *Kathak* technique helped to release anger. In addition, the *Bharatnatyam* technique helped to increase spatial awareness. The strong gestural and facial expressions utilized in Indian dance provided an even greater form of expression for individuals, as Chakraborty elucidated: "Claiming full ownership to every aspect of the dance, they are able to act out their own stories and truly express their deepest unspoken emotions" (p. 65).

A recent study on the Kolkata Sanved model was conducted by an outside evaluator (Seal, 2013). This study provided pertinent information that helped the organization address gaps in its psychosocial rehabilitation programs for survivors of trafficking. The goals of this study were to explore the emotional needs of survivors through a DMT module designed to benefit and better prepare survivors during the trial proceedings of traffickers. Participants in this study were survivors of human trafficking between the ages of 15 and 19 in Mumbai who participated in focus groups following a two-day DMT-based workshop. Interviews were conducted with functionaries of the collaborating NGOs on the rehabilitation and reintegration process of survivors. The interviews and focus groups revealed six areas that needed to be addressed when working with survivors: perception of self-image, anger, insecurity, verbal articulation and expression, handling relationships, and long-term vision of life. DMT proved effective in helping survivors lose inhibition; release emotions; increase self-confidence, self-image, and self value; and improve mood.

Bernstein's (2009) personal narrative, which described her work with survivors of human trafficking and marginalized communities, revealed similar survivor needs. She used Western dance/movement and expressive arts techniques to find areas of connection with the Indian-

based dance therapy in Kolkata. In particular, she identified the need to foster self-esteem, assertion, self-protection, and a positive self-image. Bernstein also outlined the use of vocal expression, creative writing, drumming, dance, and visual arts in working with the survivors. These techniques furthered the survivors' own therapeutic growth and provided them with skills when working in diverse situations in the field. In particular, Bernstein described the benefits of the use of voice with survivors of trauma. Through various vocal techniques, the survivors, "unmasked resources for articulating feelings and defining rights" (p. 7). Drumming additionally provided an outlet for release of "frustration, torment and power" (p. 6).

Self-care

Therapists, especially those that work in shared trauma contexts, need to make conscious efforts to recuperate through self-care. Self-care is a personal experience that can change across the lifespan and vary according to historical, sociocultural, and socioeconomic forces (Baker, 2003). A majority of literature on self-care is catered to therapists (Rothschild, 2006; Baker, 2003) and not peer-providers; however, some authors note that their strategies can be applied to anyone working in the helping profession (Rothschild, 2006). These strategies overlap in ways that apply to peer-providers, specifically with regards to the organizational support and supervision needed for both types of providers.

Self-care for trauma providers. Rothschild (2006) and Lipsky and Burk (2009) described very detailed self-care strategies for providers working with trauma. Rothschild illuminated tools for practitioners to increase overall body awareness with the goal of decreasing the risks of developing secondary trauma. Specifically, Rothschild focused on what was necessary on a neuropsychological level for clinician self-care, which included balancing empathic engagement, regulating autonomic nervous system (ANS) arousal, and maintaining the

ability to think clearly. Rothschild also addressed the importance of understanding countertransference and how a practitioner's reactions can "have roots in his [/her] own past" (p.3). Rothschild proposed managing countertransference through mindfulness and body awareness, specifically recognizing body sensations or "somatic countertransference" when working with clients. Familiarizing oneself with one's past also helped maintain clear thinking when triggered by a client's material. Additionally, Rothschild stressed that the unconscious empathy—present in the therapeutic relationship when a therapist unknowingly takes on the feelings of the client—can endure after sessions.

Lipsky and Burk (2009) also offered self-care strategies for a broad range of providers in the helping field to address secondary effects of trauma. Lipsky and Burk's method draws from their own experiences in social services, as well as anecdotes from other professionals. It is based on the trauma exposure response, which is "the wide range of strategies we have evolved, whether consciously or unconsciously, to contend with the trauma we have witnessed or shared in our lives or work" (p. 13). These responses included minimizing, fear, chronic fatigue, grandiosity, and numbing. According to Lipsky and Burk, a trauma exposure response occurs "when external trauma becomes internal reality" (p. 42).

Lipsky and Burk (2009) therefore recommended that people in the helping field practice trauma stewardship to prevent this trauma exposure response. Trauma stewardship is defined as

> …a daily practice through which individuals, organizations, and societies tend to hardship, pain or trauma experienced by humans, other living beings, or our planet itself. Those who support trauma stewardship believe that both joy and pain are realities of life, and that suffering can be transformed into meaningful growth and healing when a quality of presence is cultivated and maintained even in the face of great suffering. (p. 11)

Thus, a person's trauma exposure response, and ultimately one's trauma stewardship, can be shaped by an individual's experiences, community experiences, as well as the experiences of the society as a whole. She proposed implementing the "five directions" method to achieve trauma stewardship. This is based on the cardinal directions and natural elements and included creating a space for inquiry, choosing a focus, building compassion and community, finding balance, and implementing a daily practice of centering (Lipsky & Burk, 2009).

Literature on self-care for providers working with human trafficking survivors is limited to handbooks for caregivers published by international organizations. The IOM (2009) handbook specifically addressed self-care for health providers, such as general practitioners, emergency room staff, and mental health professionals. Workers can experience symptoms of secondary stress such as intrusive images, thoughts, and nightmares about patients' experiences. They can also experience emotions such as anger, pain frustration, sadness, shock, horror, and distress (p. 97). Recommendations for health care providers included having clear goals with patients that are derived from a treatment plan. In addition, the authors stressed gathering patients' input to avoid unrealistic expectations, and receiving supervision to discuss cases, as patients' trauma can trigger unresolved trauma and emotional difficulties in service providers. Having an adequate support network, leisure activities, and caring attitudes towards colleagues were recommended.

Self-care for shared trauma therapists and peer-providers. Researchers studying shared trauma have also emphasized the role of self-care. Like Rothschild (2006), Saakvitne (2002) illustrated the importance of the therapists' self-awareness to avoid vicarious traumatization, but with clients who have encountered shared trauma:

> Addressing vicarious traumatization requires good self-care skills. Keeping ourselves healthy is essential if we are to face the enormous stress and physical and emotional toll

> of the work. Additionally, we need to practice self-nurturing strategies, that is, engaging in activities we actively enjoy and find pleasurable. Because trauma is always about loss and pain, we need to go out of our way to create a balance and make room for joy and sensory pleasure. (p. 448)

Saakvitne (2002) explained the importance of creating meaning out of the therapeutic work and finding the supportive nature of community. However, like other researchers discussing self-care in the context of shared trauma, she does not provide an in-depth analysis of what self-care is for her, nor does she develop what it means to have "good self-care skills" (p.448).

Tosone et al (2012) identified an increase in self-care among therapists working in the shared traumatic reality. This case vignette focused on two clinicians who have experienced shared trauma: a student clinician who was a social work intern during 9/11 and a seasoned Israeli clinician who dealt with constant attacks on her city. Their narratives demonstrated the importance of social and professional support from their institutions as well as routine supervision. Wilson and Jones (2010) agreed that supervision is necessary for therapists who are trauma survivors. This study focused on the self-care practices of a psychology student who had been sexually assaulted and who was working with other trauma survivors. Wilson and Jones emphasized the importance of addressing prior trauma in supervision to decrease the psychological harm caused by working with trauma clients. They also listed practicing self-care habits, such as eating healthy, relaxing, and exercising, especially early in a therapist's career.

Despite the growing body of literature on the importance of self-care for shared trauma therapists, literature that addresses the specific needs of peer-providers remains scant. In Moultrie's (2004) study on indigenous trauma volunteers in South Africa, she revealed that self-care was a key part of the training process for the participants in her study. Echoing studies on

survivor-therapists, Moultrie highlighted the role of supervision for volunteers who were working as trauma support workers in schools. Supervision helped these volunteers process the effects of their volunteer work as it related to their own personal histories. She listed several relaxation practices that were helpful for the volunteers such as reading novels, aromatherapy, massage, and playing with children. However, self-care was not the focus of her analysis, and thus an in-depth exploration was lacking. Similarly, Goodwin and Patton's (2008) study on peer-support initiatives for sexual violence survivors indicated that there was a "strong engagement" in self-care among the participants in their study, however they did not provide details regarding specific practices. Overall, there is a gap in information on the supportive services and self-care practices for peer-providers.

Self-care and DMT. Literature on DMT and self-care has appeared mostly in graduate masters theses that addressed DMT as a form of self-care for therapists (Agor, 2003; Blazek, 2010) or more broadly for mental heath workers (Lengerich, 2001). A common theme in these studies was the need for supportive interpersonal relationships when designing self-care programs. One example was Lengerich's (2001) study on staff burnout, which included nurses, mental health counselors, social workers, and group therapists in an inpatient psychiatric unit (n=17). Lengerich's research participants expressed a need to increase the amount of teamwork and communication among staff workers, which led her to create a self-care program using DMT principles to address these needs. Moving in relationship with others was an important part of her program, including the DMT technique of *mirroring* (see Appendix A) movement. Additionally, Lengerich found it useful to incorporate *group rhythmic activity* (see Appendix A) and body sculpture techniques to foster physical connections with others. Trif (2010) also emphasized the importance of relationship as a part of self-care in her study on the effects of vicarious trauma on

a dance/movement therapist. Her findings suggested that vicarious trauma could be prevented through interpersonal support of the therapist.

Several studies have identified that fostering a sense of personal awareness and self-knowledge are integral goals for a DMT-based self-care program. Agor (2003) proposed a DMT self-care program for trauma therapists that focused on the prevention of symptoms of secondary traumatic stress. Her self-care model was based on the five psychological needs and cognitive schema of the Constructivist self-development theory. Specifically, Agor's program comprised five sessions, which focused on safety, esteem, trust, control and intimacy. Goals of this proposed program were to "increase self-awareness, increase interpersonal and self-protective skills, increase sense of balance, increase connection with self and others, and recognize and prevent signs and symptoms of vicarious traumatization, secondary traumatic stress and burnout" (p.59). Trif (2010) additionally stressed the importance of personal awareness for the prevention of vicarious trauma. She asserted that dance/movement therapists are more vulnerable to vicarious trauma due to somatic attunement and empathy, which can arise through mirroring others, often unconsciously. She ultimately realized that she needed to be more mindful of her own emotional states when working with clients.

Lengerich (2001) likewise discussed the use of DMT for self-knowledge. She incorporated DMT pioneer Trudi Schoop's body split technique in her self-care program to help foster personal awareness and self-expression for staff on the inpatient unit. The author also used a body-part warm-up and Laban's *Efforts* (see Appendix A) to help staff understand their movement preferences.

Summary

Myriad studies addressed the importance of self-care and listed common strategies and recommendations for clinicians; yet, rarely did they include a comprehensive explanation of what self-care comprises. More importantly, there was a gap in the literature with regards to how self-care addresses shared trauma in peer-providers. Using the backdrop of Kolkata Sanved, this research study will help to fill this gap, illuminating the lived experiences of self-care for human trafficking survivor-trainers in Kolkata, India who are working with other survivors. It will also report how their various life roles, support and/or challenge their self-care practices.

