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HOW FEAR AND ANXIETY IN RESPONSE TO COUNTERTRANSFERENCE AND
SOMATIC COUNTERTRANSFERENCE IMPACTED THE CLINICAL DECISION-
MAKING OF A DANCE/MOVEMENT THERAPY INTERN

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Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Department of Creative Arts Therapies

August 2015

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Abstract

This artistic inquiry self-study explored how fear and anxiety, in response to countertransference and somatic countertransference, impacted the clinical decision-making process of a dance/movement therapy intern. Primary questions surrounding the research included: How did fear and anxiety, in response to countertransference and somatic countertransference, impact the clinical decision-making of myself as a dance/movement therapy intern? Was what I experienced, as a dance/movement therapy intern, both fear and anxiety? How did I physiologically experience and embody fear and anxiety in response to countertransference and somatic countertransference? Data were collected in the form of journal entries and video recorded movement and were analyzed concurrently through the use of creative synthesis. Findings indicated that I experienced both anxiety and fear in response to countertransference and somatic countertransference. I experienced anxiety prior to becoming aware of countertransference and somatic countertransference resulting in physiological sensations, which included shallow breath and muscle tension. Physiological signs, which were associated with anxiety, indicated the possible presence of countertransference and somatic countertransference. Identification of both countertransference and somatic countertransference, and their link to feelings of anxiety, resulted in fear. Fear allowed me to respond to the clinical challenges that arose from both these phenomena and aided me in choosing effective interventions. Implications suggested that knowledge of physiological sensations, associated with anxiety, helped to indicate the presence of countertransference and somatic countertransference and aided in creating effective interventions.

Acknowledgments

Thank you to my whole family for your constant support and encouragement throughout the thesis process and graduate school and thank you for always believing in me. Thank you to the entire Department of the Creative Arts Therapies faculty for your guidance, knowledge, and support. Thank you to Laura Downey, my thesis advisor, for giving me the push I needed to pursue this topic for my thesis and for supporting me throughout this process. I would also like to thank Bethany Brownholtz and Sara Broussard for your help in bringing my thoughts to the page. Thank you to Crystal Smith for your time and your thoughtful reflections during the data collection process and for agreeing to enter into this journey with me. Thank you to both of my site supervisors, Cricket Duncan and Ellie Trif, for your support throughout my experience as a practicum student and an intern. Your guidance and help were greatly appreciated and aided in the creation of this piece. Thank you to Andrea Brown, my reader, for your time, help, and support.

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Chapter One: Introduction

The process of becoming a therapist of any sort is wrought with a number of clinical decisions that can be anxiety provoking. A therapist makes clinical decisions regarding a client's treatment goals as well as the interventions that will be effective in helping their client to meet those treatment goals. While some clinical decisions are routine, others can prove to be challenging, particularly in the earlier stages of becoming a therapist. Some have termed the early stages of counselor development as the novice stage (Ronnestad & Skovholt, 2013). During the novice stage, a counselor begins to develop personal philosophies as a therapist and is often presented with many challenging aspects of counseling for the first time (Ronnestad & Skovholt, 2013). My experience as a dance/movement therapy intern was no different. I began my dance/movement therapy internship at a behavioral health hospital during my second year as a student. Despite having applied various counseling and dance/movement therapy techniques during my time as a practicum student, I was still nervous with anticipation as I began my internship.

My first few months as an intern were filled with a number of emotions, which provided challenges as I entered my new role as a dance/movement therapy intern. I often felt disoriented, exhausted, stressed, fearful, anxious, and overwhelmed when working with clients and I feared that these emotions would have a negative impact on my clinical decision-making. Clinical decision-making is defined as a continual process of assessing clients and then selecting effective interventions based on the assessments that are made (Laiho, et al., 2013). Over time, I found that my clinical decision-making was impacted by the onset of various emotions, particularly those of fear and anxiety. When dealing with fearful or anxiety provoking situations, I often froze, or became inhibited, when contemplating what clinical interventions to make. Freezing is

defined as paralysis that is often experienced with muscles that either slack, like when a mouse is caught by a cat, or stiffen, like when a deer is caught in headlights (Rothschild & Rand, 2006, p. 102). During freezing an individual may have an almost dissociative experience in which there is “an altered sense of time and space, reduced registration of pain, and dampened emotions” (Rothschild & Rand, 2006, p.102). Though freezing appears to be a reaction of which we have no control over (Rothschild & Rand, 2006), it often caused me to become frustrated with myself. I could not understand why I had such difficulty transitioning into this new role in my second fieldwork experience when I felt that I had some successes in my first fieldwork experience. I questioned whether the fears and anxieties I was facing as an intern were normal and I wondered if these emotions were similar to what other counselors-in-training had experienced.

Many counselors-in-training identified experiencing emotions of both fear and anxiety as well during their time as students (Ronnestad & Skovholt, 2013; Skovholt & Ronnestad, 2003). Typically, the experiences of fear and anxiety have been defined as separate emotions. Fear has been defined as a situation in which an individual has an identifiable source of discomfort or unease (Bourke, 2005). This feeling is in response to the immediate onset of an event rather than the anticipation of an event as in the case of anxiety (Bourke, 2005). Alternatively, anxiety has been defined as general feelings of unease or discomfort, which cannot be linked to a specific source or situation (Bourke, 2005). This feeling is in anticipation of an event rather than in response to the immediate onset of an event (Bourke, 2005).

Feelings of anxiety within the therapeutic process have been linked to the experience of countertransference (Gelso & Hayes, 2007; Hayes & Gelso, 1991). A number of studies have suggested that the presence of anxiety in therapy was often an indication that countertransference was occurring (i.e. Gelso & Hayes, 2007; Hayes & Gelso, 1991). Countertransference, defined

as the therapist's reaction to the patient's own infantile wishes, projections, and object relations that the patient places on the therapist, was initially rooted in psychodynamic theory (Freud, 1910; Pallaro, 2007). I questioned whether or not some of the fears and anxieties that were causing me to feel overwhelmed were the result of countertransference. However, I noticed that some of my experiences did not seem to coincide with the operational definition of countertransference which psychodynamic theory refers to as a cognitive experience.

While I experienced a number of emotions towards my clients that may or may not have been influenced by countertransference, I experienced a number of visceral responses to my clients as well. When working with my clients, I often experienced muscle tension, bodily pains, sunken body posture, timeless movement and elevated heart rate. I could not understand these visceral reactions as countertransference because psychodynamic theory (Freud, 1910) referred to countertransference as a cognitive, rather than visceral, experience. As a result, I questioned what phenomena influenced the visceral responses that I was having towards my clients. I researched the experiences of countertransference reported by dance/movement therapists and came across the term somatic countertransference. Many dance/movement therapists have acknowledged the existence of somatic countertransference (Ben-Asher et al., 2002; Dosamantes-Beaudry, 2007; Pallaro, 2007; Rothschild & Rand, 2006; Stone, 2006; Wyman-McGinty, 1998). Somatic countertransference has been defined as the bodily felt responses and reactions that occur in the therapist during the therapeutic process in response to the bodily felt sensations of their client (Bernstein, 1984; Pallaro, 2007). I noticed that many of the bodily responses I had towards my clients were consistent with responses that other therapists had reported when describing incidences of somatic countertransference. This led me to question if I

was not only experiencing countertransference but somatic countertransference as well when working with my clients.

Problem

I was uncertain of whether I was experiencing countertransference and somatic countertransference when engaging in the therapeutic relationship. Furthermore, I was unsure of whether countertransference and somatic countertransference were influencing my feelings of fear and anxiety that caused me to freeze when making clinical decisions. My inability to identify some of the emotional and visceral responses I was experiencing created challenges when making clinical decisions and caused disconnection between my clients and myself.

Disconnection with my clients posed a problem as dance/movement therapy is rooted in an improvisational therapeutic approach, which relies heavily on the therapist's ability to make clinical decisions and interventions based on the client's current presentation (Levy, 2005; Sandel, Chaiklin, & Lohn, 1993). I often used the first 15 minutes of the session to assess the current presentation of the clients and determine which interventions would be necessary and effective for the session. My ability to make effective clinical decisions regarding client interventions was negatively impacted when I had difficulty connecting with my clients. I questioned if this disconnection between my clients and myself was the result of fear and anxiety in response to countertransference and somatic countertransference. I suspected it might be.

As a dance/movement therapist in training, I was interested in understanding how fear and/or anxiety, in response to countertransference and somatic countertransference, could impact my clinical decision-making. I also was curious about how the experience of fear and/or anxiety, in response to countertransference and somatic countertransference, could help me to further empathize with and connect to my clients. I was interested to see if countertransference and

somatic countertransference, when attended to mindfully, could impact my clinical-decision making positively rather than negatively by allowing me to more deeply connect with my clients.

Theoretical Framework

I used a combination of counseling and dance/movement therapy theories that place importance on the client finding connection with themselves and others. The theoretical approaches I used to encourage my clients to form intra and interpersonal connections were rooted in a counseling theory known as relational-cultural theory (RCT) along with cognitive-behavioral therapy techniques. I used these counseling theories and techniques in combination with both Chacian and Schoopian dance/movement therapy approaches. These theoretical approaches encourage personal growth by helping clients to understand the benefits of connecting with others and practicing the strategies that lead to positive intrapersonal as well as interpersonal connections (Ivey, D'Andrea, & Ivey, 2012; Levy, 2005; Sandel et al., 1993).

Relational cultural theory. RCT is rooted in the understanding that positive interpersonal connections can aid an individual in achieving personal growth throughout the lifespan (Ivey et al., 2012). Despite the fact that many individuals desire connection with others, they may engage in different maladaptive behavioral patterns that prevent them from forging healthy relationships and positive connections with others (Ivey et al., 2012). RCT focuses on improving an individual's ability to find connection with others by correcting maladaptive behavioral patterns that often create disconnection (Ivey et al., 2012). RCT explores how to correct disconnection by engaging clients in the five good things (Miller, 1988).

In order to approach the DMT sessions that I lead from a relational cultural framework, I engaged clients in the five good things (Miller, 1988): increasing energy, creating a sense of self-worth, increasing motivation to take action, increasing the clients knowledge of themselves,

and creating a desire for more connection. I encouraged connection by engaging clients in therapeutic movement experientials that fostered personal reflection, teamwork, and collaboration. This resulted in the clients increasing their energy together to achieve a common goal. It created a sense of self-worth in the clients because they were carrying out a task as a team member. The therapeutic movement experientials encouraged clients to take action to achieve a common goal. It increased clients' knowledge of themselves by allowing them to identify different aspects of the experientials they found challenging or simple. After engaging in different therapeutic movement experientials, clients often expressed a desire to continue connecting to others. I encouraged these positive reactions in the context of dance/movement therapy sessions by engaging clients in cognitive-behavioral techniques such as stress management and assertiveness training.