Chapter Three: Methods

Methodology

This study employed a transcendental phenomenological methodology. According to Mertens (2005), phenomenology focuses on the subjective, lived experiences of the research participants and their own construction of meaning of a particular phenomenon. As Wertz (2005) posited: "Phenomenological research requires an attitude of wonder that is highly empathic... The researcher empathically joins with participants ("coperforms" participants' involvement) in their lived situation(s)" (p. 172). Phenomenological research exemplifies how the participants interpret their experiences and their lives around them. As Giorgi (1985) stated, phenomenology "is to do justice to the lived aspects of human phenomena, and to do so, one first has to know how someone actually experienced what has been lived" (p. 1). Phenomenology thus provides a platform to explore the participants' own perspectives of their self-care practices, instead of theorizing or interpreting their experiences.

Participants

This study included six women who were survivors of human trafficking living in Kolkata, India. To be included in this study, participants must have worked with the Kolkata Sanved organization for at least five years as a dance/movement therapy trainer and be between the ages of 22 and 30. Participants were selected based on recommendations from the director of Kolkata Sanved and from previous experience working with me under an instructor role in 2008.

The research participants have implemented and have helped shape Kolkata Sanved's *Sampoornata* curriculum. They have also participated in courses on the theory and practice of DMT with Bonnie Bernstein, an American Board Certified Dance/Movement Therapist (Bernstein, 2012). Furthermore, to complement their work as DMT trainers, they have

participated in numerous workshops in dance, improvisation, drama therapy, expressive arts therapy, and Laban Movement Analysis (LMA), among others.

Procedure

Recruitment of participants and translators. I contacted Kolkata Sanved in the summer of 2012 to inquire about the possibility of conducting research within the organization. Upon approval from Kolkata Sanved and from Columbia College Chicago's Institutional Review Board, I consulted with the director of the organization regarding the selection of research participants as well as Bengali interpreters. Due to the sensitive nature of the topic and for the protection of the participants, we agreed to select interpreters and translators with whom the participants felt comfortable and who have previously worked with Kolkata Sanved.

Potential research participants were first verbally informed of the study and provided verbal consent to participate. Following this preliminary confirmation of participants, informed consent forms in both Bengali and English were sent via email to potential participants (see Appendix B). One participant who was initially expected to participate in the study had to withdraw her participation due to family obligations. Therefore, the minimum age requirement for participants was lowered from 25 to 22 to accommodate the proposed number of participants for the study. Participants were instructed to return consent forms via post within one month upon receiving them. However, due to time restrictions and the participants' work commitments, the six participants signed the consent forms in both Bengali and English in person upon my arrival in Kolkata. To protect the identity of the participants, all informed consent forms were scanned and password-encrypted in PDF format, and original hard copies were shredded.

Upon arrival in Kolkata, I met with the interpreter and translators to discuss the study and to sign contracts and confidentiality agreements (see Appendix C). A timeframe for submission

of translations was also created. To increase accuracy of translated interview transcripts and to take into account problems with transliteration, Regmi, Naidoo and Pilkington (2010) recommended employing Ercikan (1998) and Halai's (2007) model of translation in which two bilingual interpreters review the English translation of the interviews until any discrepancies are omitted. This process was also explained to the translators at this time.

Data collection. In accordance with the transcendental phenomenological methodology, I engaged in the Epoche process upon arriving in India and before beginning data collection. The Epoche process also served as a validation strategy in this study. During the Epoche, all biases, preconceptions, and prior knowledge of the subject are put aside in order to look at the phenomena with open, new eyes "from the vantage point of a pure or transcendental ego" (Moustakas, 1994, p. 33). I found a quiet place to review my current thoughts and feelings on the experience of self-care as well as my experiences with the research participants. While engaging in reflective meditation on this topic, I began to label my preconceptions and judgments regarding the topic in an Epoche log. This Epoche log included thoughts regarding my own perceptions of the women's engagement in self-care based on prior interactions, my preconceived notions of the level of self-awareness of each woman, and my predictions for how they might respond to certain interview questions. I reviewed the list until I was able to enter newly into the situation with these biases mitigated. I also engaged in this process after each interview. This process was particularly important in my study due to my prior experiences with the research participants.

Semi-structured interviews were the primary mode of data collection for this study. The interviews were conducted in a quiet section of the Kolkata Sanved office as per the participants' request. Interviews lasted approximately 45 minutes to one hour and were audio recorded.

Participants were first invited to take a few moments to meditate, center, or focus before commencing the interview. When participants expressed that they were ready to begin, I asked them to reflect on their experiences of self-care. In accordance with the phenomenological methodology, the interviews were interactive, informal, and included open-ended follow-up questions and comments (Moustakas, 1994). Although six interview questions (see Appendix D) were used to guide the interview, participants were not restricted to answering solely these questions in order to foster authentic and genuine responses throughout the interview.

Artistic methods were also implemented during data collection following the verbal interview. Research participants were invited to engage in movement to reflect on the interview and their experiences of self-care. The following prompt was implemented: Is there anything from the interview that resonated with you on a body-level, which you would like to reflect through movement? I documented the movement immediately following the interview through descriptive journaling using LMA taxonomy where appropriate and within the limits of my training. To protect the confidentiality of the research participants, the movement was not videotaped. Three of the six participants agreed to participate in movement, which lasted approximately 30-60 seconds.

Data Analysis

Upon completion of the interviews, the digital interview recordings were submitted to two separate translators. As per the confidentiality agreement, translators were asked to delete any electronic copies of the interview recordings and transcripts once submitted to me for review. Before entering into data analysis, I engaged in the Epoche process once more before reading the translated interview transcripts for the first time. My Epoche log addressed residual thoughts from the data collection process and identified any lingering preconceptions regarding

the process.

Moustakas' (1994) modification of the van Kaam method of analysis of phenomenological data was employed in this study. This seven step method of data analysis includes a) horizonilization, b) reduction and elimination, c) clustering and thematizing, d) final identification of themes, e) constructing an individual textural description, f) constructing an individual structural description, and g) creating a textural-structural description of the essence of the experiences. After a preliminary reading of the interview transcripts, I identified the horizons (step 1), which are any expressions relevant to the experience. Each horizon was considered to have equal value and was included if it added meaning to the overall experience of the participant. Reduction and elimination (step 2) was then completed to determine the invariant constituents, or themes most relevant to the study. Horizons that contained an aspect of the experience of self-care that was necessary to understand it, and which could be abstracted and labeled, were identified as invariant constituents; Redundant or unclear phrases were removed (Moustakas, 1994).

Next, I embarked on clustering and thematizing invariant constituents (step 3). I listed and clustered meaning units into common categories, establishing the core themes of the experience for each participant. Key phrases and words relevant to the experience were underlined to facilitate creation of meaning units. Any repetitive and overlapping statements were further removed.

During final identification of the invariant constituents (step 4), I returned to the complete transcripts of each participant. I verified that the invariant constituents and their core themes were both "compatible and expressed explicitly" (Moustakas, 1994, p. 121) in the transcription of each interviewee. Invariant constituents that were not explicitly expressed were removed. Data

saturation occurred after reviewing the transcripts and invariant constituents multiple times until no new themes arose.

Following the final identification of themes, I developed individual textural descriptions for each research participant (step 5). The textural descriptions were constructed from the validated invariant constituents and themes and included verbatim examples from the interviews. The textural language is "what one sees, not only in terms of the external object but also the internal act of consciousness, the experiences as such, the rhythm and relationship between phenomenon and self" (Moustakas, 1994, p. 90). Thus, when constructing the textural descriptions, I focused on the qualities of the experience as well as the nature and meaning of the experience.

The structural descriptions (step 6) included the essential structures of the phenomenon and were based on imaginative variation. These descriptions included themes and qualities that elucidated the "underlying dynamics of the experience" (Moustakas, 1994, p. 135). Through utilizing imagination, exploring polarities, and "varying the frames of reference" (p. 97) I was able to approach the phenomena from different perspectives. Finally, I crafted individual textural-structural descriptions (step 7) to incorporate the invariant constituents and themes. Themes that surfaced from the movement portion of the interview were integrated into these descriptions for the three participants who engaged in movement.

To further the validity of the study, individual textural-structural descriptions were translated into Bengali and sent to the participants via email for review. All of the participants agreed that the themes were accurate to their experiences. Two participants did not wish to add or delete anything from the descriptions. Three participants wrote additional comments in certain sections to complement the existing descriptions. Additionally, one participant requested to

change one of her quotations in the descriptions and offered an alternate quotation that better expressed her thoughts on the subject. After receiving this feedback from the participants, I created a composite textural-structural description to represent the meanings and essences of the group as a whole. In addition, thematic elements were compared across the movement sequences and integrated into the composite description to complement the themes from the verbal interviews. As Moustakas (1994) postulated, essences can never be completely exhausted as the researcher can only depict essences from a certain time and place.

Chapter Four: Results

This research provides a glimpse into the self-care experiences of human trafficking survivor-trainers in India who were fulfilling the dual role of survivor and provider. Through in-depth interviews, participants described their lived experiences of self-care and addressed ways in which their various life roles impacted their self-care practices, thus answering primary and secondary research questions. All of the participants recognized the need for self-care, as well as the influence of movement and DMT on their self-care practices. The following themes emerged from data analysis: self-reflecting, engaging in the creative process, demonstrating autonomy, finding connection through movement, using movement for emotional awareness and release, sharing within relationships, balancing life roles through dignity, working in Kolkata Sanved, and valuing the interview process. Some of these themes were derived directly from the language of the participants, and these words have been ascribed throughout this Results chapter in an effort to honor the women's choice of language. For example, the use of the words "sharing" and "dignity" were expressed in English by the trainers and not in Bengali. I further selected thematic labels such as "self-reflection" and the "creative process" to illustrate the essence of the women's experiences as a whole. These themes are further detailed below in the synthesis of the women's self-care experiences.

Self-reflecting

The experience of self-care for the women in this study was characterized by an adept ability to self-reflect. Self-reflection was a way for the women to measure their growth throughout their lives and their journeys to become DMT trainers. Reflections on their current and past thoughts, emotions, and body awareness were prevalent and ultimately furthered their self-awareness. Specifically, the women took a step back from their daily lives to look deep

within themselves during challenging times. One woman described her experience of self-reflection, which facilitated insight into ways to address difficult life situations: "Every morning when I wake up to the time I went to bed at night, I would think about what I have done today, what I am going to do the next day, and then focus on my target and my *Lokho* (vision). Then I would try to rectify those things or make them better."

Through self-reflection, the women discovered the most useful forms of self-care, which were conducive to their own personal needs. These self-care practices varied from person to person: "…If someone wants to lead a good healthy life, then that person has to search for that particular thing which can be helpful to lead a good life." It was an ongoing process for the women to find the most relevant practice to help them return to a place where they felt confident and prepared to continue their work. One woman expressed: "There is this thing in me; I am always searching for what is working for me. Due to this, my process is faster." This process, which was facilitated through self-reflection, often included tension-release techniques to manage pain symptoms. Self-reflection ultimately fostered a greater sense of self-awareness for the women. The following subthemes of self-reflection included emotional awareness, body awareness, and prevention of re-traumatization, which were a result of the women's ability to self-reflect.

Emotional awareness. Feelings of pride accompanied the women's growth when they compared their past to their present experiences. This growth often stemmed from the women's awareness of their moods and triggers: "Many times I can see that my mood isn't fine one day, and there is no reason… Probably I have seen something that has triggered another memory of mine. As I have learned, seeing an incident and connecting it to the past." Emotional awareness was also present in their ability to find emotional balance. One woman observed this balance

when reflecting on her increased ability to release anger, thereby regulating her emotions: "Before I would hold on to one thing and stay that way. So if I would get angry, I would be angry the whole day...If I was sad, I would remain sad for the whole day, not talk to anyone. And because I have gone through a process, that's why, if I get angry I let go…" Reflecting on balance and loss of balance thus provided insight into emotions the women were experiencing. Aside from anger, the women also recognized feelings of peace, openness, and freedom that were elicited from their reflections.