Cognitive-behavioral techniques. The main cognitive-behavioral techniques that I employed during therapeutic experientials were stress management and helping clients to cope with their environment (Ivey et al., 2012). Stress management has three phases which include: Helping clients to identify the role that stress plays in their lives, providing clients with specific coping skills so that they may effectively deal with stress, and working through thoughts and feelings that a client has towards stress-inducing situations so they may become motivated to deal with these stressful situations outside of therapy (Ivey et al., p. 304). One experiential, which I used to encourage all three of these phases, was called group juggle. During group juggle, each group member tossed a beanbag to one group member and then received a beanbag from another group member. The group member that each client received the beanbag from and tossed the beanbag to remained the same throughout the experiential, however the number of beanbags that were in play continued to increase as the experiential went on. Afterwards clients

reflected on the experience. Group members identified situations of stress within the experiential such as dropping the beanbag or over throwing the beanbag as a result of being rushed. Clients then related these feelings symbolically to their lives. Some discussed the feeling of dropping the beanbag as similar to dropping the ball in their life when they are feeling rushed at work or at home. Clients came together across their differences and engaged in conversation about how to cope with these situations by symbolically discussing how they coped during the experiential. Group members discussed the importance of focusing on one thing at a time or reaching out to others and working together. Clients then demonstrated motivation to deal with the stressful situations in their life by using the insight they gained in the experiential as they applied it to issues related to their personal lives.

I used movement experientials to further engage clients in cognitive-behavioral techniques that focused on helping clients to cope with their environment (Ivey et al., 2012). I did this by engaging clients in dance/movement therapy experientials that focused on helping clients to “anticipate difficult situations”, “regulate their thoughts and feelings”, “diagnose necessary support skills”, and “regulate consequences” (Ivey et al., 2012, p. 313). Often during verbal reflection of movement experientials, clients brought up difficult situations such as school and discussed how to cope with the environment based on what they had learned from the experiential. With the beanbag experiential, some students mentioned they could work on focusing on one thing at a time in order to cope with feelings of anticipation related to homework or assignments. To help client’s to regulate their thoughts and feelings I brought in different meditative and mindfulness techniques for clients to practice and reflect on. Clients often identified whether the meditation or other stress reduction techniques we worked on would be effective support skills to use when maintaining the behavioral changes they were working on in

therapy. Lastly, experientials were often followed with reflections on how the clients would maintain the positive behavioral changes they had made. Often clients discussed changes they had noticed in themselves, such as feeling more positive or social, as motivators they would use to continue to engage in the effective support skills and coping skills they had learned in the hospital. Clients also discussed joining support groups outside of the hospital, such as Alcoholics Anonymous, in order to continue to find connection with others that would foster positive support in maintaining the changes they had made in their life

Chacian Theory. Chacian theory was founded on the basis that individuals could find healing and connection with one another through dance (Levy, 2005; Sandel et al., 1993). Chace's theory developed these connections by implementing her four core concepts: body action, rhythmic group activity, symbolism, and therapeutic movement relationship (Levy, 2005; Sandel et al., 1993). Body action enables clients to find connection within their own bodies by exploring the experience of moving different parts of the body to music (Levy, 2005; Sandel, et al., 1993). Rhythmic group activity allows clients to connect with one another by creating a shared rhythm that group members engage in with one another through movement that may include clapping, tapping of the feet or swinging arms to the beat of music (Levy, 2005; Sandel et al., 1993). Symbolism allows group members to share their experience of movement and any symbolic meaning that the movement they are engaging in may have for them (Levy, 2005; Sandel et al., 1993). The therapeutic movement relationship, in particular, fosters connections among group members and the therapist through a process referred to by Chace as picking up (Sandel, et al., 1993).

Picking up, often referred to as empathic reflection, is a process that Chace used to further empathize with and understand her clients (Sandel et al., 1993). Chace often picked up

on the emotions of her clients by engaging in a technique that is referred to as mirroring (Levy, 2005, Sandel et al., 1993). Mirroring, also known as kinesthetic empathy, may occur during the empathic process of picking up (Levy, 2005; Sandel et al., 1993). When mirroring, a dance/movement therapist does not simply reproduce the actions of their client. Mirroring has been further defined as the dance/movement therapist's ability to, "kinesthetically and visually experience that which the patient was experiencing and trying to communicate" (Levy, 2005, p. 24). It has been referred to as, "...Participating in another's total movement experience, i.e., patterns, qualities, emotional tone, etc." (Sandel et al., 1993, p.100). A dance/movement therapist engages in mirroring by fully embodying all aspects of the client's total movement experience including the client's affect, respiration pattern, gestures, postures, muscular tension, movements, and vocal intonations (Rothschild & Rand, 2006; Sandel et al., 1993). The therapist may also demonstrate mirroring by associating an image with a particular movement in order to expand the movement repertoire of their clients and further explore emotions associated with the movements being presented (Sandel et al., 1993). Embodying the client's total movement experience allows a dance/movement therapist to more deeply understand and empathize with their client.

I used mirroring not only to better empathize with my clients but to encourage my clients to mirror one another in order to develop their own empathy skills. The use of mirroring helped to facilitate not only a therapeutic movement relationship but the three other core concepts as well. Body action, rhythmic group activity, and symbolism are all components that may be encouraged through the technique of mirroring one another's movement (Levy, 2005; Sandel et al., 1993). I used the group member's movement that was derived from mirroring to develop the other three core concepts and presenting movement themes through the use of structured

movement experientials. Structured movement experientials were comprised of either therapeutic movement games or opportunities for clients to choreograph a piece using some of the improvisational movement they explored during a session dance/movement therapy sessions. The technique of applying the four core concepts to a choreographed piece more closely aligns with Schoopian theory as Chace developed her four core concepts through the exploration of improvisational movement (Levy, 2005; Sandel et al., 1993).

Schoopian Theory. Schoopian theory values the improvisational movement of group members within a structured and organized experience (Levy, 2005). Schoop defined improvisational movement as, “a process of nonverbal free association during which the individual permits his body to move spontaneously and unguardedly (Schoop & Mitchell, 1974, pg. 143)”. Schoop felt that improvisational movement was important in creating a cathartic experience for a client. However, she believed that this improvisational cathartic experience, defined as a process in which a client openly expresses their emotions in order to gain a deeper “understanding of and appreciation for the psychological forces that impact their lives” (Ivey et al., pg. 246), then needed to be processed in an organized and structured manner to create meaning and understanding for the clients (Levy, 2005). She helped clients to make meaning of these improvisational movement experiences by encouraging them to create choreographed pieces and to perform for one another (Levy, 2005). She also instilled empathy and humor in clients by engaging in the technique of mirroring and exaggerating her client’s movement (Levy, 2005).

I integrated these aspects of Schoopian theory when leading DMT group sessions by encouraging clients to make meaning of improvisational movement by engaging clients in structured movement experientials that often included dance/movement therapy techniques such

as mirroring. Group members were given opportunities to explore movement improvisationally but then were given a structured opportunity in which to process the movement that was developed. For example, I gave group members the opportunity to explore what Schoop termed opposites, meaning that group members explored opposite movements such as push and pull or mobility and stability (Levy, 2005). Like Schoop, I encouraged clients to explore the feeling of these opposites in different parts of the body at the same time in order to experience what disconnection and disorganization felt like in the body (Levy, 2005). For example, I encouraged clients to explore what it felt like to move one leg around while keeping the other leg in one spot. We then used these improvisational movements that were developed to either create a structured piece of choreography or engage in a structured movement game. The exaggeration with which the improvisational movements were performed, in both the context of a structured piece and a movement game, gave rise to humor. As Schoop discussed, this humor allowed clients to view their situation from a different perspective in which they were able to connect to one another through laughter despite the seriousness of their situation (Levy, 2005). These experientials were followed by verbal processing during which clients identified the symbolic movement themes associated with disconnection. Group members then processed how one reconnects with themselves as well as others within their external environment.

Purpose of the Research

Because the very nature of dance/movement therapy is often rooted in an improvisational approach to therapy, the current presentation of the clients at the start of the group determined the clinical decisions I made. These situations were compounded by the presence of fear and anxiety that I suspected were arising because of countertransference and somatic countertransference. Therefore, I set out to explore the impact of fear and anxiety in response to

countertransference and how this impacted my clinical decision-making process and development as a dance/movement therapy intern. Furthermore, I explored and implemented strategies, which I hoped would prove useful in addressing symptoms of fear and anxiety, in response to countertransference and somatic countertransference, in not only myself but future mental health professionals.

Chapter Two: Literature Review

Countertransference, somatic countertransference, fear, and anxiety appear to be widely recognized experiences that many psychotherapists have encountered at some point in their clinical practice (Gelso & Hayes, 2007; Hayes, Nelson, & Fauth, 2015; Menninger, 1990). Despite this finding, many counselors and trainees, in particular, appeared to conceal experiences of countertransference, somatic countertransference, fear and anxiety (Ronnestad & Skovholt, 1993; Smith, 2003; Yourman & Farber, 1996). As a result much of the literature in this area consists mainly of theoretical considerations rather than empirical evidence (Smith, 2003). The literature that exists suggested that the experience of fear within the counseling field was often related to situations that were ambiguous in nature and occurred suddenly (Dupre et al., 2014; Richards, 2000; Smith, 2000; Smith, 2003). Counselors often identified the following situations as fearful: suicide assessment, loss of control within the therapeutic relationship, malpractice, and termination (Menninger, 1990; Richards, 2000; Smith, 2000; Smith, 2003). Counselors also reported anxiety and feelings of anticipation in relation to death, trauma work, and countertransference (Dupre et al., 2014; Richards, 2000; Rothschild & Rand, 2006).

The literature suggested that countertransference, somatic countertransference, fear, and anxiety appeared to decrease in counselors who have had more experience (Gelso & Hayes, 2007; Ronnestad & Skovholt, 2013). Counselors in training reported higher levels of anxiety and reportedly experienced more countertransference (Gelso & Hayes, 2007). It has been suggested as a result of these findings, that the experience of both fear and anxiety may indicate the presence of countertransference within the therapeutic relationship (Gelso & Hayes, 2007).

Countertransference

Many mental health professionals have discussed not only the frequency with which countertransference appears within the therapeutic relationship, but also the ways in which it may impact the therapeutic relationship (Ben-Asher et al., 2002; Ellis, 2001; Gelso & Hayes, 2007; Hayes & Gelso, 1991; Miller, 2000; Pallaro, 2007; Richards, 2000; Rothschild & Rand; 2006; Stone, 2006; Wyman-McGinty, 1998). While some have described countertransference as potentially harmful to the therapeutic relationship, others have argued that countertransference may benefit the therapeutic process of the client if the therapist attends to it in both a mindful and intentional manner (Gelso & Hayes, 2007; Rothschild & Rand, 2006). Though countertransference appears to be a common phenomena experienced by most mental health professionals not all counseling theories acknowledge that such a phenomena exists (Gelso & Hayes, 2007; Hayes, Nelson, & Fauth, 2015; Ivey et al., 2012). The main counseling theory to not only define but also recognize the existence of countertransference is psychodynamic theory (Gelso & Hayes, 2007; Ivey et al., 2012).

Psychodynamic Theory

Psychodynamic theory places a significant amount of importance on exploring the client's unconscious in order to solve the presenting problems the client brings to therapy (Ivey et al., 2012). Freud believed that the unconscious played a role in the human development and psychological problems that clients faced (Ivey et al., 2012). Freud felt that the psychological problems that an individual experienced were somehow linked to different thoughts, feelings and experiences that a client had endured unconsciously (Ivey et al., 2012). In fact, the word unconscious has been defined as "lack of awareness of one's own mental functioning" (Ivey et al., 2012, p.179). Psychodynamic theory looks into a client's past developmental history to

understand the client's presenting psychological problem (Ivey et al., 2012). Specifically, psychodynamic theory explores the client's past object relations, or "relationships the client has developed with important people and the continuing impact that these relational experiences have on their lives" (Ivey et al., 2012, p. 180). Freud believed that it was through object relations that an individual identified the cause for some of the psychological problems that the client might face (Ivey et al., 2012). For example, if an individual grew up in a household with a very anxious mother, the individual may also have identified with these feelings and as an adult became very anxious as well. These object relations may also come up in the course of therapy and the individual may begin to place some of their unconscious object relations onto the therapist in a process known as transference (Ivey et al., 2012).