Body awareness. Interviewees discussed the reciprocal relationship between emotional awareness and bodily awareness. One woman elucidated the connection between emotional awareness, body awareness, and the body-mind connection: "If I am worrying too much, or I can't find a solution, then those days my head and body feel heavy. At that time I try to relax my mind and body." For all of the women, tuning into one's body signals and sensations produced a greater understanding of the type of self-care that they needed: "I make a note of which body part I feel the pain and thus try to shift that pain somewhere else." Likewise, while engaging in movement, one woman remarked: "When I start this dance, my hands start to become ticklish, then within I feel… shiver? Sensation? Then I hear my soul asking me to dance…?" In some cases the women experienced emotions bodily: "When I am feeling low at home, first my body becomes stiff. Before words, the body reacts." Overall, the women's experiences of self-reflection informed them about what kinds of self-care practices were needed and when to implement these practices.

Prevention of re-traumatization. Through reflecting, the women in this study became more aware of how past trauma could influence their current situations. This self-awareness consequently helped them to find ways to face past trauma: "Until I can learn to deal with

trauma, trauma will remain trauma…trauma teaches man, and only then can he move forward… and if one feels they can't handle it, then one goes back into re-traumatization." Part of this self-awareness included recognizing the signs of secondary trauma or burnout. For one woman, her awareness of moments of instability, when she felt "like everything is upside down," manifested through no eye contact, lack of concentration, and problems communicating.

Recognizing personal limitations was integral in helping the women prevent re-traumatization when working with other survivors. This consisted of acknowledging signs of burnout and choosing to engage in needed self-care: "I was unable to give any time to myself. And because of that I was making many mistakes. And I used to forget all of the important things I had to do." One woman emphasized the importance of reflecting on one's own mental and physical state before classes: "If I find that I am not feeling well, physically, or mentally, then I try to have another trainer go in my place to the classes." Another woman described her self-healing experience that she implemented when she was encountering difficulty in her life: "I was not feeling good inside, so what to do?... That's why I entered the office and went into a separate room…And I just sat down for my self-healing experience." This self-healing experience included a series of deep breathing exercises, focusing, and prayer, which helped her to regain peace in her life.

Engaging in the Creative Process

The creative process fostered self-reflection and further facilitated the women's ability to examine the past, present, and future. They engaged in creative processes like art, creative writing, and play. Dance was a primary form of creative expression, addressed thoroughly in later sections of this chapter.

Drawing and writing. Some women reflected on their pasts and personal journeys

through drawing: “I like green trees a lot; at all times in my journey, it started from a tree. Because a tree grows from something small to big and it’s open.” Vibrant images in the women’s drawings helped to deepen the women’s reflections on the past: “When I draw my roads, my roads are never straight, because for me, life has always been twisted…” Some women identified the use of colors to help convey deeper meaning when reflecting on certain situations: “I would say black represents a dark world, and if I see it, then I feel uncomfortable, but red is such a bright color, it draws you to it.”

Through creative writing, one woman was able to develop clarity about the present and the future: “When I write, and once I’m done writing, I read the whole thing. And it feels like I can see the whole picture. It feels really good. After writing I am able to dream and see what is ahead, the next step. I can see the whole thing in front of my eyes.” Another woman acknowledged the importance of using expressive drawing and writing to reflect on both her past and current experiences and as a way to listen and bring awareness about her own needs. Through these media she recognized the significance of creativity in her self-care practices, expressing a “sense of happiness and joy,” which has resulted from this type of creative expression: “Through creativity, if I can do self-care then… one can free oneself.”

Play. The women identified playing with children or other family members as sources of self-care. Play brought a sense of peace for the women. One woman described her ritual play with her son every morning: “…When he goes to play, falls in the mud, or plays with the ball, we have a fun time…At that time I feel good, I feel peaceful that I could be a mother. Because he is getting from me and he is getting his own space and what he wants.” Like other forms of movement, play helped to elicit emotions and foster connections with others. Play also allowed them to feel like children again: “Everyone [in the neighborhood] says, ‘Two kids are

playing….(laughing) We have not seen a mother and son like the two of you. Getting up in the morning and playing football.' I like being a child (laughing)." Another woman discovered a way to incorporate play into her chores: "It was raining and I was washing the floor outside of my house…so while I was sweeping I was jumping in the rain puddle, which was fun…My husband was asking me to do the sweeping later, but I was enjoying it, so I told him I will finish it. " The creative process, as demonstrated through artistic expression and play, brought a sense of freedom for the women that was integral in their self-care practices.

Sharing within Relationships

Supportive interpersonal relationships enabled the women to feel comfortable and open in discussing both positive and negative aspects of various life situations. Specifically, husbands, boyfriends, family members, office colleagues, and other DMT trainers who had faced similar experiences, provided spaces for the women to be heard. The participants acknowledged the importance of connecting and sharing with others as a form of self-care.

For the women, feelings of relief, happiness, and peace emerged through sharing, and feelings of "stuckness" surfaced when they were alone. "So when I share, at that time there is a good feeling of happiness, that itself is a big space for me… the fact that the person is listening." Sharing was not always verbal; sometimes it took the form of artwork: "I have a boyfriend, and I show him my chartpaper [large poster board] and tell him that I experience peace and this is my self-care." Movement also served as an outlet to share experiences with others: "To dance with others feels very good, because one, I am able to learn. What I know I am sharing and learning." Sharing artwork and movement that conveyed strong emotional content were alternative avenues for the women to assist others in understanding their experiences.

It was also beneficial for the women to share their experiences with other DMT trainers

following their classes as a way to debrief their experiences. However, as one woman remarked, thoughts from the past surfaced when there was no one around immediately following sessions: "After I finish class and bid everyone goodbye, then the thoughts which were bothering me come back as I am alone and there is no friend with me to share or release."

Self-disclosure with participants. The women used self-disclosure to connect with their participants in the community-based programs they implemented. They expressed that this was another beneficial form of sharing: "I share my own experience about how I reached where I have. Listening to this, some are inspired. Some try to reflect on what has happened in life or what they feel like sharing." Likewise, sharing life stories helped to reinforce the perception of their growth, including overcoming challenges: "Everyday I work with various participants and situations, and I know how to deal with that. And I share my life story with lots of people and connect with their situations." Self-disclosure was therefore a positive experience for the women that enabled them to inspire hope in their participants.

Finding Connection with Others Through Movement

The creative process previously described surfaced as the women found connection with one another through movement. They expressed a sense of togetherness through movement, particularly when moving with the other DMT trainers: "I feel extreme happiness, and all far away things seem to have come near, and my friends, we dance together; I feel very close." Another woman commented on the improvement of her mood when witnessing and joining others in dance: "Sometimes I watch when the juniors are dancing. If I am feeling low and someone is dancing, and they can't do something, then I show them, and that low feeling goes." Moving together also brought both comfort and enthusiasm for the women, inspiring them to create and choreograph dances together: "If I am alone, then I am not able to put it [movement]

together, but if we are in a group, then automatically we don't realize that we are choreographing. It just happens in a group when we are dancing. Then I feel that I am able to take a lot of creativity."

Using Movement for Emotional Awareness and Release

All of the women expressed the benefits of movement for emotional release. In particular, the women acknowledged the use of movement to express feelings of anger, sadness, and happiness. Movement brought awareness about emotions the women were experiencing and also helped them to deepen their emotional exploration; as one woman expressed, "Movement gets one out of sadness and also takes one there." For some women, strong emotions seemed to dissipate at the onset of movement: "So when I dance, all my anger, pain, etc. just disappears in a second." Another woman described a technique which helped her to release anger: "There is a particular movement and we verbally say *Ja Ja* (go go) and do the movement, which helps to release a lot of pressure." She recounted that this has helped both her and her participants release any residual anger and sadness at the end of a session. Another woman described her experience of listening to different kinds of music while dancing, which helped her to release her emotions:

> One day a person came and saw me dancing on the roof and said, 'You are dancing on the roof, you are really very daring!' I replied, 'Sorry I didn't know that you were downstairs, otherwise I wouldn't have danced.' But I did not leave this dance, one day I danced 'til 12 am.

When asked what kind of dance she was doing, the woman replied: "I bank [depend] on the kind of music loaded in my mobile- it's not that I do not listen to Bollywood, I listen to all kinds of music… but in the process I am releasing my emotions." Through engaging in various dance forms, the women found ways of using structured dance for emotional expression.

In addition to structured movement expression, the women found that spontaneous movement improvisations helped them to express their worries, thoughts, and internal needs: "The whole body wants to move… and there is no particular way… whichever movement comes…I get very happy, and I like doing it." Another woman remarked: "There is nothing specific [in my movement]… so I dance and enjoy, and everyone thinks I have gone crazy." The women also identified the power of everyday movement, such as chores, as beneficial forms of self-care. One woman used the water pump outside her home to release stress while pumping water: "So there is a lot of self-care that happens as I have to apply pressure, as my whole body is being used." The sound of the well pumping was also enjoyable and served as a release for her, in particular when she did fast movements: "When I have to slow it down, the sound also becomes slow, which I find boring. So I feel like doing it fast again." The women recognized the benefits of employing everyday movements as well as more structured dance forms for emotional expression.

Balancing Life Roles with Dignity

The women found balance among the various life roles they occupied as DMT trainers, wives, girlfriends, *didis* (sisters), leaders in the community, and mothers. The impact of the women's life roles on their self-care practices was characterized by their ability to stand up and find a sense of dignity and power within. The women have described dignity as garnering respect from others and showing pride and confidence in one's life actions. Despite varying approaches to addressing situations in their lives, a commonality surfaced through the ways in which they addressed past experiences. They did not dwell on the negative aspects of the past. Instead, they had used their dignity and growth to claim their roles as DMT trainers within their families and communities. It was empowering for them to be employed and "stand on [their]

own which is [their] dream." The ability to claim this role was also demonstrated in one woman's description of her movements: "And when I close myself in, no one can remove that movement from me. And when I am open, that also no one can take away from me." As the women managed their various life roles, their sense of dignity ultimately informed their interactions with family members and with people in their community. These life roles created both a) supportive and b) challenging factors, as outlined below.

Supportive factors. The women were frequently pulled in several directions due to their office obligations as well as demands from their families. However, the women's colleagues in the Kolkata Sanved office offered support to the women when they encountered challenging situations. Moreover, the support they received from Kolkata Sanved impacted the way the women in this study related to their partners. In particular, the women often emphasized the supportive role of Sanved in their recovery process to their family members. One woman felt it necessary to explain to her boyfriend why she was working as a DMT trainer: "My life was broken at one point…if it wasn't for Kolkata Sanved, I would not be able to stand up today."

Many of the women experienced resistance from some family members who did not want them to leave the house to work. Some women identified that their ability to engage in self-care was facilitated by the shift from resistance to support from family members. One woman described her family's change in viewpoint, which greatly differed from that of her community's: "Where we are from, there is no family per se, no one has supported in that sense, the way my family has." Familial support was also manifested in decreased pressure to get married. Another woman expressed the importance of receiving support from her husband in sharing the chores around the home: "I feel this family belongs to both of us, we should share our work [at home]. He has a job outside, and so do I." The support the women received from

their family members and colleagues, accompanied by the dignity they demonstrated, helped them find balance among many aspects in their lives.