Transference. Transference is the process in which the client is "literally transferring the feelings and thoughts they have towards other people onto the counselor" (Ivey et al., 2012, p. 210). For example, a teenager may begin to transfer feelings they have towards their father onto the therapist as another adult attempting to control their life. The teenage client may then start to treat the therapist in a manner consistent with how he treats his father. The reactions and responses a therapist has towards the client's transference, that are rooted in the therapist's past experience are known as countertransference (Gelso & Hayes, 2007).

Countertransference. Countertransference is developed in response to the transference that a client places upon the counselor (Ivey et al., 2012). Freud (1910) defined countertransference as a therapist's "unconscious reactions to the patient which needed to be identified and eliminated in order not to interfere with treatment" (p. 177). However, while some therapists believe countertransference to be maladaptive to the therapeutic relationship others have embraced it as a tool from which to access the patient's unconscious experience (Pallaro,

2007; Wyman-McGinty, 1998). Many clinicians have identified countertransference as a phenomenon from which to further understand the unconscious projections that a client places upon the therapist (Pallaro, 2007).

Though countertransference is widely viewed as a phenomenon that is often the result of object relations that the client places upon the therapist it has been categorized into different countertransferential responses (Gelso & Hayes, 2007; Ivey et al., 2012; Racker, 1968). Racker (1968) defined countertransference proper as two separate countertransferential responses. The first type is known as concordant which occurs when the therapist is empathizing with the client (Racker, 1968). The second response, complementary countertransference, occurs when the therapist begins to react to the client with behavioral patterns consistent of the bad object the client has projected onto the therapist (Racker, 1968).

Complimentary Countertransference. Complimentary countertransference was first defined as the result of the patient transforming the therapist into an aversive object from their past or their present. Identifying the client as an aversive object was thought to activate an aversive side of the therapist's self, resulting in countertransferential reactions towards the client. The therapist may be annoyed or angry because the client has provoked a negative or unwanted part of the therapist that they do not wish to share with their client (Gelso & Hayes, 2007).

Concordant Countertransference. Concordant countertransference occurs when a therapist empathizes with their clients (Carverth, 2012; Pallaro, 2007). The therapist achieves this empathic state of countertransference by personally identifying a clients id with their id, a client's ego with their ego, or a client's superego with their superego (Carverth, 2012). While many see concordant countertransference as a legitimate phenomenon much debate still exists about what exactly Racker (1968) meant on a conscious level when discussing concordant

countertransference (Carveth, 2012). Racker (1968) has defined concordant countertransference as the result of preconscious, conscious, and unconscious empathy. However, Carveth (2012) has argued that concordant countertransference may only result when a therapist can preconsciously or consciously identify their id with the id of their clients, their ego with the ego of their clients, or their superego with the superego of their clients. He further argued that if this process takes place within the therapist's unconscious then it is likely projective identification, as the therapist is not consciously aligning any aspects of themselves with the selves of the client (Carveth, 2012).

Projective identification. Because the experience of countertransference exists under many different subtypes, countertransference is often confused with projective identification. Some have even termed projective identification as a type of countertransference while others have suggested that it is a separate concept (Carverth, 2012; Rothschild & Rand, 2006). Rothschild and Rand (2006) described countertransference responses as reactions a therapist had towards a client which were rooted in the therapist's past experiences. For example, a therapist may notice they become annoyed by the presence of a specific client. Upon examining their response they may begin to notice a type of complementary countertransference in which the therapist is annoyed by their client because the client feels lonely and this emotion stirs up past emotions that the therapist held during a similar time in their past (Pallaro, 2007).

In the situation of projective identification, a therapist may feel sad in response to a client that expresses feeling lonely. After the client has expressed their loneliness they may no longer feel sad yet the therapist feels an overwhelming amount of sadness towards their client. In this situation the therapist is holding onto and containing the feelings of sadness rather than the client (Rothschild & Rand, 2006). Though projective identification may provide the therapist

with insight into the client's feelings it can also have a detrimental impact on the therapist, especially if the therapist begins to unconsciously empathize when attuning with their clients (Rothschild & Rand, 2006). In either case it is important that a therapist remain aware of projective identification as it may lead a therapist to engage in a phenomena known as chronic countertransference.

Chronic countertransference. Gelso and Hayes (2007) characterized chronic countertransference as a phenomenon that many therapists experience at some point in their practice. Chronic countertransference occurs when a therapist projects certain habitual needs onto their clients (Gelso & Hayes, 2007). For example, a therapist may promote the more energetic and active sides of their patients because of fears they had towards their own passive side (Gelso & Hayes, 2007). By engaging the active side of their client the therapist also avoids engaging in the passive side of themselves. However, engaging the client's active side could inhibit the therapeutic process by not allowing the client to explore how to safely reside in a passive state of mind.

Acute countertransference. Acute countertransference on the other hand occurs during specific situations with specific clients (Reich, 1951). Rather than being attributable to more schematic and generalizable situations, acute countertransference occurs "under specific circumstances with specific patients" (Reich, 1951, p. 26). These specific circumstances may differ across practicing mental health professionals. While one therapist may experience feeling depressed in the presence of clients who are assaultive as a result of having a father who was assaultive, another therapist may continue to reinforce a client's submissiveness due to their need to be dominant or in control (Gelso & Hayes, 2007).

While most of these topics have debated the definitions and meanings of a wide variety of countertransference responses within the therapeutic relationship, they remain within the realm of countertransference that is experienced cognitively. An additional form of countertransference is known as somatic countertransference (Bernstein, 1984; Pallaro, 2007; Rothschild & Rand, 2006). Somatic countertransference is a visceral rather than cognitive experience (Bernstein, 1984; Pallaro, 2007; Rothschild, 2006).

Somatic countertransference

Though the topic of transference and countertransference has been in existence since 1910, it was not until recently that researchers began to explore a newer concept known as somatic countertransference (Bernstein, 1984; Dosamantes-Beaudry, 2007; Pallaro, 2007; Rothschild & Rand, 2006). While countertransference results from the emotional projections a patient has placed on their therapist during the therapeutic process, situations termed somatic countertransference and embodied countertransference focus on the therapist's bodily felt sensations in response to the bodily felt sensations of their clients (Bernstein, 1984; Pallaro, 2007). Embodied and dance/movement therapists have begun to study this work to further understand how countertransference may impact a therapist physiologically (Ben-Asher et al., 2002; Pallaro, 2007; Rothschild & Rand, 2006; Stone, 2006).

Some common sensations associated with somatic countertransference, include dizziness, pain, hunger, fullness, claustrophobia, sleepiness, restlessness, and sexual arousal (Pallaro, 2007). Other sensations that have been reported as a result of somatic countertransference included pains, aches, and shortness of breath (Stone, 2006). Though clinicians often report that somatic countertransference, if undetected, can hinder the therapeutic relationship, it can also,

when recognized and used effectively, be a helpful source for understanding and empathizing with a client (Dosamantes-Beaudry, 2007; Pallaro, 2007).

Many clinicians have viewed somatic countertransference as a phenomenon from which to further empathize, understand, and treat their clients (Ben-Asher et al., 2002; Dosamantes-Beaudry, 2007; Gelso & Hayes, 2007; Pallaro, 2007; Rothschild & Rand, 2006; Stone, 2006; Wyman-McGinty, 1998). Stone (2006) described somatic countertransference as metaphorically similar to a tuning fork. She discussed that the bodily felt responses the therapist had towards the client could assist the therapist in attuning to the emotions of their client (Stone, 2006). Ben-Asher et al. (2002) further described somatic countertransference as a phenomenon that may be used to further understand the client's unconscious.

Ben-Asher et al. (2002) discussed a case study in which somatic countertransference was used to inform a therapist of a potentially abusive situation that their client had been exposed to. The therapist was able to identify somatic countertransference within the therapeutic relationship and correlate their embodied response to countertransference with symptoms consistent in children who have been the victim of sexual abuse. The somatic countertransference that the therapist experienced within the therapeutic relationship led the therapist to question whether or not the client had been sexually abused at some point in their life. The therapist asked the client's parents if the client had a history of being sexually abused. The client's parents confirmed that the client's sister was sexually abused but were unaware if the offender had abused their other daughter as well. The therapist was able to use the information gained from somatic countertransference to identify that the client had been sexually abused as well. The therapist was then able to use this information to help the client to resolve some of the maladaptive behavior the client had developed as a result of the abuse.

Despite the fact that many therapists have identified the experience of somatic countertransference as well as countertransference as helpful when attempting to access the patient's subconscious thoughts and emotions, it is not a phenomena that is recognized by all theoretical orientations (Gelso & Hayes, 2007; Pallaro, 2007; Wyman-McGinty, 1998). Though some theoretical orientations such as cognitive therapy, cognitive-behavioral theory and relational cultural theory, have begun to recognize countertransference, the ways in which situations of countertransference are defined and approached differ from traditional psychoanalytic theory (Haarhoff, 2006; Ivey, 2013; Malove, 2014; Shaeffer, 2014). Despite the fact that different theoretical orientations define and approach countertransference in slightly different manners, many believe that a clinician will experience countertransference at some point while practicing (Gelso & Hayes, 2007; Halperin, 1991; Hayes, Nelson & Fauth, 2015; Prasko et. al, 2010).

Countertransference and Theoretical Orientation

Countertransference was initially defined by Freud (1910) within the theoretical framework of psychoanalytic theory. It has since been acknowledged as a clinical complexity that impacts therapists across all theoretical orientations (Halperin, 1991; Hayes et al., 2015; Prasko et al., 2010). A number of studies have examined the impact of countertransference across a diverse set of therapists who identify with a pure, eclectic, or integrated theoretical approaches which sometimes differ from psychodynamic counseling theories and techniques (Arnd-Caddigan, 2013; Cain, 2000; Ganzer, 2013; Lantz, 1993; Malove, 2014; Mark, 1998; Ponton & Sauerheber, 2014; Shaeffer, 2014). The literature has collectively shown countertransference as a phenomenon that all therapists experience regardless of their theoretical

orientation (Halperin, 1991; Hayes et al., 2015; Prasko et al., 2010). While many therapists from various theoretical orientations have reported experiencing countertransference within their work, few detailed accounts that exist address the experience of countertransference within theoretical orientations other than psychodynamic theory (Arnd-Caddigan, 2013; Cain, 2000; Ganzer, 2013; Hayes et al., 2015; Ivey, 2013).

Despite the fact that research addressing the experience of countertransference from a theoretical framework other than psychodynamic theory appears to be rare, it does exist. Researchers have examined the impact of countertransference across a range of theoretical orientations, which include cognitive therapy, relational emotive behavioral therapy, and relational-cultural therapy (Arnd-Caddigan, 2013; Cain, 2000; Ganzer, 2013; Haarhoff, 2006; Hayes et al., 2015; Malove, 2014; Ponton & Sauerheber, 2014; Shaeffer, 2014). Cognitive therapy (CT) is one theoretical orientation with research that addressed the differences between approaching countertransference from a psychoanalytic versus a CT framework (Haarhoff, 2006; Ivey, 2013).

Cognitive Therapy. CT approached the experience of countertransference as different from the original definition (Freud, 1910). This is largely due to the fact that cognitive therapy does not recognize the unconscious thought that Freud (1910) defined as occurring in instances of transference and countertransference (Ivey, 2013). Instead, cognitive therapy defined countertransference as “the therapist’s cognitive, emotional, and behavioral reactions to the patient which are conscious and accessible to the therapist” (Haarhoff, 2006, p. 127). This definition addressed the reactions that a therapist may have towards a client but unlike the traditional psychoanalytical definition of countertransference, cognitive therapy does not specify countertransferential reactions as being rooted in the clinicians’ past experiences or unconscious

(Haarhoff, 2006; Ivey, 2013). This distinction is intentional in order to distinguish the psychoanalytical and cognitive approaches towards countertransference (Haarhoff, 2006; Ivey, 2013).

In psychoanalytic theory, the fate of the client rests on the therapist's ability to identify and grow transference within the therapeutic relationship in order to assist the client in healing (Ivey, 2013). Through the framework of cognitive therapy, transference is not the main focus and as a result neither is countertransference (Ivey, 2013). Overall, cognitive therapy identifies countertransference as potentially useful when attempting to discern different schematic relationships of the client but does not find that transference or countertransference to exist in every therapeutic case (Ivey, 2013). As a result of this discrepancy, little research exists exemplifying the experience of countertransference using cognitive therapy (Ivey, 2013).

Relational cultural theory. Similar to cognitive therapy, relational cultural theory addresses countertransference in a slightly different manner than psychodynamic theory. Unlike psychodynamic theory, relational cultural theory puts an emphasis on the client and the counselor engaging in a process of mutual empathy and self-disclosure in order to deepen the perspective that both have throughout the therapeutic process (Ivey et al., 2012). The process of mutual empathy, impacts both the client and the counselor allowing them both to become aware of some of the maladaptive experiences and what psychodynamic theory would term maladaptive object relations of the client's past (Ivey et al., 2012). Unlike psychodynamic theory, in RCT the client and the counselor engage in an egalitarian relationship (Ivey et al., 2012). This results in the therapist and client working together to create a corrective emotional experience that repairs the client's maladaptive behaviors of the past that have prevented the client from forming positive relationships (Ivey et al., 2012).

A couple of case studies have elaborated on the use of countertransference within RCT (Malove, 2014; Shaeffer, 2014). Malove (2014) demonstrated how countertransference might improve the therapist's ability to relate to the client by deepening their understanding of the client's situation. Malove (2014) discussed the maladaptive relationships that her client had engaged in. Her client had been referred due to the fact that peers who were previously her friends were victimizing her. Eventually Malove (2014) discussed how the maladaptive relationships of the client became re-enacted within the therapeutic relationship as a result of countertransference. Malove (2014) discussed how her client began to take on the role of the victimizer within the therapeutic relationship and the therapist took on the role of the victim. Malove (2014) reported that she gained a stronger understanding of what her client experienced as well as what her client needed as a result of the countertransference that ensued. Malove (2014) was able to use this information to identify that the client had felt abandoned by her peers and her previous relationship with her mother and needed the therapist to stand by her.

Shaeffer (2014) also discussed how approaching countertransference from a RCT approach strengthened his understanding of his client. Shaeffer (2014) discussed his experience of countertransference when working with a client he highly identified with. Despite the fact that he related to his client in many ways, Shaeffer (2014) refrained from any sort of self-disclosure as psychodynamic theory views self-disclosure as removing the emphasis from the client to the clinician during therapy. Shaeffer (2014) avoided self-disclosure aside from sharing some similar musical tastes with his client. However, once his client expressed his disappointment at the way in which the therapist was treating the client's depression Shaeffer (2014) utilized RCT techniques in order to strengthen his connection with his client. Shaeffer (2014) self-disclosed about his difficulties struggling with depression and engaged his client in

an egalitarian relationship by suggesting they work through the therapeutic process together. Shaeffer (2014) found that after approaching countertransference through an RCT approach his client became more open during sessions. While countertransference may be beneficial to the therapeutic process (Malove, 2014; Shaeffer, 2014), it can also be detrimental if used incorrectly (Rothschild & Rand, 2006).

According to Rothschild & Rand (2006), verbal and non-verbal unconscious mirroring can be detrimental to the therapist and the therapy itself. When a therapist engages in unconscious empathy with their client, it can lead to other phenomena occurring unconsciously within the therapeutic relationship including countertransference, somatic countertransference, projective identification, compassion fatigue, vicarious trauma, and even burnout (Rothschild & Rand, 2006). A state of burnout, may lead a therapist into a chronic state of hyperarousal or anticipation leading to feelings of both anxiety and fear (Rothschild & Rand, 2006).

Fear and Counseling

Many novice and even seasoned therapists in the field have reported feelings such as anxiety and fear during different clinical situations (Dupre et al., 2014; Menninger, 1990; Miller, 2000; Richards, 2000; Smith, 2000; Smith, 2003). Menninger (1990), found that 87 of the 88 psychotherapists being surveyed reported feelings of anxiety in relation to one or more aspects of their work. Other studies have explored feelings of fear in the therapist in relation to a number of different clinical situations including suicide risk assessment, violence, and termination of treatment (Martin & Schurtman, 1985; Menninger, 1990; Skovholt & Mathison-Trotter, 2011). However, despite the global attitude that fear and anxiety may be an integral aspect of the development of mental health professionals, the research in this area of study is limited as well

as dated. Recently, no concrete definition exists that differentiates fear from anxiety across all studies.

Definition of Fear

More recently, fear and anxiety are differentiated in terms of situational application (Bourke, 2005; Clarkson, 2002; Smith, 2003). While fear is often used to describe a specific or concrete object or situation, anxiety was used to describe situations, which are more ambiguous in nature (Bourke, 2005; Clarkson, 2002). Fear, on the other hand, was defined as a feeling of unease, often triggered by the sudden onset of a specific object or situation that initiates arousal of the sympathetic nervous system (Bourke, 2005; Clarkson, 2002; Rothschild & Rand, 2006).

Fear has been studied by many behavioral scientists in relation to a number of situational circumstances (Brodsky, 1988; Dupre et al., 2014; Smith, 2000; Smith, 2003; White & Depue, 1999). Of the literature reviewed, the most common interpretation of fear is that it is the feeling of discomfort or unease that is associated with either a conditioned stimulus, as in the case of phobias such as agoraphobia, or an unconditioned stimulus, as in the case of the sudden or unexpected onset of a familiar object or stimulus (White & Depue, 1999). In situations such as these, prior experience with the object or situation may never have been associated with feelings of fear until encountered in a different context and thus the object or situation becomes conditioned as fearful. Since research in this area is sparse, psychotherapists have begun to study the body's neurophysiologic response to fear in order to better understand both the physical and neurological impact that fear has on an individual (Rothschild & Rand, 2006; Porges, 1995).

Neurobiology of Fear

Fear, whether conditioned or not, is a complex emotion which results in a number of neurobiological responses (Rothschild & Rand, 2006). Whether experienced in response to a specific stimuli, situation or object, fear is first processed by the amygdala, which identifies sources of danger and determines how to react in situations of threat (Rothschild & Rand, 2006). If a situation or stimulus is found to be threatening, the amygdala will sound an alarm sending into motion the autonomic nervous system (ANS) which is made up of two branches: the parasympathetic nervous system (PNS) and the sympathetic nervous system (SNS) (Rothschild & Rand, 2006). The SNS is activated at the immediate or sudden onset of a fearful stimulus (Rothschild & Rand, 2006). When the SNS is activated, a number of physiological responses are induced within the body included but not limited to: increased heart rate, heart palpitations, accelerated respiration, dilation of pupils, increased perspiration, cool skin, and decreased digestion (Rothschild & Rand, 2006). When activated, the ANS may also produce specific hormones known as epinephron, which induces hyperarousal, and cortisol, which assists the body in achieving homeostasis after the activation of the SNS (Rothschild & Rand, 2006). While arousal of the SNS brings the body into a state of hyperarousal, the PNS is activated when either a threatening stimulus is no longer present or is no longer found to be threatening (Rothschild & Rand, 2006). This results in the following physiological symptoms: constricted pupils, slowed respiration, and decreased heart rate and blood pressure (Rothschild & Rand, 2006).

Though little discrepancy exists about the physiological responses induced by the onset of a fearful stimulus the decisional reactions that follow in the presence of these aversive events have been disputed (Grillon et. al, 2004; Porges, 1995; Rothschild & Rand, 2006). While some postulate that fight or flight are the only two responses with which the sympathetic nervous

system responds to a situation of imminent threat, recent literature has suggested otherwise (Rothschild & Rand, 2006; Porges, 1995). Rothschild and Rand (2006) and Porges (1995) have theorized that there are actually three responses that may be triggered by a fearful stimulus. They suggest that in addition to fight or flight a third response, freeze, may also exist (Porges, 1995; Rothschild & Rand, 2006).

Freeze

There is some uncertainty as to what causes the freeze response. Rothschild & Rand (2006) theorized that the freeze response occurs in the presence of a fearful object when both the parasympathetic and the sympathetic nervous system are aroused simultaneously. The dual activation of both the sympathetic and parasympathetic nervous systems ultimately results in the body becoming overwhelmed resulting in the subsequent inhibition or paralysis exhibited during the freeze response (Rothschild & Rand, 2006).

Porges (1995), on the other hand, believed that the freeze response may be the result of another cause. Porges' (1995) polyvagal theory, speculated that the freeze response is triggered not by the dual activation of both the SNS and the PNS, but by the dorsal branch of the vagus nerve. According to Porges (1995), the dorsal branch of the vagus nerve is activated when the fear responder becomes inhibited.

Fright

However, the most recent fear response theories included not only fight, flight, and freeze but also fright as potential responses to danger (Wise, 2009). Similar to the freeze response, the fright response occurs when the body becomes limp (Wise, 2009). However during the fright response the body goes limp in the presence of a dangerous stimulus. This response is often referred to in the primal sense as playing dead (Wise, 2009). An individual may purposely act as

though they are dead or injured in order to appear non-threatening thus ceasing their attacker's actions (Wise, 2009). Evidence in this area of study is still evolving thus fueling the overall discrepancy surrounding whether or not certain factors in the presence of fear contribute to certain stress responses within the ANS.

As fear becomes more prevalent in both a societal and pathological sense, the importance of this subject matter has begun to peak the interest of different counselors in terms of how the fear response in reaction to their clients impacts the behavioral health professionals themselves (Dupre et al, 2014; Gardner, 2008; Menninger, 1990; Richards, 2000; Rothschild & Rand, 2006; Smith, 2000; Smith, 2003). Different behavioral health professionals have affirmed the presence of both fear and anxiety within different clinical contexts (Menninger, 1990). However, while this finding maybe confirmed across many practicing clinicians, the research reporting the impact of such experiences is sparse and consists mainly of theoretical considerations rather than documented qualitative data exhumed from the detailed accounts of practicing clinicians (Smith, 2003). The limited data that exists suggested that clinical situations, which are most frequently feared by clinicians, are often ambiguous in nature and occur suddenly (Martin & Schurtman, 1985; Miller, 2000; Richards, 2000; Smith, 2003).