Challenging factors. Despite receiving support from their families, family obligations created challenges for the women when working as DMT trainers. For example, when family members developed health problems, the women had to choose between their work and caring for their families. These obligations often impacted their ability to engage in self-care. In addition, some women predicted challenges that could arise in their relationships if they chose to marry one day: "The fact that I am coming to office [once married] I will feel that I have been successful in life… I have given him an option, that if you don't let me work after marriage then I will not marry you."

Caring for children also created challenges for the women. For many of the women, the responsibility of caring for their children often impacted the time they were able to devote to their own self-care practices. One woman described the challenges as well as the strength she found in balancing numerous responsibilities: "The power was so much, I would travel in a bus, I would carry the baby on the bus for 6 months, and everyone was surprised."

Financial obligations within the family were ever present, including the pressure for some of the women to provide for their families as the sole earners: "Now my duty is to earn and give my parents a life full of happiness and content as they have shown me the light of the world." Many of the women expressed the need to set limitations and boundaries with regards to financial support for family members, which they identified as self-care. However, there was also a sense of pride, which accompanied the role of financial provider. Financial responsibility involved validation of the women's role within the family: "I used to make him [my husband] understand about our equal roles and participating in family life, and also told him not to feel

guilty as he was looking after my child when I was at work." Finding a sense of power and dignity within the home, as well as in their professional lives, was vital in helping the women address life challenges.

Demonstrating Autonomy

Autonomy was an overarching theme that transcended the women's approach to the diverse ways they engaged in self-care. These qualities also shaped their interpersonal relationships, as evidenced by the supportive and challenging factors in their lives. Having a sense of autonomy was particularly key when the women interacted with their family members and communities. One woman demonstrated this autonomy when discussing her interactions with her family: "That's why today my relationship is good. Because now I do things myself, I answer myself, and tell them things myself." The women's autonomy also enabled them to take initiative in reflecting on their self-care needs: "It's upon every individual how they apply self-care in their lives for themselves…" Although the women sought supportive relationships in times of need, they were also empowered by their autonomy.

For some women, autonomy was manifested through creating personal boundaries. "Within my self-boundary, I will only permit someone that I like, that's also self-care…If I don't like someone, and that person enters my self-boundary, then there is no self-care." Boundaries were used to protect, but also reinforce the ability of the women to stand on their own and think about their own needs. Acknowledging the importance of taking care of oneself first before helping others was essential in their work with other survivors.

Working in Kolkata Sanved

Relating to the women's life roles, the women identified their work as DMT trainers as a form of self-care. The recovery process within Kolkata Sanved ultimately influenced their

current work, elicited self-confidence in the women, and fostered growth. One woman discussed the power of her work as a DMT trainer at the end of the interview process following her movement reflection:

> I may have a lot of pain, but I am happy when I go to class, watching participants… I feel immense happiness. I mean, even I forget that I have pain or sadness. This has really helped me. If this was not there, then I would not have been able to get it out. I would have held on, and it would harm me. So that is gone, and I feel good and am able to adjust with others…They [participants] have so much enthusiasm; they are always asking, '*Didi*, how are you?' Just hearing that, I feel relief because I go as a teacher to them.

DMT and the *Sampoornata* process have also influenced their self-care practices and their work as trainers. One woman conveyed: "It's through the dance/movement therapy process that I developed this [awareness], with some practice." Another woman explained the impact of her experiences with Kolkata Sanved on her current work as a trainer:

> I believe that everybody in this world has a dream, and in order to realize that dream, one has to constantly struggle and fight with one's self. One can do so with the help of the good qualities which one has. One should never accept defeat and lag behind in one's life, but move ahead in life, along with the pain and happiness which one experiences."

The influence of DMT on their lives and work was evident: "I always carry dance/movement therapy with me. I feel it; I carry it. My self is already with it… Learned, gave, took. It's in my blood." Ultimately, the women identified that the process of growth as it relates to the DMT experience was ongoing and played an influential role on their daily work as DMT trainers.

Valuing the Experience of the Interview Process

An emergent theme that appeared in each interview was the appreciation of the interview process and the opportunity it afforded the subjects to reflect on their self-care practices. As evidenced by the above themes, it was clear that each woman was practicing self-care in her own way. However, reflecting on their self-care practices led to greater self-awareness about self-care and how it affected their roles as DMT trainers: "… Probably in the unconscious I have thought about it that I do these [practices]. I think about these things, so I am also able to know myself." The women also acknowledged the importance of having an additional person to listen to them.

The movement portion of the interview was another opportunity for the women to reflect on the interview process as a whole. The three women who engaged in movement expressed that they wanted to use movement to represent how they felt about sharing their experiences during the interview. The following paragraph is an excerpt from my movement journal and describes one woman's movement:

> She began by counting "1, 2, 3, 4" while opening her arms and swaying side to side. Her movement and sound increased in intensity, displaying increasing pressure in both her voice and her body. Successive body part phrasing in her arms was present as she moved them in the horizontal plane. She stopped suddenly and placed both arms up above her head, then slowly lowered them down by her side. She was smiling the entire time while dancing.

After moving, this woman expressed: "To be honest, I feel very happy. So, I wanted to bring out that happiness, but I don't know what you have observed….When a person is happy, rhythm becomes an automatic response." Similarly, another woman used movement to represent the benefits she received from the interview process:

> The woman began her movement with a yawn like stretch, descending and accelerating in the vertical plane until her hands reached her side. Her arms began ascending in the horizontal plane while she rolled her wrists. She moved her arms in front of her body and opened her palms towards me. I responded by opening my palms towards her to receive her gesture.

Her verbal response was similar to that of her colleague's: "Thank you, I am feeling good about sharing. There were many things which I have felt but have never shared before ..."

Chapter Five: Discussion

The overarching phenomenological research question that guided this study was as follows: What are the lived experiences of self-care for human trafficking survivor-trainers in Kolkata, India who are working with other survivors? To complement this question, a sub-question was posed: How do the survivors' myriad life roles support and/or challenge their self-care practices? Survivor-trainers explored these topics through specific interview questions, complemented by an organic, open-ended format that helped to deepen the women's reflections on self-care. Many of these questions were answered naturally over the course of the interviews without further prompting. The women's responses to these questions influenced the emerging themes, shown in Figure 1. Layered on top of these themes were the categories of self, others, and community and how these categories connected to *self-care* (see Appendix A). For example, the themes of self-reflecting and using movement for emotional awareness and release were primarily linked to the "balancing of connections among self" (Baker, 2003, p. 14); the themes of demonstrating autonomy, engaging in the creative process, finding connections with others through movement, and sharing within relationship, were all associated to self and others; and the themes of working within Sanved and balancing life through dignity, related to self, others, and the larger community.

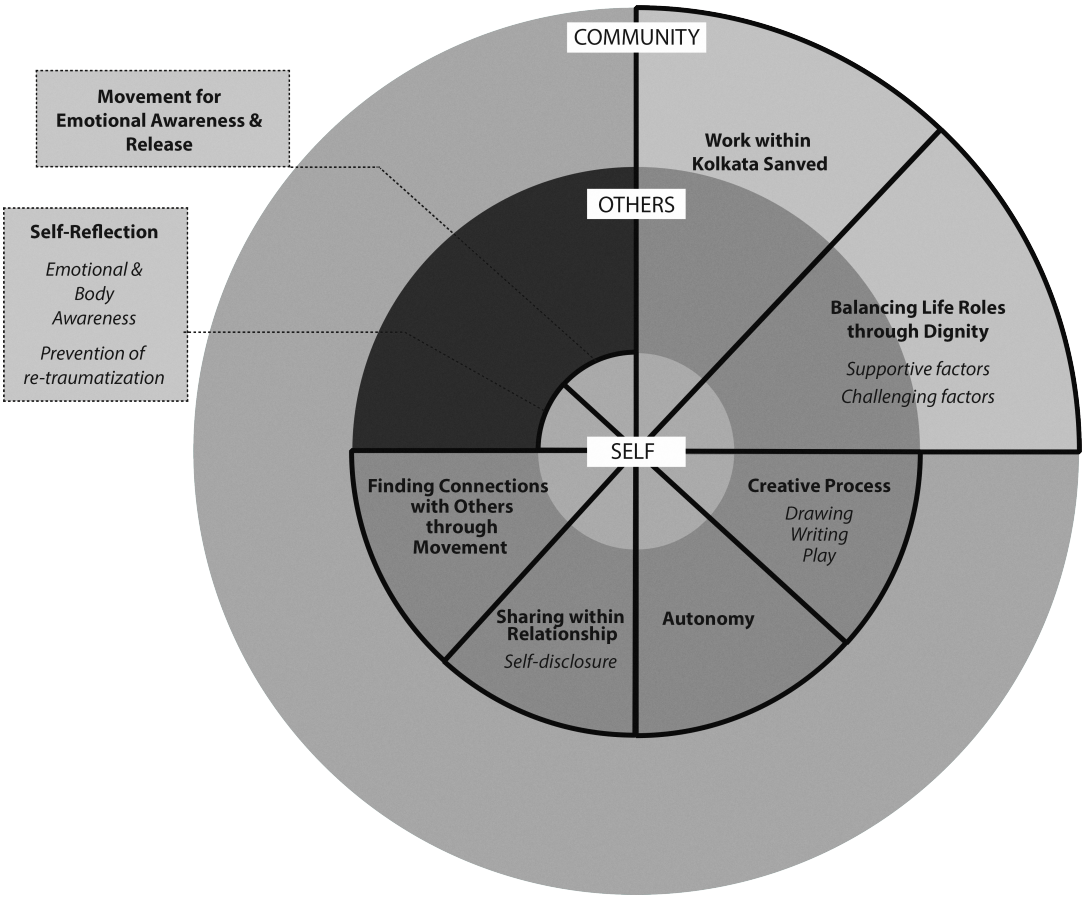

Figure 1. Representation of key themes and subthemes as they relate to the definition of *self-care* (see Appendix A) and the ways in which these themes and subthemes related to the self, others, and/or community.

Self-reflecting

Self-reflection (see Appendix A) was an essential theme that emerged from the women's descriptions of their lived experiences of self-care. My findings indicated the importance of continual reflection on current and past experiences. The women did not express that they reflected on specific details of trauma; instead they acknowledged their growth in their recovery process. Self-reflection was a way for the women to measure change in their lives. It was also evident through their descriptions that this growth impacted their roles as DMT trainers. Specifically, they used the insight they gained through self-reflection to bring awareness about their own challenges they were experiencing. This type of reflection ultimately helped to prevent

these challenges from influencing their work as DMT trainers. Lipsky and Burk (2009) emphasized the importance of self-reflection for self-awareness and self-knowledge, specifically for providers who are working with populations who have a shared history. Having awareness regarding "where our own self ends and another's self begins" (p. 21) can help to distinguish the provider from the population being helped. This awareness can help to prevent vulnerabilities that can arise when the provider is from a similar background as the clients. White (2010) stated that these vulnerabilities could include problems with boundaries between provider and client, burnout, and overextension.

Self-reflection was also a way for the women to accept their pasts. Harris (2007a) emphasized the benefits of addressing one's past, including trauma, for future growth. Likewise, as Aarts and Op den Velde (2007) stated, this awareness could have important implications as the women grow older:

> Acceptance of one's past and present states and experiences is another shared prerequisite for an adequate adaptation to aging and for trauma recovery. A further mutual challenge or task is the maintenance or establishment of a sense of self-coherence and feeling of continuity in the self. This is particularly difficult for trauma survivors, because their traumatic experiences may well have caused a serious rupture in their self-perception and sense of continuity. (p. 373)

The women's ability to self-reflect was key in helping the women maintain their self-perception, especially when separating their own trauma from their participants' trauma. As Brothers (2009) stated, this separation is necessary to help prevent re-traumatization among peer-providers. The consequences of experiencing re-traumatization when working with a client included lack of empathy, feelings of shame and guilt, and dissociation, all of which can impact the relationship

between peer-providers and their peers.

The emotional and body awareness that developed as a result of the self-reflection also helped to minimize the effects of re-traumatization when working with other survivors. As the results demonstrated, the women were aware of their triggers and the effects of these triggers on both the body and mind. This awareness helped the women to understand when it was necessary to seek further help. The importance of self and body awareness also aligned with the literature on the integration of DMT in self-care practices (Agor, 2003). As one woman expressed, it was vital for her to find a replacement when her physical and mental wellbeing were in question. Rothschild (2006) emphasized the dangers of a lack of self and body awareness, which can lead to vicarious trauma and compassion fatigue. Likewise, in her discussion of the steps to combat forms of secondary trauma, Rothschild stated: "You have to learn to watch for and recognize signals which tell you that you need to take a break, to rest, to talk to someone about your own experience, to be with family and friends, to cry, to regroup and so on" (p. 103). This recognition of self-care needs was demonstrated in the story of one interviewee's self-healing experience that she implemented when losing her emotional balance. Instead of working immediately upon her arrival at the office, she set aside time to focus on herself and what she was experiencing at that moment. As Lipsky and Burk (2009) stated: "We can sustain our work with trauma only if we combine our capacity for empathy with a dedication to personal insight and mindfulness" (p. 21). The presence and insight the women gained by first taking care of themselves prepared them to work with others.

Engaging in the Creative Process

The freedom elicited from the women's creative reflection incorporated drawing, writing, dancing, and playing. All of these forms of creative reflection helped them measure change in

their lives. May (1975) illustrated that "[t]he creative process must be explored not as the product of sickness, but as representing the highest degree of emotional health, as the expression of normal people actualizing themselves" (p. 40). For the women, creativity was indeed a manifestation of their health and growth, whether that meant drawing about their journeys, writing about future aspirations, or creating dances with one another. In particular, connecting with others during the creative act was an essential part of their creative process. Not only did the women connect with one another, they also connected through sharing their drawings or writings with friends and loved ones.

The use of play was also indicative of the creative process and the creativity that was an essential part of their self-care practices. As Mills and Daniluk (2002) found in their study on dance therapy with sexual abuse survivors, the permission to play was an important theme in their sessions. Play elicited childlike behaviors and a sense of feeling carefree, which the women did not experience previously due to interrupted childhoods. For one woman in my study, playing with her child also gave her permission to feel like a child again. Play brought her peace and an opportunity to let go of any inhibitions. Playing with her child was part of her daily routine, and she benefitted from the community witnessing her. Another woman's incorporation of play into her chores also demonstrated this sentiment. The movement evoked through play was not restricted, and the women were able to follow their impulses.

Sharing within Relationships

The opportunity for the women to engage in trusting relationships was an essential form of self-care. Having a strong support network aligned with multiple studies on self-care for providers (Banyard, Siegel, & Williams, 2002; Lengerich, 2001; Lipsky & Burk, 2009). Lipsky and Burk (2009) described the "microculture" of support that is needed for providers: "Its

members must be people we can debrief with, laugh with, brainstorm with, consult with, cry with, and become better people with" (p. 185). This is also consistent with the literature on DMT and self-care, which highlighted the importance of interpersonal support (Lengerich 2001; Trif, 2010). The women's "microculture" comprised fellow DMT trainers, family members, and co-workers within Kolkata Sanved. As the results demonstrated, the lack of opportunity to share created a vulnerable situation for one of the women. She described how negative thoughts surfaced immediately following a class when she was alone and did not have the opportunity to debrief. This experience thus emphasized the importance of a strong support network as well as supervision and debriefing for peer-providers. It also demonstrated the ease with which peer-providers can become triggered when working within the context of shared trauma.

The women's use of self-disclosure encouraged openness in other survivors, in addition to being a source of self-care. The women displayed a sense of pride in their recovery, and they wanted to share this with the participants in their classes. Self-disclosure can help the therapeutic process when used appropriately, but hinder the process if used for self-gain (Martins, 2010). Rabinovitz (2003) discussed the negative psychological effects that can occur among peer providers when constantly sharing one's story; the survivor identity can become one's primary identity, preventing other facets of a survivor's personality from surfacing. The results in my study indicated that the women used self-disclosure to connect with their participants on a deeper level. Moreover, the participants' responses to the use of self-disclosure by the trainers suggested that the disclosure was mutually beneficial. It could be inferred that the women's self-awareness could also help to prevent any enmeshment that could result from self-disclosure when working with survivors of a similar background, as described by Rance, Moller, and Douglas (2010).

Finding Connection with Others through Movement

The relationships that the women forged between the other DMT trainers were strengthened through movement. Using movement as a form of self-care seemed organic due to the women's implementation of movement and DMT in their own recovery processes. Additionally, the experience of connecting through movement with other DMT trainers prepared them to develop the empathy and trust that was necessary when working with their participants. Multiple studies (Bernstein, 1995; Gray, 2001; Gray 2008) emphasized the importance of the power of movement in establishing the therapeutic relationship with trauma survivors. Having an opportunity to create dances together awakened the trainers' creativity and skills that were necessary in leading classes with their participants. Overall, the women's movement interactions with one another informed how their classes with their participants were shaped.

Using Movement for Emotional Awareness and Release

The women used spontaneous, free movement to elicit emotional expression for self-care, as well as more structured, traditional dance forms. DMT pioneer, Blanche Evan, described the ability to use the body to experience emotions and the spontaneity involved in improvisation (Levy, 1992). The women in my study were able to release emotions through dancing on the roof and other opportunities to improvise. Additionally, the use of everyday movement such as chores and play were equally beneficial for the women. They identified specific elements of these movements such as using their "whole body" to pump water during chores, or using "pressure"; they described these movements as recuperative. Hackney (1998) explained how "function and expression integrate to create meaning in movement" (p.49). Moreover, the women had insight into how they could use both improvisation and more functional movement for emotional release.

For a majority of the women, the use of the weight motion factor, in particular increasing pressure, was present in their descriptions of the movements they used for self-care, as well as in their movement demonstrations at the end of the interview. Weight is one of the four motion factors of Effort as described by LMA taxonomy. Within this system, Effort explains how movement stems from an "inner intent that results in an observable action" (Moore, 2009, p. 147). Increasing pressure, which is characterized as "forceful and firm" (p. 151) was present in the women's movement descriptions. In particular, increasing pressure was described by one woman when using the water pump outside of her house. Another woman indicated that the use of increasing pressure in both feet helped her release anger for her and her participants. This experience aligned with Chakraborty's (2010) description of survivors of trafficking using percussive *Kathak* footsteps to release anger, as well as Bernstein's (2009) endorsement of drumming to vent frustration. Several women also displayed the use of increasing pressure in both their movements and in their voices during their movement reflections following the interviews. Additionally, the Effort motion factor of time surfaced in the women's descriptions. Specifically, one woman indicated how she enjoyed accelerating in her movement when retrieving water from the pump.

Balancing Life Roles with Dignity and Autonomy

My sub-question addressed the influence of the women's life roles on their self-care practices. The theme of autonomy is included in this section due to overlap between these themes. For the women, autonomy was illustrated through the importance the women placed on creating boundaries. The women demonstrated boundary setting through knowing when to care for themselves first before addressing the needs of others. While examining the women's autonomy, it is also interesting to return to the women's use of increasing pressure, which was

observed in several of their movements following the interview process. These movements—which Hackney (1998) might have identified as "powerful, forceful, impactful" (p. 220)—supported the women's autonomy and assertiveness with regards to their lives. These movements also aligned with the literature on Kolkata Sanved's model of working with human trafficking survivors. Specifically, the language used when working with survivors included "confidence," "self-esteem," "power of the individual," and "inner strength" (Chakraborty, 2011). All of these words were indicative of the organization's goals to prepare autonomous individuals, which in turn greatly impacted how the women approached and viewed their self-care practices.

The women's descriptions conveyed both the supportive and challenging factors that resulted from their family and work obligations. Many of these obligations impeded their ability to engage in self-care. They used the support from the Kolkata Sanved office and from their families to help address necessary life obligations. Many of the women's families and partners were at first not supportive of them working after marriage. Their autonomy is a manifestation of this reduced resistance, which ultimately facilitated their ability to engage in self-care.

The women found balance in their life roles through emanating a sense of dignity and self-power, which helped them to overcome challenging situations. This was demonstrated through the women's ability to stand up to family members or partners regarding marriage preferences and their decisions to continue working with Sanved. The results suggested that the dignity and respect, which are inherent core principles of the Kolkata Sanved *Sampoornata* model, have greatly influenced both their recovery and their self-care practices. The women repeatedly mentioned the impact of the Kolkata Sanved model in their recovery. The director of Kolkata Sanved's motto further illustrates the impact of the organization in helping individuals exude dignity and autonomy: "What I fight for is not just to teach them dance, but make them

strong individuals in society with dignity and self-respect" (Chakraborty, 2010, p. 234). The women's descriptions of self-care clearly reflected this dignity, which pervaded their daily lives and resulted from their recovery process. The theme of dignity and autonomy is also consistent with the literature addressing needs of human trafficking survivors: "Individuals who have been through traumatic events need to regain a sense of safety, dignity, and control over their bodies and actions. They need to be encouraged to seek information, question their options and assert their choices" (IOM, 2009, p. 27).

Working in Kolkata Sanved

Although many researchers (Lipsky & Burk, 2009; Rothschild 2006; Saakvitne, 2002; Tosone et al., 2012) emphasized the need for self-care to address the challenges of working with trauma survivors, the results of my study indicated that the women found self-care in working as peer-providers. Herman (1992) illuminated the empowering nature of the "survivor mission," during which survivors "can transform the meaning of their personal tragedy by making it the basis for social action" (p. 207). Herman described the survivor mission as part of the recovery and healing process for some survivors, and she does not specifically identify this phenomenon as self-care. However, the benefits of the survivor mission, in particular the connection with others, reflect the essential role of interpersonal connections in the self-care practices of the women in this study.

Goodwin and Patton (2008) additionally revealed that peer-providers are able to benefit from the emotional support and relationships they form with their peers. Specifically, they benefit from acting as role models. The women in my study expressed feeling proud when their class participants were excited to see them. The results also illustrated that their participants

viewed them as role models. As Hotaling et al. (2003) expressed, working as peer-providers can be inspiring for both the peers as well as the providers.

The influence of the Kolkata Sanved model was also apparent in the benefits of working as a peer-provider. The women's experience with DMT-based practices in Kolkata Sanved during their own recovery process informed how they worked with their participants. This was evident in the women's acknowledgement of the awareness they gained through their experiences with DMT and how they carried it with them every day. Identifying that their work as peer-providers was in itself a form of self-care further demonstrated the survivors' insight.