Ambiguity

While fear is most frequently referred to and defined as an association to a specific situation or object, conditioned or unconditioned, the impact of fear can vary based on the level of ambiguity surrounding it (Bourke, 2005; Martin & Schurtman, 1985; Miller, 2000; Richards, 2000; Smith, 2003). The literature suggests that the level of ambiguity and subsequent uncertainty surrounding each clinical circumstance impacted the overall fear that a clinician experienced in the presence of different clients (Martin & Schurtman, 1985; Miller, 2000;

Richards, 2000; Smith, 2003). While a counselor may encounter feelings of fear and unease in the presence of a particular client the reasons for which they fear that individual may be ambiguous (Miller, 2000). A clinician may exhibit both physiological and emotional manifestations of distress when working with the client yet be unable to explicitly distinguish the cause of such distress (Miller, 2000; Rothschild & Rand; 2006; Smith, 2003).

The most common fears counselors reported when in the presence of a specific client were often related to a specific clinical situation in which the outcome was ambiguous. Suicide assessment, termination, sexual assault, physical assault, loss of control and legal threat are all clinical situations that mental health professionals have identified as fearful and often anxiety provoking because their onset is often sudden and unpredictable (Boyer & Hoffman, 1993; Brodsky, 1988; Dupre et al., 2014; Martin & Schurtman, 1985; Richards, 2000; Smith, 2003). Based on the literature, the most frequent situations of fear occurred within the context of these four categories: fear of losing control, fear of physical or sexual assault, fear of legal liability, and fear of termination (Boyer & Hoffman, 1993; Brodsky, 1988; Dupre et al., 2014; Martin & Schurtman, 1985; Richards, 2000; Smith, 2003).

Loss of control. Therapists reported loss of control as a common fear they encountered when in the presence of a specific client (Richards, 2000; Smith, 2003). Therapists described fear of losing control within the session as a result of countertransference (Richards, 2000; Smith, 2003). Countertransference that is not understood or managed by the therapist may damage the treatment (Ellis, 2001; Gelso & Hayes, 2007). Often times, countertransference which is left somewhat ambiguous to the therapist may lead to issues in terms of boundary setting within the therapeutic relationship (Richards, 2000). One therapist discussed the personal issues countertransference created between her client and herself,

I felt at times completely useless, hopeless as a therapist and a human being, always doing and saying the wrong thing. I also had strong feelings of her dependence and panic at the degree of it. Sometimes the feelings were acknowledged by her to be hers, at other times I carried them all. (Richards, 2000, p. 332)

Feelings such as these may become so intense that the therapist begins to fear the possibility of both the client and themselves losing control of their emotions in the course of a session (Miller, 2000; Smith, 2003).

The presence of countertransference within the therapeutic relationship, as well as the intensity of emotional content, are additional factors which therapists have attributed toward becoming overwhelmed and consequently stressed (Killian, 2008; Miller 2000; Smith, 2003). Smith (2003) identified becoming overwhelmed in a session as one factor, which impacted clinician's fears of loss of control due to its sudden and often ambiguous presence within a session. As one therapist reported,

In truth, we probably fear the patient or ourselves becoming too sexual, or too angry, or too violent, or too noisy. During a recent noisy session, I found myself concerned about colleagues when one of my own patients started shouting loudly. Somehow I felt I was responsible and thus likely to incur my adjacent colleague's displeasure, even though I often hear her client's noise in my room. (Miller, 2000, p. 442).

Similar conclusions have been made by those who engage in therapy that utilize the body and movement as therapeutic techniques (Miller, 2000; Rothschild & Rand; 2006). Miller (2000) discussed his fears of losing control when working with a client through the use of

bioenergetics, a form of psychotherapy that utilizes the body. His client was interested in using movement and the body to further explore his recent suicide attempt, however, his controlling and underlying perfectionism prevented him from moving. He feared that movement may cause him to lose control, but was comfortable verbalizing during sessions. The therapist began to wonder if it was not only the client who feared losing control but if he, the therapist, feared his client losing control as well. The therapist discussed how therapeutic work that engaged the body added a different level of unpredictability to therapy and that it was not always clear what movement might uncover an unexpected implicit or internalized memory. The therapist admitted that because the client began to fear losing control, he also feared the client losing control within the session. He discussed issues of the client's deep seeded rage and his fear that if this rage were unleashed too rapidly, especially through physical exercise, that he might not be able to contain it.

Fear of physical or sexual assault. Other counselors have also reported a fear of their clients losing control and either physically or sexually harming the therapist during a session as a result of overwhelming emotional content (Dupre et al., 2014; Miller, 2000; Smith, 2000; Smith, 2003). Mental health professionals who have reported situations of physical or sexual assault have discussed the suddenness and ambiguity with which the threats present themselves (Dupre et al., 2014; Miller, 2000; Smith, 2003). Smith (2000) shared narratives of two social workers who discussed the suddenness with which their clients attacked them. In another study, clinicians discussed the suddenness with which aggression broke out during crisis situations that not only put the therapists in danger but the other group participants as well (Dupre et al., 2014).

Clinicians also discussed situations in which a client's behavior, either prior to or during treatment, instilled fear in the therapist of being sexually or physically assaulted (Smith, 2003).

One female counselor described a client whose previous relationships with women were typically sexual in nature. She discussed that he often talked about sex and violence, in relation to the anger he felt towards women, within the session. Smith (2003) discussed the possible transference communication underlying the comments the male client had made regarding his tendency to only engage in sexual relationships with women as well as the anger he felt towards them as a possible threat towards the counselor. The ambiguous nature surrounding the transference communication with this client led the therapist to feel fearful for 2 or 3 weeks when walking to the parking lot at night. Another female counselor discussed fears surrounding visiting a client at his home:

The door was suddenly pulled open and he was a man of about four feet and six inches tall and very strange looking. He bolted the door with a number of bolts and I felt trapped. He looked at my wedding ring and I felt uncomfortable. I feared he may sexually assault me. (Smith, 2003, p. 236)

This same therapist had also worked with a client who had acted out violently against others while he was in prison. Again, the client had not acted out aggressively with her but the fact that he had lashed out violently against others caused the therapist to fear him.

Perhaps this fear of control loss remains a general fear in many therapists because if a session does become too emotionally intense, the client may act out against the therapist (Miller, 2000). Also, if the emotions are too overwhelming the client may decide not to return to therapy (Miller, 2000). There is an instilled fear in the therapist that if the session does not stop before the emotional content becomes unmanageable or before the next patient arrives that the therapist will be found incompetent and responsible for the actions and feelings of their client (Miller, 2000; Smith, 2000; Smith, 2003).

Two therapists described feeling this way after they were both the victims of a violent assault (Smith, 2000). In one case, the therapist attempted to follow an agitated client out because she would not be allowed to exit the building without internal permission. In the midst of her client's exit, the therapist was publically attacked in the front lobby of the building. She described the experience,

I wondered if I had fed into the situation in some way. Had I created it? Done the wrong thing? If I hadn't gone after her it wouldn't have happened. You question your tone of voice, your body language. Had I not run after her like that she could have had a less violent exit from the building... You think, 'What if someone else has a go at you? How can they see you as innocent? They will see you as having created it'. There's always that fear. (Smith, 2000, pp. 20-21)

Miller (2000) suggested that perhaps a therapist's fear of losing control, whether as a result of the client or the therapist, is really in light of an even bigger fear: shame. This is a fear held by many who have experienced legal threat or been sued for malpractice (Brodsky, 1988; Poythress & Brodsky, 1992; Smith, 2003). In fact, fear of malpractice has become so prevalent that it has been termed litigaphobia (Brodsky, 1983a, 1983b).

Malpractice. While some deny that litigaphobia has become prevalent in mental health workers, others are in agreement that it has impacted the field in more ways than one (Brodsky, 1988; Poythress & Brodsky, 1992; Wilbert & Fulero, 1988). Wilbert and Fulero (1988) found that 56% of therapists reported they took clinical situations of patient suicidality more seriously due to the potential of legal threat and 53% reported keeping better records in light of legal pursuit.

It is suspected that litigaphobia may have increased over the years as legal threat continues to linger over mental health professionals due to the rising rate with which malpractice suits were sought starting in the 1980's and continuing to rise into the late 1990's (Appelbaum & Gutheil, 2007). The numbers in malpractice suits have since appeared to remain consistent with the number of cases sought in the late 1990's (Appelbaum & Gutheil, 2007). While this trend has resulted in reportedly more safeguards taken across mental health institutions, it has also unleashed a fear of shame in many mental health workers (Smith, 2003). Many therapists have described the fear of making the wrong clinical decisions or of being deemed professionally incompetent as the result of a lawsuit (Miller, 2000; Poythress & Brodsky, 1992; Smith, 2000).

Poythress and Brodsky (1992) discussed the increased fear of litigation in mental health workers who had been sued for the negligent release of a patient. The hospital for which they worked was found guilty until the case had been appealed and the ruling reversed. However, despite the dropped charges, the lawsuit had a lasting impact on many of the mental health workers involved in the case. Two years later, those affected reported that the lawsuit had an adverse impact on their work that resulted in an increased fear of litigation.

Similar fears of lawsuit are most frequently reported in cases involving suicide attempt or completion, self-injury, custody battles involving children and unresolved deaths of clients (Brodsky, 1988; Richards, 2000; Veilleux, 2011). The fear of litigation in many cases has lead therapists to consider retiring early or ending their practice all together (Brodsky, 1988; Poythress & Brodsky, 1992). Many who have been investigated for malpractice regardless of receiving a finding of not guilty still reported feeling a loss of nerve, depressed, hopeless, and uncertain (Brodsky, 1988; Poythress & Brodsky, 1992). Wilbert and Fulero (1988) found that 58% of therapists reported that they would exclude patients who they perceived to be more

litigious. In light of legal threat, 48 % of therapists reported they were more likely “to refer patients with whose problems they have little experience” (Wilbert & Fulero, 1988, p. 381). As a result of these findings, it is not unreasonable to questions whether or not the uncertainty of a legal threat has impacted therapists when contemplating whether or not to terminate with a client. The literature already suggests that there is fear surrounding the decision to terminate with a client for different reasons (Boyer & Hoffman, 1993; Martin & Schurtman, 1985).

Termination and Loss. Clinicians discussed the subsequent fear that results when trying to determine whether to proceed with termination (Boyer & Hoffman, 1993). Boyer & Hoffman (1993) found that fear may be a result of unexamined losses in the lives of the therapist. The ambiguity which surrounds issues of loss, which may be personal and deep seeded within the therapist, are theorized to have an impact on the therapist and their feelings towards the termination of therapy (Boyer & Hoffman, 1993; Martin & Schurtman, 1985).