Valuing the Experience of the Interview Process

The women's reactions following the interview process were additional indicators of their level of self-awareness. The interview was an opportunity for self-reflection and illuminated aspects about their self-care practices that they had not previously expressed. The women conveyed feelings of happiness and appreciation after the interviews, which were reflected in their movement responses. One woman remarked that "rhythm becomes an automatic response" when she is happy. This rhythm was evident in her movement demonstration, which exhibited a clear use of increasing pressure and acceleration. Maletic (2005) described the psychological implication of the combination of increasing pressure and acceleration as an "emphatic assertion" (p. 30). It would appear that this woman accessed the rhythm state, evoking an inner state of presence (Bartenieff, 1980) and engagement in activities or attitudes (Maletic, 2005). It is thus not surprising that several of the women accessed the rhythm state while discussing the self-awareness elicited from the interview process.

Limitations

This study was limited in several ways. I hoped to eliminate my biases by engaging in the

Epoche process, which helped me view my research participants from an empathic and non-judgmental perspective. However, it was inevitable that my Western viewpoint could have influenced the way in which the study was conducted as well as the analysis of themes. Member checking was thus essential in helping to eliminate any discrepancies in the themes that emerged.

Due to the small sample size, and the fact that the women in this study had very specific training and support, it was difficult to generalize the results to other populations of peer-providers. In addition, only three out of the six women in this study decided to engage in movement following the interview. Therefore, I was not able to triangulate the movement and verbal data for all of the participants. Finally, the use of internal interpreters and translators was a double-edged sword: the trainers may have been more comfortable during the interviews because of their established relationship with the translators. However, full transparency in their responses may have been impeded due to their ongoing relationship with the translators.

Summary

The purpose of this phenomenological study was to explore the self-care experiences of human trafficking survivor-trainers in India who were fulfilling the dual role of survivor and provider. In particular, this study addressed ways in which these survivor-trainers helped to prevent or minimize their own re-traumatization when working with other survivors. Themes of self-reflecting, engaging in the creative process, demonstrating autonomy, finding connection through movement, using movement for emotional awareness and release, sharing within relationships, balancing life roles through dignity, working in Kolkata Sanved, and valuing the interview process, emerged in response to the research question: "What are the lived experience of self-care for survivors of human trafficking who are working with other survivors?" This study helped to bridge the gap in the literature by addressing the self-care needs of survivors of

human trafficking who are peer-providers.

The self-care practices of the DMT trainers aligned with recent literature on self-care as it relates to the themes of self-reflection, self-awareness, and interpersonal support. However, this study can be distinguished from research on self-care for peer-providers due to the incorporation of movement and DMT based techniques into the women's self-care practices. Core premises intrinsic to DMT such as the creative process, body awareness, the use of movement for emotional expression, and core concepts such as the therapeutic movement relationship and rhythmic group activity, all emerged in the women's self-care practices.

Implications of these results for the field of DMT are here discussed with regards to recent developments on scope of practice. The results indicate that with ample social support and awareness about self-care practices, peer-providers could protect themselves while providing support to other survivors. The women's experiences with DMT-based techniques in Kolkata Sanved's model, as well as their exposure to Western DMT, helped to facilitate their self-awareness and body awareness. However, as the results suggested, it was necessary that the women in this study be cognizant of their limitations. This awareness included recognizing when they needed to seek further assistance from trained clinicians for their own well-being. In addition, it was important for them to be aware of any triggers they were experiencing on a body level that could indicate possible re-traumatization. Finally, it was essential that the women recognized therapeutic boundaries for the protection of their class participants.

This brings us to the discussion on scope of practice, a current topic in the field of DMT. With the influx of dance and *arts in healthcare* programs (see Appendix A, State of the Field Committee, 2009), clear differentiation between what is considered DMT and therapeutic dance is needed to help protect the populations receiving services (Imus, 2012). Yet, it is important to

acknowledge that organizations in countries such as India are developing their own culturally relevant programs based on Western DMT practices, which respond to the specific needs of the communities they serve. In areas where DMT is not yet developed, how can peer-providers in community settings benefit from DMT techniques when it is not always feasible to have a licensed dance/movement therapist on site due to war or lack of resources? With the increase of community-based programs such as Kolkata Sanved that are employing peer-providers, further research could delve more deeply into specific boundaries for peer-providers that are implementing DMT-based practices.

Moving beyond the field of DMT, the implications of this study for other peer-provider programs are numerous, in particular for those working with survivors of human trafficking. As Rothschild (2006) specified, body and self-awareness are integral in helping providers avoid secondary effects of trauma. Additionally, van der Kolk and McFarlane (2007) stressed the importance of finding safety in the body when treating trauma. The specific skillset of dance/movement therapists, in particular their knowledge of the body-mind connection, movement observation and analysis, and therapeutic processes, are all valuable skills that can be applied in community settings when addressing self-care for peer-providers, especially when shared trauma is at the heart of the experience. Peer-providers may be unaware of what is occurring implicitly at a body level when working with other survivors, increasing possibilities of re-traumatization. Future studies could develop a DMT-based self-care program to address the specific needs of peer-providers, focusing on risk factors such as re-traumatization. In particular, further exploration and development of recuperation techniques that incorporate LMA taxonomy's rhythm state would be beneficial for this population. The use of DMT for providers' self-care is thus recommended, especially for peer-providers who are survivors of human

trafficking.

References

Aarts, P., & Op den Velde, W. (2007). Prior traumatization and the process of aging: Theory and clinical implications. In B. van der Kolk, A. MacFarlene, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 359-377). New York, NY: Guilford Press.

Abas, M., Ostrovschi, N. V., Prince, M., Gorceag, V. I., Trigub, C., & Oram, S. (2013). Risk factors for mental disorders in women survivors of human trafficking: a historical cohort study. *BMC Psychiatry, 13*(1), 1-11. doi:10.1186/1471-244X-13-204

Adame, A. L. (2011). Negotiating discourses: The dialectical identities of survivor-therapists. *Humanistic Psychologist*, *39*(4), 324-337. doi:10.1080/08873267.2011.618038

Agor, B. C. (2003). *The impact of dance/movement therapy on symptoms of vicarious traumatization and secondary traumatic stress in the trauma therapist* (Unpublished master's thesis). Columbia College Chicago, IL.

Baker, E. K. (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being*. Washington, DC: American Psychological Association.

Banyard, V.L., Williams, L.M., Siegel, J.A. (2002). Retraumatization among adult women sexually abused in childhood: Exploratory analyses in a prospective study. *Journal of Child Sexual Abuse, 11*(3), 19-48.

Bartenieff, I. (with Lewis, D.). (1980). *Body movement: Coping with the environment*. New York, NY: Gordon and Breach.

Baum, N. (2012). Trap of conflicting needs: Helping professionals in the wake of a shared traumatic reality. *Clinical Social Work Journal, 40*(1), 37-45. doi:10.1007/s10615-011-0347-0

Bernstein, B. (1995). Dancing beyond trauma: Women survivors of sexual abuse. In

F. Levy (Ed.), *Dance and other expressive art therapies: When words are not enough* (pp. 41-58). New York, New York: Routledge.

Bernstein, B. (2009, January). Survivors to healers: Dance/movement therapy and expressive arts therapy in Kolkata. *Newsletter of the International Expressive Arts Therapy Association (IEATA)*, 1, 4-7.

Bernstein, B. (2012). From survivors to healers: Dance/movement therapy in Kolkata, India. *American Dance Therapy Association Newsletter, 46*(1), 27.

Blazek, M. J. (2010). *Finding my feet: A dance/movement therapy intern's heuristic inquiry of clinician self-care* (Unpublished master's thesis). Columbia College Chicago, IL.

Brothers, D. (2009). On the love of work, the work of love, and what Kohut didn't warn us about plying the empathy trades: Personal reflections. *International Journal of Psychoanalytic Self Psychology*, *4,* 498-509. doi:10.1080/15551020903185857

Capello, P. (2006). Training dance/movement therapists: The international challenge. *American Journal of Dance Therapy, 28*(1), 31-40. doi:10.1007/s10465-006-9009-0

Capello, P. (2008). Dance/movement therapy with children throughout the world. *American Journal of Dance Therapy, 30*(1), 24-36. doi:10.1007/s10465-008-9045-z

Chaiklin, S., & Schmais, C. (1993). The Chace approach to dance therapy. In S. Sandel, S. Chaiklin, & A. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 75-97). Columbia, Maryland: The Marian Chace Memorial Fund of the ADTA.

Chakraborty, S. (2010). Dance as healing: Kolkata Sanved. In P. Chakravorty, P. & G. Nilanjana (Eds.), *Dance matters: performing India on local and global stages* (pp. 62-

72). New Delhi, India: Routledge India.

Chakraborty, S. (2011). Empowering through dance movement therapy. In U.S. Munsi, & S. Burrige (Eds.), *Traversing tradition: Celebrating dance in India* (pp. 222-234). New Delhi, India: Routledge.

Child Recovery and Reintegration network. (n.d). Sharing experiences: Founder and Director of Dance Movement Therapy Organisation, India. Retrieved from http://www.childrecovery.info/index.php?id=160

Chronicle Guidance Publications. (2006, February). *Dance/movement therapists* (Issue Brief No. 386). Moravia, New York: Author.

Farley, M., Cotton, A., Lynne, J., Zumbeck, S., Spiwak, F., Reyes, M.,…Sezgin, U. (2003). Prostitution and trafficking in nine countries: An update on violence and posttraumatic stress disorder. In M. Farley (Ed.), *Prostitution, Trafficking and Traumatic Stress* (pp. 33-74). New York, NY: Routledge.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1433-1441.

Freed, W. (2003). From dusty to despair: Brothel prostitution in Cambodia. In M. Farley (Ed.), *Prostitution, Trafficking and Traumatic Stress* (pp. 133-146). New York, NY: Routledge.

Giorgi, A. (1985). *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press.

Goodwin, R., & Patton, M. (2008). Survivors helping survivors: A study of the benefits, risks, & challenges of peer-support with survivors of sexual violence in the Province of Ontario (Cornwall Inquiry Report- Phase 2). Retrieved from http://www.themensproject.ca/CornwallInquiryReports

Gray, A. E. (2001). The body remembers: Dance/movement therapy with an adult survivor of

torture. *American Journal of Dance Therapy*, *23*(1), 29-43.

Gray, A. E. L. (2002). The body as voice: Somatic psychology and dance/ movement therapy with survivors of war and torture. *Connections, 3*(2), 2-4.

Gray, A. E. (2008). Dancing in our blood: Dance/movement therapy with street children and victims of organized violence in Haiti. In N. Jackson & T. Shapiro-Lim (Eds.), *Dance, human rights and social justice: Dignity in motion* (pp. 222-236*).* Lantham, MD: Scarecrow Press.

Hackney, P. (1998). *Making connections: Total body integration through Bartenieff Fundamentals.* New York, NY: Gordon and Breach.

Harris, D. (2007a). Dance/movement therapy approaches to fostering resilience and recovery among African adolescent torture survivors. *Torture*: *Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, 17(2), 134-155.

Harris, D. (2007b). Pathways to embodied empathy and reconciliation after atrocity: Former boy soldiers in a dance/movement therapy group in Sierra Leone. *Intervention*: *International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict 5*(3), 203-231.

Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence-from domestic abuse to political terror.* New York, NY: Basic Books

Hooper, C. A., & Warwick, I. (2006). Gender and the politics of service provision for adults with a history of childhood sexual abuse. *Critical Social Policy, 26*, 467-479.