Ultimately, the impact of fear can lead to chronic hyperarousal and potential symptoms of PTSD in therapists if the specific issues surrounding their fears cannot be identified or explored (Rothschild & Rand, 2006). Unfortunately, many counselors avoid exploring or processing fears as they fear consulting with others may result in shame (Bradly & Gould, 1994; Yourman & Farber, 1996). The result is that the fears are not shared and counselors begin to become unaware of what their fears or bodily symptoms of distress are really communicating (Rothschild & Rand, 2006). This in turn can result in distress and chronic anxiety within the counselor as there is no identifiable source linked to their fears (Rothschild & Rand, 2006). Without an identifiable source of fear the therapist remains in a continued state of anxiety accompanied by symptoms of hyperarousal and anticipation (Rothschild & Rand, 2006).

Anxiety and Counseling

Many counselors-in-training as well as novice mental health professionals have discussed anxiety as a factor when beginning to practice (Ronnestad & Skovholt, 2013; Skovholt & Ronnestad, 2003). This anxiety is not only the result of anticipation but also of the unknown (Ronnestad & Skovholt, 2013; Skovholt & Ronnestad, 2003). Unlike fear, which results in reaction to a known source, anxiety is sometimes considered far more debilitating because it is in reaction to or anticipation of something that cannot be identified (Smith, 2003).

Definition of Anxiety

Anxiety has been characterized and referred to as a similar emotion as fear, perhaps as a result of the fact that anxiety and fear can often occur simultaneously (Erikson, 1977; Smith, 2003). However, despite the shared feelings of discomfort and unease between both fear and anxiety, these two emotions tend to differ in terms of situational context (Bourke, 2005).

Anxiety is often experienced as feelings of unease or discomfort, which usually cannot be linked to a specific source or situation (Bourke, 2005). These feelings are also in anticipation of an event rather than in response to the immediate onset of an event as is the situation of fear (Bourke, 2005). Anxiety is often associated with situations in which the onset of a threatening experience is unpredictable (White & Depue, 1999). This often results in anxiety rather than fear as the individual is anticipating events, which are not predictable and have not yet occurred (Grillon et al., 2004; Seligman & Binik, 1977).

Anticipation

Predictability has been an arguable contributor when examining the impact that a fearful stimulus has on an individual. Many believe that when an aversive object is consistently preceded by a specific cue, an individual becomes conditioned to expect the fearful or aversive

stimulus following the onset of the predicting cue (Grillon et al., 2004; Seligman & Binik, 1977). The individual is then capable of identifying moments of danger and fear based on the presence of the predicting cue (Grillon et al., 2004; Seligman & Binik, 1977). Similarly, moments of safety are recognized in the absence of the cue (Grillon et al., 2004; Seligman & Binik, 1977). However, situations in which there are no identifiable cues to predict the presence of an aversive stimuli also result in an inability to identify periods of safety (Grillon et al., 2004; Seligman & Binik, 1977). Thus it is postulated that a person may feel the stressful effects of anxiety even in the absence of an aversive stimulus if there are no cues that precede the onset of a dangerous object or event (Grillon et al., 2004; Seligman & Binik, 1977). In cases such as these an individual is left in a situation that is uncertain and unpredictable and ultimately results in a state of anxiety (Grillon et al., 2004; Seligman & Binik, 1977).

Death anxiety. Similar situations arise in counseling particularly when dealing with different clinical situations of crisis that occur suddenly and without warning (Dupre et al., 2014). Clinicians begin to feel a sense of anticipation in the face of many clinical situations of crisis (Bugen, 1979; Dupre et al., 2014; Harrawood, Doughty, & Wilde, 2011; Kirchberg, Neimeyer, & James, 1998; Maglio, 1990). One situation which the literature suggested as the source for much of the anticipatory anxiety in both counselors-in-training and experienced counselors are in cases involving grief or the death of a patient (Bugen, 1979; Harrawood et al., 2011; Kirchberg et al., 1998; Maglio, 1990). Maglio (1990) found that both male and female counselors-in-training reported having death anxiety; female counselors-in-training reported the highest levels of death anxiety. Similarly, more than 45% of psychotherapists, psychologists, and psychiatrists treating patients with eating disorders reported worrying about their patients surviving (Warren et al., 2013). Richards (2000) discussed that therapists commonly reported

anxiety alongside feelings of despair and aggression as invasive when working with clients who had either attempted or completed suicide. Additionally, therapists also reported a growing concern for their client's self-destructive actions. Fleet and Mintz (2013) found that all five participants reported feeling anxious when working with patients who self-harm. Fleet and Mintz (2013) posit that this may be due to the discrepant stances of the literature in regards to proper treatment of self-harm. Regardless of theoretical beliefs in treatment, many therapists have described feeling shocked and surprised when hearing of their patient's self-destructive behaviors (Fleet & Mintz, 2013; Richards, 2000).

After incidences of suicidal behavior, therapists described feelings of surprise and anxiety (Richards, 2000). One therapist described his experience of the news, "I experienced something of his desperation and feelings of helplessness and hopelessness" (Richards, 2000, p. 334). Another therapist stated, "I was extremely upset. I felt we had faced the anger and worked it through. In the last session she was much more relaxed and talking about the future" (Richards, 2000, p. 334), illustrating the unpredictability and suddenness of the situation.

However, these feelings were not only reported in situations involving self-harm, suicide attempt, and suicide. They were also the result of situations in which the unexpected death of a client is accidental or unknown (Richards, 2000; Veilleux, 2011). In situations such as these, a therapist may feel anxious and fear potential blame or responsibility that remains unresolved because there is no definitive cause of death. However, there is little research on client deaths that are the result of an accidental or unknown cause (Veilleux, 2011). Veilleux (2011) discussed her experience of working with a client for 8 months who unexpectedly died. She discussed that her feelings towards the client's death did not differ much from many of the

feelings felt by clients who have had a patient die by suicide (Veilleux, 2011). She too discussed feelings of surprise and guilt in response to the death of her client (Veilleux, 2011).

Countertransference. Anxiety may be a predictor of countertransference within the therapeutic relationship (Gelso & Hayes, 2007; Hayes & Gelso, 1991). Gelso & Hayes (2007) have shown evidence that state anxiety was accompanied by countertransference in male therapists. State anxiety was defined as, “a therapist factor that seems theoretically central to countertransference, but that has not been examined empirically” (Hayes & Gelso, 1991, p. 285). Furthermore, Hayes & Gelso (1991) also showed that when male counselors-in-training became increasingly anxious around their clients, they tended to withdraw from the therapeutic relationship.

Anxiety that is related to countertransference may result in countertransference resistance (Bernstein, 1993) or countertransference defense (Shur, 1994). Both of these terms represent the defense mechanisms with which a therapist may project upon a patient in response to anxiety in order to protect themselves from potential countertransference reactions. Common examples of defense mechanisms employed by therapists include intellectualization, reaction formation, and denial (Hansen, 1997). Therapists may exhibit these defense mechanisms in order to avoid symptoms of PTSD including hypervigilance and anxiety that may become pervasive in the therapist (Dupre et al., 2014; Richards, 2000; Smith, 2003).

Trauma. Often crisis situations that are the result of trauma may occur rapidly or without warning and induce fear as well as anxiety in both the client as well as the counselor (Dupre et al., 2014). Though a client may exhibit potential signs of escalation, many have described the experience of a crisis situation as sudden and unpredictable with little time to

identify how to react to the situation (Dupre et al., 2014). One therapist described one of her first encounters of a crisis situation as such:

She cut her hair off, and she's never hurt herself before. So, having that history and knowing that she cut her hair off...if the police hadn't come and intervened with the neighbor, was she going to attack the neighbor? And I mean, just the concern for her safety. It was an uncomfortable thing to see her in that much pain. (Dupre et al., 2014, p. 88)

Another discussed the uncertainty and doubt she felt when handling a case in which both of her clients parents had been killed in a violent death:

Just as I was going through it, just the fears. Am I doing the right thing? Is this the right step to take? What can I do to help them? You know, at times I felt like it wasn't enough. Just a lot of uncertainty, a lot of sadness for them. Just the violent nature of the whole thing was disturbing. (Dupre et al., 2014, p. 89)

Events such as these that are experienced by therapists without prediction can often lead to the hyperarousal of a therapist's ANS (Dupre et al., 2014; Killian, 2008; Richards, 2000; Smith, 2000). Research has been done exploring both the experience of working with situations of trauma in therapies that utilize both verbal as well as visceral therapy to resolve some of the lasting issues that the trauma had on the individuals (Ben-Asher et al., 2002; Ross, 2000).

Responses of those who worked with victims of sexual or physical abuse often discussed the lasting impact that manifest in their bodies after working with their clients (Ben-Asher et al., 2002; Ross, 2002). One therapist who worked as a massage therapist discussed his experience of working with a man who was the victim of an assault (Ross, 2000). The therapist recalled the client being in severe pain when he first arrived to the session (Ross, 2000). Though the client

reported feeling physically much better after the session, the therapist reported having an intense headache and debilitating pain throughout the rest of the body predominantly in the head, neck, and shoulders (Ross, 2000). The therapist was ill for a series of days afterward and was able to attribute the encounter to a potential situation of unconscious somatic countertransference when reflecting on the event (Ross, 2000). Ben-Asher et al. (2002) described a similar experience. The therapist described intense somatic countertransference that took place when treating a child who had been sexually abused (Ben-Asher et al.; 2002). The somatic countertransference led the therapist to become violently ill after a session (Ben-Asher et al., 2002).

Aftermath

The aftermath of anxiety provoking situations often lead individuals to remain in an anticipatory state of hyperarousal for months after a chronically stressful clinical position or situation (Dupre et al., 2014; Richards, 2000). Counselors have reported symptoms of posttraumatic stress disorder, vicarious traumatization and compassion fatigue often accompanied by heightened levels of depression, anxiety, exaggerated startle response and hypervigilance, in response to clinical situations which are endured with chronically high levels of stress (Dupre et al., 2014; Killian, 2008; Rothschild & Rand, 2006; Smith, 2000).

Compassion Fatigue. Compassion fatigue, coined by Figley (1995), is described by Rothschild and Rand (2006) as, “a general term applied to anyone who suffers as a result of serving in the helping capacity” (pg. 14). Killian (2008) elaborated on this term and associates compassion fatigue as being “in the neighborhood of fear and anxiety” (p. 33). Compassion fatigue may be brought on very suddenly when working with a client (Rothschild & Rand, 2006).

Rothschild and Rand (2006) further discussed that compassion fatigue, if left untreated may lead to burnout. Unlike burnout, which develops progressively, the onset of compassion fatigue is often sudden. If left untreated, the effects of compassion fatigue can be long lasting and result in other issues such as vicarious trauma when working in chronically stressful environments (Rothschild & Rand, 2006).

Vicarious trauma. Another salient factor that may emerge for therapists due to continued exposure to symptoms of PTSD is vicarious trauma (Rothschild & Rand, 2006). Rothschild and Rand (2006) described vicarious trauma as, “psychotherapists who become impacted by working with traumatized individuals”(p. 15). She stated that although the therapist may not have first hand experienced the traumatic events of a client they may still be “vicariously experienced” (Rothschild and Rand, 2006, p. 15) in the nervous system of the therapist.

In order for any one of these symptoms to be dealt with, preventative measures must be taken by the therapist in order to insure their health and well being in dealing with these factors. Many therapists have identified self-care strategies such as spending time with their families or exercising as beneficial in relieving some of the devastating symptoms that accompany vicarious trauma, compassion fatigue, and burnout (Jordan, 2010; Killian, 2008). Others have also discussed maintaining contact with support systems such as family, friends, and supervision (both group and individual) as helpful in processing the stressful and anxiety provoking aspects of being a therapist (Dupre et al., 2014; Jordan, 2010; Killian, 2008; Smith, 2003).

Fear and Anxiety as it Relates to Clinician Development

In addition to supervision, many counselors have also identified further education and experience as beneficial in coping with the stress of both anxiety and fear (Barbee, Scherer, &

Combs, 2003; Harrawood et al., 2011; Martin et al., 1989; Mayfield, Kardash, & Kivlighan, Jr., 1999). Studies have shown that experienced therapists often endure less anxiety and appear to have highly developed schemas which allow them to conceptualize the cases of their clients more rapidly and at times accurately (Barbee et al., 2003; Harrawood et al., 2011; Martin et al., 1989; Mayfield et al., 1999). Novice counselors and counselor trainees, on the other hand, often appear to experience more anxiety and fear when entering the mental health profession (Ronnestad & Skovholt, 1993; Ronnestad & Skovholt, 2013). Unfortunately, despite the devastating impact that unprocessed feelings of fear or anxiety may have on an individual, and the therapeutic relationship itself, counselor trainees often attempt to hide feelings of anxiety and fear from within the supervisory relationship (Ronnestad & Skovholt, 1993; Yourman & Farber, 1996).

Supervision

Studies show supervisory relationships in which counselors feel comfortable disclosing fears or anxieties may be helpful in alleviating these feelings and provide an opportunity for supervisees to process fears or anxieties rather than hide them (Ronnestad & Skovholt, 1993; Yourman & Farber, 1996). Supervision has been shown to decrease anxiety in both novice and experienced counselors if it was conducted utilizing the ideal qualities identified by various clinicians (Daniels & Larsen, 2001; Dupre et al., 2014; Richards 2000; Smith, 2003). Clinicians described guidance, support, empathy, validation and positive feedback as aspects that they associated with an ideal supervisor (Daniels & Larsen, 2001; Dupre et al., 2014; Richards, 2000; Ronnestad & Skovholt, 2013; Smith, 2003). Furthermore, clinicians found both individual and group supervision to be beneficial and in most cases integral in resolving clinical situations (Dupre et al., 2014). Much of the literature suggested that supervisory feedback is pivotal in

decreasing anxiety and restoring self-efficacy in both counselors-in-training and seasoned counselors who have been negatively impacted by a traumatic event within their fieldwork, internship, or general practice (Daniels & Larsen, 2001).

Daniels & Larsen (2001) found that positive feedback within the supervisory relationship not only significantly decreased anxiety in supervisees, but significantly increased counselor self-efficacy in the novice. Ronnestad and Skovholt's (1993) findings also showed that specific feedback, especially in the novice therapist lead to less performance anxiety. Ronnestad and Skovholt (2013) also discussed the importance with which students and even novice professionals place on positive supervisory feedback in relation to professional development.

Despite the fact that supervision has been identified as helpful when coping with high stress situations as well as symptoms of fear and/or anxiety, there are many who do not routinely seek it (Dupre et al., 2014). Many have avoided supervision because they have identified previous experiences as a supervisee to be debilitating and in some cases traumatic when working within a dysfunctional supervisory relationship (Daniels & Larsen, 2001; Dupre et al., 2014). While novice counselors report wanting honest and clear feedback they also acknowledge that negative supervisor feedback and evaluation is routinely feared and may be received traumatically by the supervisee (Ronnestad & Skovholt, 2013). One counselor described a traumatic experience she had when seeking supervision for a crisis situation (Dupre et al., 2014). In her report she described the supervisor as unable to understand the fearful feelings she had towards the situation (Dupre et al., 2014). Furthermore, she described her supervisor as unable to identify that there was a lack of trust within the supervisory relationship, particularly when it came to situations involving direct intervention (Dupre et al., 2014). As a result of poor rapport within the supervisor and supervisee dyad, many supervisees have

exhibited defense mechanisms such as resistance in order to protect themselves against negative evaluation and inadequacy (Bradly & Gould, 1994). Trainees have reportedly created resistance within the supervisory relationship through tactics such as declining supervisor advice and not fully disclosing information during supervision (Bradly & Gould, 1994; Yourman & Fiber, 1993).

Unfortunately fear and anxiety of being shamed appeared to be a catalyst for supervisee resistance (Smith, 2003; Yourman, 2003). Some supervisees have avoided disclosing certain aspects of their work during supervision because they feared being shamed or being rejected by their supervisor (Smith, 2003; Yourman, 2003). Others have avoided fear of shame as well by either withholding or intentionally denying experiences of countertransference during supervision (Yourman & Farber, 1996).

However, the ways in which fear and anxiety seemed to motivate counseling professionals appeared to differ among counselor trainees versus seasoned professionals (Skovholt & Ronnestad, 1992; Ronnestad & Skovholt, 1993). Friedlander et al. (1986) have suggested from their work that counselor trainees may be more accepting and inviting of their supervisors suggestions. Trainees appeared more likely to dismiss their own intuition, possibly as a result of the increased levels of self-doubt, fear, and anxiety that are often experienced by beginners (Friedlander et al., 1996; Ronnestad & Skovholt, 2013).

Identification of Schemas

While Russell and Snyder (1963) reported that graduate training and experience did not have an impact on counselor anxiety, recent literature suggested otherwise (Menninger, 1991; Ronnestad & Skovholt, 2013; Skovholt & Ronnestad, 2003). Fear and anxiety appear to be experienced by counselors-in-training, novice counselors and experienced clinicians alike;

however, the level at which fear and/or anxiety are experienced seemed to differ (Menninger, 1991; Ronnestad & Skovholt, 2013; Skovholt & Ronnestad, 2003). Studies have shown that anxiety levels differ based on years of clinical experience (Barbee et al., 2003; Friedlander et al., 1986; Harrawood et al., 2011; Skovholt & Ronnestad, 2003). Some attributed this to the fact that novice counselors and counselors-in-training typically have a lower sense of self-efficacy which has been shown to lead to greater anxiety (Friedlander et al., 1986; Skovholt & Ronnestad, 2003). Other studies suggested that anxiety levels in the novice might be mitigated by continued education, service learning, and exposure to clinical experience (Barbee, et al., 2003; Harrawood et al., 2011). Evidence has shown that exposure to all three of these variables resulted in increased levels of self-confidence and decreased levels of anxiety (Barbee et al., 2003; Harrawood et al., 2011).

Findings suggested that more years of clinical experience impacted the ways in which counselors conceptualized different clinical cases (Martin et al., 1989; Mayfield et al., 1999). Martin et al. (1989) showed that experienced counselors were able to think more abstractly resulting in more parsimonious and effective case conceptualizations. Mayfield et al. (1999) supported these findings and also showed that novice therapists tended to focus on less relevant details in client cases causing them to spend more time synthesizing client conceptualizations. In contrast, experienced counselors appeared to have “highly complex, domain-specific schemas that allowed them to structure knowledge obtained about a client parsimoniously...”(p. 512). Schemas may not only reduce symptoms of fear and anxiety by analyzing a client’s presentation but also help counselors to recognize sources of stagnation quicker within the therapeutic relationship.

Summary

Though many in the field agree that fear and anxiety are natural experiences in becoming a therapist, little research has been done to explore the impact that such feelings may have upon a counselor that is in training rather than practicing and experienced professionals (Rothschild & Rand, 2006; Skovholt & Mathison-Trotter, 2011; Skovholt & Ronnestad, 2003). There has been minimal research done to determine the effects that both fear and anxiety have on clinician development and much of the research that exists is dated and consists mainly of theoretical considerations rather than empirical evidence (Smith, 2003). As a result, some have drawn conclusions that fear and anxiety may inhibit the therapeutic process while others have pointed out that fear and anxiety may serve as an indicator for the presence of potentially derailing clinical situations such as countertransference and somatic countertransference (Hayes & Gelso, 1991; Ronnestad & Skovholt, 2013). Though many sources agree that feelings in response to countertransference may provide a therapist with insight into a client's experiences it often goes unreported by interns within the therapy field (Ben-Asher et al., 2002; Gelso & Hayes, 2007; Pallaro, 2007; Rothschild & Rand, 2006; Yourman & Farber, 1996). As a result, it is unclear as to how feelings of both fear and anxiety, in response to countertransference and somatic countertransference, impact the clinical decision-making of counselors in training. Furthermore, there is little research that discusses the physical impact that both these phenomena have on other mental health professionals, particularly embodied and dance/movement therapists.

Further research is necessary to fully understand the implications that fear and anxiety in response to countertransference and somatic countertransference have on the clinical

development of a therapist in training. Through this study, I hope to explore how fear and anxiety impact the clinical decision making of a dance/movement therapy intern by answering the following questions: How do fear and anxiety, in response to countertransference and somatic countertransference, impact my clinical decision-making as a dance/movement therapy intern? Is what I am experiencing fear or anxiety? How do I physiologically experience fear and anxiety? How do I embody fear and anxiety?

Chapter Three: Methods

This artistic inquiry self-study took place over the course of ten weeks. Data were collected in the form of written journal entries as well as embodied movement that was captured during embodiment sessions. Video recorded embodiment sessions occurred weekly and were overseen by a board certified dance/movement therapist (BC-DMT) who acted as a consultant and external auditor throughout the course of the study. I used the movement that was derived during embodiment sessions to choreograph a piece.

Methodology

Artistic inquiry is a methodology inherently rooted in the understanding that human experience has been explored for centuries in the qualitative forms of aesthetics, kinesthetics, emotions, and intuition (Hervey, 2012). As a result, data within this methodology are traditionally qualitative and are typically expressed in the form of art, movement, writing/speech or music (Hervey, 2012). Since fear, anxiety, countertransference and somatic countertransference are all experienced both viscerally and cognitively, I knew my findings needed to be expressed within a qualitative format. As a dancer, I wanted my findings to convey the physical and psychological impact that both fear and anxiety, in response to countertransference and somatic countertransference, had on myself.

I used embodied movement to study my experience of physiological symptoms, as they related to my experience of countertransference and somatic countertransference. This seemed the natural way to obtain meaning of the physiological and embodied responses I had to countertransference due to the fact that embodied movement is an artistic outlet that I have used to track and express my personal experiences for years. As a result I felt artistic inquiry was the appropriate methodology for this type of research because it allowed me to explore my personal

experience of fear and anxiety through dance and present my findings in their qualitative yet authentic form of movement.

Population

I was the sole participant of this artistic inquiry self-study. I was a twenty-four year old dance/movement therapy and counseling intern. I grew up in a household made up of my mother and father and my two brothers. I grew up in a very structured environment in a Chicago suburb and adhered to strict set of household rules. Though strict in their rules, my family was always supportive and pushed me to be the best version of myself that I could be. I often felt the pressure to set goals and to constantly be working towards achieving those goals.

Many of the clients I saw also lived in an environment that seemed similar to the one that I came from. Some of my clients grew up in a community similar to the suburban community I was from and some had even attended the same suburban high school that I attended. While this provided me with insight when addressing the needs of my clients, it also created clinical challenges. I often experienced countertransference and somatic countertransference as a result of closely identifying with some of the experiences that my clients discussed.

Setting

The majority of my data were collected at my internship site due to the fact that my research questions were directly related to my clinical experience. I gathered and recorded additional written and movement data at school, home, and throughout weekly individual improvisational movement explorations. The improvisational movement explorations occurred at Columbia College Chicago.