Hossain, M., Zimmerman, C., Abas, M., Light, M., & Watts, C. (2010). The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. *American Journal of Public Health*, *100*(12), 2442-2449. doi:10.2105/

AJPH.2009.173229

Hotaling, N., Burris, A., Johnsons, B. M., Bird, Y., Melbye, K. 2003. Been there done that: SAGE, a peer leadership model among prostitution survivors. In M. Farley (Ed.), *Prostitution, trafficking and traumatic stress* (pp. 255-266). New York, NY: Routledge.

Human Rights Watch. (2002). *Hopes betrayed: Trafficking of women and girls to post-conflict Bosnia and Herzegovina for forced prostitution* (HRW Publication No. 14-9). Retrieved from http://www.hrw.org/reports/2002/bosnia/Bosnia1102.pdf

Imus, S. (2012, October). *DMT's scope of practice in healthcare: Soaring to new heights.* Paper presented at the annual conference of the American Dance Therapy Association, Albuquerque, NM.

International Organization for Migration. (2009). *Caring for trafficked persons: Guidance for health providers*. (Eds. C. Zimmerman & R. Borland). Retrieved from http://publications.iom.int/bookstore/free/CT_Handbook.pdf

Koch, S. (2009). Traumatised refugees: An integrated dance and verbal therapy approach. *The Arts in Psychotherapy, 36*(5), 289–296. doi:10.1016/j.aip.2009.07.002

Lengerich, S. (2001). *An investigative study of staff burnout using dance/movement therapy principles on an inpatient psychiatric unit* (Unpublished master's thesis). Columbia College Chicago, Illinois.

Levy, F. J. (1992). *Dance/movement therapy: A healing art*. Reston, Virginia: AAHPERD

Lipsky, L., & Burk, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco, California: Berrett-Koehler Publishers.

Lumsden, M. (2006). The affective self and affective regulation in dance movement therapy. In

Koch, S, & Brauninger, I (Eds.), *Advances in dance/movement therapy: Theoretical perspectives and empirical findings* (pp. 29-39). Berlin, Germany: Logos Verlag

Maletic, V. (2005). *Dance dynamics: Effort and phrasing* [pdf]. Retrieved from http://www.ele-mental.org/dropbox/dancedynamics/Dynamics-FINAL4.pdf

Martin, D. G. (2010). *Counseling & therapy skills*. Long Grove, Illinois: Waveland Press

Maslach, C. (2003). *Burnout: The cost of caring*. Cambridge, MA: Malor Books.

May, R. (1975). *The courage to create*. New York, NY: W.W Norton.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131–149.

Mertens, D. M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods*. Thousand Oaks, California: Sage Publications.

Mills, L., & Daniluk, J. (2002). Her body speaks: The experience of dance therapy for women survivors of child sexual abuse. *Journal of Counseling & Development, 80*(1), 77-85.

Moore, C.-L. (2009). *The harmonic structure of movement, music, and dance according to Rudolf Laban.* Lewiston, NY: Edwin Mellen Press.

Moore, C. (2006). Dance movement therapy in the light of trauma: research findings of a multidisciplinary project. In S. Koch & I. Brauninger (Eds.), *Advances in dance/movement therapy: Theoretical perspectives and empirical findings* (pp. 104-115). Berlin, Germany: Logos Verlag.

Moultrie, A. (2004). *Indigenous trauma volunteers: Survivors with a mission* (Unpublished Dissertation). Rhodes University, Grahamstown, South Africa.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: SAGE Publications.

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practice In Mental Health, 6*(2), 57-68.

Rabinovitch, J. (2003). Peers: The prostitutes' empowerment, education and resource society. In M. Farley (Ed.), *Prostitution, Trafficking and Traumatic Stress* (pp. 239-255). New York, NY: Routledge.

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

Regmi, K., Naidoo, J., & Pilkington, P. (2010). Understanding the processes of translation and transliteration in qualitative research. *International Journal Of Qualitative Methods, 9*(1), 16-26.

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

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York, NY: W.W. Norton & Company.

Saakvitne, K (2002). Shared trauma: The therapist's increased vulnerability. *Psychoanalytical Dialogues, 12*(3): 443-449. doi:10.1080/10481881209348678

Sandel, S. (1993). The process of empathic reflection in dance therapy. In S. Sandel, S. Chaiklin, & A. Lohn (Eds.), *Foundations of dance/movement therapy: The life and work of Marian Chace* (pp. 98-111). Columbia, Maryland: The Marian Chace Memorial Fund of the ADTA.

Seal, A. (2013). Restoring smiles through dance: Research findings on dance movement therapy

for survivors of human trafficking in institutional rehabilitation. Retrieved from http://www.guidestarindia.org/Uploads/cc8392ea-eedc-4e09-944b-3dfd460a2f57/Final%20Kol%20Sanved%20Research%20Restoring%20Smiles%20Through%20Dance.pdf

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are.* New York, NY: Guilford Press.

Singer, A. J. (2006). Hidden treasures, hidden voices: An ethnographic study into the use of movement and creativity in psychosocial work with war-affected refugee children in Serbia. In H. Payne, H (Ed.), *Dance movement therapy: Theory, research and practice* (pp. 101-111). New York, NY: Routledge.

Stamm, B.H. (2010). The Concise ProQOL Manual. Pocatello, ID: ProQOL.org

State of the Field Committee. (2009). State of the field report: Arts in healthcare 2009. Washington, DC: Society for the Arts in Healthcare.

Tosone, C., Bialkin, L., Campbell, M., Charters, M., Gieri, K., Gross, S., & ... Stefan, A. (2003). Shared trauma: Group reflections on the September 11th disaster. *Psychoanalytic Social Work, 10*(1), 57-77.

Tosone, C., Nuttman-Shwartz, O., Stephens, T. (2012). Shared trauma: When the professional is personal. *Clinical Social Work Journal*, *40*, 231-239. doi:10.1007/s10615-012-0395-0

Trif, E.M. (2010). *A dance/movement therapist's experience of vicarious trauma and burn-out: An autoethnography* (Unpublished master's thesis). Columbia College Chicago, Chicago, IL.

Tsutsumi, A., Izutsu, T., Poudyal, A., Kato, S., Marui, E. (2008). Mental health of female survivors of human trafficking in Nepal. *Social Science and Medicine,*1841-1847. doi:10.1016/j.socscimed.2007.12.025

Turner, S., McFarlane, A., & van der Kolk, B. (2007). The therapeutic environment and new

explorations in the treatment of post-traumatic stress disorder. In B. van der Kolk, A. MacFarlene, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 214-241). New York, NY: Guilford Press

United Nations Office on Drugs and Crime. (2004). *United Nations convention against transnational organized crime and the protocols thereto*. Retrieved from http://www.unodc.org/documents/treaties/UNTOC/Publications/TOC%20Convention/TOCebook-e.pdf

United Nations Office on Drugs and Crime. (2012). *Global report on trafficking in persons*. Retrieved from http://www.unodc.org/documents/data-and-analysis/glotip/Trafficking_in_Persons_2012_web.pdf

U.S. Department of State. (2013). *Trafficking in Person's Report 2013.* Retrieved from http://www.state.gov/j/tip/rls/tiprpt/2013/

Valentine, G. E. (2007). Dance/movement therapy with woman survivors of sexual abuse. In S. Brooks (Ed.), *The use of creative therapies with sexual abuse survivors* (pp. 181-195). Springfield, IL: Charles C. Thomas.

van der Kolk., B & McFarlane, S. (2007). The Black hole of trauma. In B. van der Kolk, A. MacFarlene, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 3-23). New York, NY: Guilford Press

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology*, *52*(2), 167-177.

White, W. L. (2010). Nonclinical addiction recovery support services: History, rationale, models, potentials, and pitfalls. *Alcoholism Treatment Quarterly*, *28*(3), 256-272. doi:10.1080/07347324.2010.488527

Wilson, L., & Jones, R. (2010). Therapists as trauma survivors: A case study detailing

cognitive processing therapy for rape victims with a psychology graduate student. *Clinical Case Studies, 9*(6), 442-456. doi: 10.1177/1534650110386106

Appendix A

Definition of Terms

Arts in Healthcare

"Arts in Healthcare is a diverse, multidisciplinary field dedicated to transforming the healthcare experience by connecting people with the power of the arts at key moments in their lives. This rapidly growing field integrates the arts, including literary, performing, and visual arts and design, into a wide variety of healthcare and community settings for therapeutic, educational, and expressive purposes" (State of the Field Committee, 2009, para. 1).

Burnout

"Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems...what is unique about burnout is that the stress arises from the *social* interaction between helper and recipient" (Maslach, 2003, p. 2).

Compassion Fatigue

"The very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer. The meaning of compassion is to bear suffering. Compassion fatigue, like any other fatigue, reduces our capacity or interest in bearing the suffering of others" (Figley, 2002, p. 1434).

Dance/Movement Therapy

A human service profession that is one of six practices in the creative arts therapies which include; art, drama, psychodrama, poetry, and music. In particular, "[d]ance/movement therapists use dance and movement to foster health, communication, and expression; promote the

integration of physical, emotional, cognitive, and social functioning; enhance self-awareness; and facilitate change" (Chronicle Guidance Publication, 2006, p. 4).

Effort and Combined Effort

Effort is one of the four categories of movement in Laban Movement Analysis and includes the motion factors of weight, time, space and flow. Effort explains how movement stems from an "inner intent that results in an observable action" (Moore, 2009, p. 147). The weight motion factor includes the polarities of increasing pressure, which is "forceful and firm" and decreasing pressure, described as "light and delicate." The motion factor of time includes the polarities of accelerating and decelerating. Weight and time combine to form the rhythm state.

Human Trafficking

"The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" (United Nations, 2004, p. 42).

Mirroring

"Mirroring, which may occur as part of the empathy process, involves participating in another's total movement experience, i.e., patterns, qualities, emotional tone, etc. It implies a quality of selflessness, a sense of entering another's experiences in an open manner. Mirroring is often the first step in establishing empathic connections…" (Sandel, 1993, p. 100).

Peer-provider

Non-clinical workers who have undergone the same trauma and/or experiences as the peers with whom they are providing services, commonly seen in addiction recovery services

(White, 2010).

Re-traumatization

A situation that reactivates overwhelming memories and/or trauma symptoms of an original traumatic event (Hooper & Warwick, 2006).

Rhythmic Group Activity

One of four core concepts, termed by DMT pioneer Marian Chace, in which rhythm is seen "as organizing individual behavior and creating a feeling of solidarity and contagion among people" (Chaiklin & Schmais, 1993, p. 80).

Secondary Trauma

A term that describes a therapist's reactions to a client's distress or traumatic experiences. The term secondary trauma includes the following constructs: compassion fatigue, burnout, vicarious trauma, and secondary traumatic stress (Newell & MacNeil; Tosone et al. 2012).

Secondary Traumatic Stress

"…secondary exposure to people who have experienced extremely or traumatically stressful events. The negative effects of STS may include fear, sleep difficulties, intrusive images, or avoiding reminders of the person's traumatic experiences" (Stamm, 2010, p.13). Secondary traumatic stress is often considered a component of compassion fatigue.

Self-Care

"The processes of self-awareness and self-regulation and the balancing of connections among self (involving the psychological, physical and spiritual, as well as the professional), others (including personal and professional relationships), and the larger community (encompassing civic and professional involvement)" (Baker, 2003, p. 14).

Self-reflection

Self-reflection, as it appears in the results, can also be described as "autonoesis," or self-knowing. Autonoesis, as defined by Daniel Siegel (1999) is "to have a sense of recollection of the self at a particular time in the past, awareness of self in the lived present, and projections of self into the imagined future…" (p. 35).

Survivor-Trainer

A term created by this author to identify the survivors of human trafficking in Kolkata, India who are implementing therapeutic dance with other survivors.

Survivor-Therapist

Providers who have undergone the same trauma and/or experiences as their clients and have received formal graduate training in counseling or psychology.

Therapeutic Movement Relationship

One of four core concepts, termed by DMT pioneer Marian Chace, in which the therapist establishes the therapeutic relationship on a movement level, while "visually and kinesthetically perceiving the patient's movement expressions" (Chaiklin & Schmais, 1993, p. 79).

Transcendental Phenomenological Study

Transcendental phenomenology is derived from philosopher Edmund Husserl's work on "subjective openness" (Moustakas, 1994, p.25) and includes the key concepts of intentionality and intuition. Transcendental phenomenology is based on the following core processes: the Epoche, "when everyday understandings, judgments, and knowings are set aside" (Moustakas, 1994, p.34); Transcendental-Phenomenological Reduction, during which "each experience is considered in its singularity, in and for itself" (p.34); and Imaginative Variation, which "grasp[s] the structural essences of an experience" (p.35).

Trauma

"Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning…Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence and death" (Herman, 1992, p. 33). Rothschild (2000) further asserted that "trauma is a psychophysical experience," (p.5) emphasizing the effects of trauma on the body.

Vicarious Trauma

"Therapists' reactions to clients' traumatic material...which can be understood as related both to the graphic and painful material trauma clients often present" (McCann & Pearlman, 1990, p. 131) and the effects of a client's trauma on "the therapist's unique cognitive schemas or beliefs, expectations, and assumptions about self and others" (McCann & Pearlman, 1990, p. 131).

Appendix B

Informed consent form

Columbia COLLEGE CHICAGO

Informed Consent Form

Consent Form for Participation in a Research Study

Title of Research Project: Maintaining Stability in the Face of Adversity: Self-care Practices of Human Trafficking Survivor-Trainers in India
Principal Investigator: Ashley Fargnoli, ashleyfargnoli@gmail.com, +1 215-260-3000
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INTRODUCTION

You are invited to participate in a research study which will explore the self-care practices of human-trafficking survivor-trainers in India. This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. You are encouraged to take some time to think this over. You are also encouraged to ask questions now and at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called 'informed consent.' You will receive a copy of this form for your records. Please review the informed consent form provided to you and return via post within one month of receiving this form.

You are being asked to participate because the researcher believes you fall into the following categories: has at least five years as a dance/movement Trainer with Kolkata Sanved and/or is a founding member of Kolkata Sanved.

PURPOSE OF THE STUDY

The purpose of this research study is to explore the experiences of self-care of the dance/movement trainers of Kolkata Sanved in India. Specifically, I hope to have a better understanding of self-care practices that help to prevent re-traumatization while working with other survivors.

PROCEDURES

- The first step in the research process will be to select participants. Participants are being chosen based on their experience as dance/movement trainers with Kolkata Sanved, and evidence of engagement in self-care as observed by this researcher when interning with Kolkata Sanved in 2008.
    - Self care is defined as any activity which allows you to function more fully in daily life and to feel more balanced in relation to your self, personal relationships and in the community.

- Your potential role as a participant means that this will be a collaborative process between you and me (principal investigator). You will be encouraged to provide input into the findings.

- The research information necessary for this study will be gathered through personal interviews. The interviews will include questions or statements that invite you, as the participant, to give detailed accounts of your experience(s) with self-care. The interview questions will cover topics such as what kinds of movement-based practices you incorporate into your self-care as well as how your self-care helps to prevent re-traumatization. You will be invited to improvise through movement following the interview to further reflect on your experiences of self-care.

- If you begin to experience symptoms of re-traumatization during the interview process, you agree to be engaged in therapy or counseling support outside of the study, and plan to remain engaged in these services throughout the study or withdraw from the study to prevent further re-traumatization. If a mental health clinician recommends withdrawal from the study for your own safety, you are recommended to comply.

- The interviews for this research project will be conducted in person in Kolkata, India in a quiet place where you feel comfortable and safe. The research will be conducted at a time that is convenient for both you and me in June 2013. A Bengali interpreter will be provided during the interview. The interviews will last no more than two hours. If for some reason more information is required, you will be contacted in order to schedule a second interview session. A second interview might be necessary if important information was not collected during the initial interview or if the first interview is interrupted due to unforeseen circumstances. If necessary, the second interview session will last no more than one hour. Two translators will be used to review the translation of the interview from Bengali to English to assure for accuracy.

- After your initial interview, you will be contacted again at a later stage of the study to review the findings which will be translated into Bengali, provided to you by the principal investigator. You will be invited to provide feedback, clarifications and/or additional information you feel is relevant.

- Portions of your interview may be included and possibly quoted in the final presentation of the research study. You will remain anonymous in the study.

- The interview will be recorded via digital audio recording. You will be told when the digital

audio tape will be turned on and off, representing the beginning and ending of the interview process

If you agree to participate in this study, you will be asked to do the following:

- Read over and sign this informed consent form
- Respond to any communication from myself prior to the interview process
- Schedule a date and time for the interview to take place with researcher
- Set aside at least 2 hours for the interview process
- Commit to the possibility of a second, one hour interview
- Provide feedback on the results of the study

POSSIBLE RISKS OR DISCOMFORTS

The risks in this study are:

- The interview process may bring up memories of your past experiences. These risks may occur immediately, before, during, or after the interview process. In order to minimize these risks, you will be provided with a list of local therapists, if needed, throughout the research process. You will have permission to choose what you do or don't want to share, if you wish to stop the interview, and when you would like to take breaks.

- Audio recordings and written interview data will be protected via secure laptop password and firewall protection. Backup copies will be stored in a locked home office safe and destroyed five years after submission of the thesis.

- Risks of confidentiality due to translator use will be minimized by the confidentiality contract, but cannot be guaranteed.

Possible inconveniences as a result of the study procedures may include the time it takes to complete the interviews, the time it takes to review the findings, and any unforeseen interruptions.

POSSIBLE BENEFITS

The possible benefits of being in this study include:

- Sharing your self-care experiences in a safe, supportive environment
- Contribution to the increased acknowledgement and understanding of self-care on individual, organizational, and societal levels.
- Contribution to the increased knowledge of the role of the self-care as a preventative measure for re-traumatization for survivor-trainers
- Contribution to future research and programming related to organizations that employ survivors who work with other survivors through publishing this study.

CONFIDENTIALITY

Confidentiality means that the investigator will keep the names and other identifying information of the research participants private. The investigator will change the names and identifying

information of research participants when writing about them or when talking about them with others, such as the investigator's supervisors.

The following procedures will be used to protect the confidentiality of your information:

1. The researcher will keep all study records locked in a secure location.
2. Any personal communication between you and I will be retrieved in a private location, on my private computer. My private computer and e-mail will be protected through the use of a firewall, as well as an encrypted password.
3. Personal communication before and after the interview which takes place over the phone via Skype will be from a secure and private location.
4. Any audiotapes from the interview will be destroyed after five years.
5. The Bengali translator and interpreter is the only person besides the primary investigator (me) that will have access to original data. The designated translator and interpreter will sign a document respecting your confidentiality both during interviews and when transcribing the interviews. The Bengali translator will permanently delete all translated interviews once provided to this researcher.
6. Any personal communication via email for the review of the findings will be exchanged through my personal email account.
7. All electronic files containing personal information will be password protected on my personal computer.
8. As the consent forms are collected, primary investigator will scan and password-encrypt a PDF of all the returned informed consents, and then shred the original hard copies.
9. Information about you that will be shared with others will be unnamed to help protect your identity.
10. Data will be de-identified through assigned pseudonyms by this investigator
11. Personal study notes may be kept indefinitely with the data stripped of all identifiable information.
12. At the end of this study, I may publish my findings. You will not be identified in any publications or presentations.

RIGHTS

Being a research participant in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty.

Please return this consent form within one month of receiving it. We will be happy to answer any question(s) you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator Ashley Fargnoli at +1215-260-3000 or the faculty advisor Susan Imus at +1 312-369-8617. If you have any questions concerning your rights as a research subject, you may contact the Columbia College Chicago Institutional Review Board staff (IRB) at +1 312-369-7384.

COST OR COMMITMENT

- Participants will receive lunch or dinner following the interview, and tea during the interview.

- There are no costs related to participation in this research study.
- Your potential time commitment includes:
    - Travel time to and from the interview location, if applicable.
    - Approximately two hours for the initial interview (this time allotment includes a twenty minute break for bathroom, snack or other personal needs). Additional breaks will occur as requested.
    - Approximately one hour for a secondary interview (if necessary). This time allotment does not include any breaks needed for bathroom, snack or other personal needs, unless otherwise requested.
    - Time to review the data findings

PARTICIPANT STATEMENT

This study has been explained to me. I volunteer to take part in this research. I have had the opportunity to ask questions. If I have questions later about the research or my rights as a research participant, I can ask one of the contacts listed above. I understand that I may withdraw from the study or refuse to participate at any time without penalty. I will receive a copy of this consent form.

_____	_____	
Participant Signature	Print Name:	Date:
_____	_____	
Signature of Person Obtaining Consent	Print Name:	Date:
_____	_____	
Principal Investigator's Signature	Print Name:	Date

Appendix C

Confidentiality Agreement for
Transcription and/or Translation Services
(Adapted From Purdue University, 2011)

I, _____, transcriptionist and/or translator, individually and on behalf of _____ [name of business or entity if applicable], do hereby agree to maintain full confidentiality in regards to any and all audiotapes, videotapes, non-verbal performance pieces and oral or written documentation received from __Ashley Fargnoli_ related to her research study titled Maintaining Stability in the Face of Adversity: Self-care Practices of Human Trafficking Survivor-Trainers in India

Furthermore, I agree:

- To hold in strictest confidence the identification of any individual that be inadvertently revealed during the transcription of the audio-taped or live oral interviews, or in any associated documents
- To not disclose any information received for profit, gain, or otherwise
- To not make copies of any audiotapes, videotapes, or computerized files of the transcribed interview texts, unless specifically requested to do so by Ashley Fargnoli.
- To store all study-related audiotapes, and materials in a safe, secure location as long as they are in my possession.
- To return all audiotapes and study-related documents to Ashley Fargnoli in a complete and timely manner.
- To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

Please provide the following contact information for the researcher and the transcriber and/or translator:

For Transcriber/Translator:	For Researcher:
Address:_____	Address:_____
_____	_____
Telephone:_____	Telephone:_____

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes, videotapes and/or paper files to which I will have access. I am further aware that if any breach of confidentiality occurs, I will be fully subject to the laws of the State of Illinois, USA.

Transcriber/ Translator's name_____
Transcriber/Translator's signature _____
Transcriber/Translator's Name of Business and Title (if applicable)_____
Date_____

Appendix D

Interview Questions

1. Do you engage in self-care? If so, can you elaborate on your self-care experiences?

2. Is movement included in your self-care practices? If so, can you describe?

3. Have any DMT techniques informed your self-care practices? If so, which techniques?

4. Have your self-care practices helped to prevent or minimize re-traumatization? If so, in what ways?

5. Do your various life roles support or challenge your self-care practices? If so, how?

6. What about your self-care experience do you most want to be heard?

7. Movement prompt: Is there anything from the interview that resonated with you on a body-level, which you would like to reflect through movement?