Data Collection Methods

Data were collected over the course of ten weeks, nine of which were used to collect data and one week, week six, which was used for incubation (Moustakas, 1990). According to Moustakas (1990), “the period of incubation allows the inner workings of the tacit dimension and intuition to continue to clarify and extend understanding on levels outside immediate awareness” (p.29). He discussed that allowing for periods of incubation, “gives birth to a new understanding or perspective that reveals additional qualities of the phenomenon” (Moustakas, 1990, p. 29). During the sixth week, I did not collect written or movement data nor did I attend internship. The incubation week was solely used for reflection and fermentation of the first five weeks of data collection. The nine weeks of data collection were used to collect both written and movement data. Data were collected in two forms: journal entries and embodied movement.

Journal entries. Written data were documented in the form of journal entries. Journal entries reflected on the research questions I posed in relation to the manifestation of fear and anxiety that I experienced in response to countertransference and somatic countertransference. I further reflected on how fear and anxiety in response to countertransference and somatic countertransference impacted my clinical decision-making. The journal entries were about one to two pages in length and were synthesized once a week, during embodiment sessions. Journal entries were written in reflection of my experiences at my internship, which occurred every Monday, Wednesday, and Friday, and after embodiment sessions every Sunday.

Though I had originally intended on writing five to six journal entries a week, I ultimately ended up journaling four times a week. Attempting to journal more than four times a week felt overwhelming and did not allow me sufficient time to accurately process the majority of the information I gathered at internship. Using the evening after internship as an incubation period allowed time for me to reflect on my experience mentally and physically for a short period of

time each day without feeling pressure to instantly document everything I experienced. As a result, I typically documented my experience each day that followed my internship. For example, if I worked at my internship site on Monday I often used the evening to decompress and process the experience physically and mentally. I then recorded my experience in writing the following day, in this case Tuesday. Recurrent themes within the journal entries were identified at the end of each week of data collection and synthesized during embodiment sessions.

Embodiment sessions. Recurrent themes were read and responded to during one-hour embodiment sessions through improvisational movement explorations, which occurred once a week during the nine weeks of data collection. It is important to note that each week of data collection was reflected on during a one-hour embodiment session except for week eight. On week eight the seventh and eighth week of data collection were synthesized over the course of a two-hour embodiment session.

Embodiment sessions were facilitated by a board certified dance/movement therapist (BC-DMT) who served as both a collaborator and witness throughout the study. The dance/movement therapist acted as a witness by observing all improvisational movement explorations and helping to process any personal complications that arose during the study. She also acted as a collaborator by video recording movement data, verbalizing observations she made in relation to the movement data and the study at large, and illuminating the meaning making that the movement elicited in response to the research questions. The dance/movement therapist was solely used for the purpose of the study and not for additional personal therapy.

The embodiment sessions were structured similarly each meeting. Each session began with a 25 to 35 minute verbal reflection, between my dance/movement therapist and myself, of

the recurrent themes that surfaced throughout the week based on my journal entries. Verbal reflections were followed by a three to fifteen minute improvisational movement exploration during which I explored my embodied response to the recurrent themes we discussed. Improvisational movement explorations appeared to vary in duration based on the content of the reflected themes and appeared to increase in length of time during the later weeks of data collection. My dance/movement therapist auditor assisted with recording data obtained during embodiment sessions through the use of video recording improvisational movement explorations. Often, but not always, improvisational movement explorations were followed by a brief reflection between the dance/movement therapist and myself. We reflected on what we noticed both viscerally and cognitively throughout my embodiment of the themes. Verbal reflections afterwards also served as a short debriefing period particularly during weeks in which more intensive themes had been explored.

Data analysis methods. Data analysis was considered an integral part of the creative process and occurred concurrently during data collection through the use of creative synthesis. Written data were analyzed through the identification of recurrent themes in written context. Specific words that occurred repeatedly in relation to written self-reflections of countertransference and somatic countertransference as well as emotions and physical sensations were highlighted during verbal processing with my dance/movement therapist and further synthesized through embodied improvisational responses. Movement data were initially synthesized during improvisational movement explorations in response to reoccurring written themes. Movement data were further analyzed through creative synthesis in the form of a formal dance piece comprised of the reoccurring movement themes derived during DMT sessions. The formal dance piece consisted of three separate sections representing the beginning, middle and

end of the study and the themes that surfaced during each period. The first section of the piece was performed at Manifest on May 16, 2014. The complete piece was performed on March 13, 2015 at the performance entitled “Marginal Voices: Bringing Forth the Untold”.

Validation Strategies

The two validation strategies I used were thick description and external audit (Mertens, 2005). Researchers use thick description by explaining in extensive and careful detail the time, place, context, and culture within which the study takes place (Mertens, 2005). I demonstrated thick description by describing in detail the amount of time the study lasted as well as when, where, and how often data were collected throughout the 10 weeks of data collection. I also included information on the context with which data were collected by describing in detail the structure and process of journal entries and embodiment sessions. Furthermore, I employed the help of a dance/movement therapy consultant to ensure that the process occurred systematically and followed the detailed process with which data were collected. Thick description illuminated the possibilities and limitations of transfereability of the findings to individuals other than myself.

Additionally, my dance/movement therapist served as an external auditor as she was able to witness the research process without having any direct relationship with the research. She provided observations during embodiment sessions and asked questions that helped to minimize my own biases throughout the process. She also validated the authenticity of the study by being able to attest that the process was directly related to the exploration of the research questions and was explored as thoroughly as possible including identification of my biases and assumptions.

Chapter Four & Five: Results and Discussion

I became interested in understanding how fear and anxiety, in response to countertransference and somatic countertransference, impacted my clinical decision making as a dance/movement therapy intern when my internship started. I began to notice fear and anxiety during the initial days of internship. I felt that exploring my decision-making process through embodied movement would aid me in further understanding my clients and myself. Though I realize that fear and anxiety are two emotions that may contribute to the experience of countertransference and somatic countertransference (Ronnestad & Skovholt, 2013), I truly believe that when recognized and mindfully attended to, fear and anxiety can be used to further understand and aid in the therapy process. I found that by remaining aware of countertransference and somatic countertransference reactions, I was able to make clinical decisions more efficiently that allowed my clients and myself to connect across our differences.

Identifying Fear and Anxiety

When I began my data collection, I was entering my second semester of internship and was still regularly exposed to many of the challenges that not only interns, but also therapists at large, face in their work. The initial challenge that I faced when I began this study was in recognizing moments of fear as well as anxiety during dance/movement therapy sessions. This was important to me as I knew that identifying and differentiating between experiences of fear and anxiety during the course of a session could be useful when making clinical decisions based in a RCT theoretical framework. While I identified that I used a combination of RCT, Chacian, and Schoopian theories in my theoretical framework throughout my internship, I found that I mainly engaged clients in techniques that were related to Chacian and RCT theory when using interventions related to this study. I found that through an RCT theoretical framework, I was

able to use countertransference and somatic countertransference to understand not only my fears and anxieties but also the fears and anxieties of my clients and engage in mutual empathy with my clients. I often found that engaging in mutual empathy lead to the identification of the parallel process that I entered into with my clients. For example, I often noticed that my clients were coping with fears and anxieties related to rejection. I have also dealt with fears and anxieties related to rejection in my past. When I noticed feelings of fear related to rejection resurfacing in myself during the course of a session I often identified that this was a result of countertransference and somatic countertransference. This was often an indication that many of the clients were new to the program. I used this information to influence my clinical-decision making by choosing an intervention that would allow my clients to begin to identify what they shared in common rather than what differentiated them from one another.

One intervention I would use to assist clients in connecting to one another across their differences was a therapeutic movement game called come to the middle. During this game one group member would stand in the middle and state, “come to the middle if...”. For example, a group member might state, “come to the middle if you like chocolate”. If other group members related to the phrase, (i.e. they liked chocolate as well) then they would come to the middle and go to a different chair. There was one less chair than people in the group so one individual would always be left standing. The individual that was left standing then made their own statement beginning with “come to the middle if...”. This intervention encouraged clients to practice their interpersonal skills by encouraging clients to stand up in front of a group of people, which many identified as anxiety provoking. Furthermore, it encouraged clients to make eye contact with one another when speaking to the group. Often, during verbal processing at the end of the session, group members were able to relate to one another by acknowledging that they felt

anxious at the beginning of the experiential. However, group members identified feeling less anxious as the experiential came to a close. Group members discussed feeling more comfortable around other group members after having shared with one another.

I specifically studied the impact that fear and anxiety, in response to countertransference and somatic countertransference, had on my clinical decision-making. For the purposes of this study, countertransference was defined as the reactions experienced by a therapist in response to the patient's own infantile wishes, projections, and object relations the patient places on the therapist (Freud, 1910; Pallaro, 2007). Somatic countertransference was defined as the bodily felt responses and reactions which occur in a therapist during the therapeutic process in response to the bodily felt sensations of a client (Bernstein, 1984; Pallaro, 2007). I choose to study specifically fear and anxiety in response to countertransference and somatic countertransference for two reasons. First, I took a personal interest in the experience of fear and anxiety as an intern, and I was interested in understanding what differentiated these two emotions from one another. Secondly, I was interested in understanding how identifying fear and anxiety that was the result of countertransference and somatic countertransference could allow me to form a deeper connection with my clients.

Differentiating between countertransferential responses, which were rooted in fear versus those, which were the product of anxiety, posed an additional challenge. Though I had settled on definitions for both fear and anxiety (see Appendix A) I had difficulty identifying which of these feelings I was experiencing at the beginning of the study; both of these feelings were far more pervasive viscerally than they were cognitively. I had difficulty making sense cognitively of what I was feeling viscerally. At times I felt that I was experiencing a mind body split as a result of the strong physiological and embodied responses I had towards my clients.

As time went on I began to recognize that both feelings of fear and anxiety often occurred simultaneously, which added to the difficulty I had in distinguishing between the two. Both fear and anxiety occurred at the same time in multiple situations, perhaps as a result of the fact that I was facilitating group rather than individual therapy. This often resulted in my experiencing countertransference and somatic countertransference with multiple group members at a time.

Additionally, the countertransference and somatic countertransference that I experienced in response to one client often brought about both feelings of fear and anxiety rather than one or the other. In situations where the clients became angry and resistant, I would often experience both fear and anxiety. I felt anxious because I could not identify anything I did to cause the anger or resistance that was being projected onto myself. In these instances I knew that I was experiencing anxiety as a result of countertransference. I was afraid of the anger that clients were displacing onto me and furthermore I was afraid that clients would rebel or lash out against me. Prior to being able to routinely identify moments of countertransference and somatic countertransference while it was occurring, I questioned if how the clients were presenting was a result of my own personality traits that I brought to the session like the fact that I am more introverted as well as shy when I meet people for the first time. Furthermore, I wondered if these personality traits made me more vulnerable to the experiences of countertransference and somatic countertransference. As a result, I often questioned my decision-making and my self-efficacy, particularly when I was having difficulty identifying whether or not I was experiencing feelings of fear and anxiety as a result of countertransference. Through conversations with my dance/movement therapy consultant, I began to realize that the reason I had difficulty distinguishing between the experience of fear and anxiety was because I often experienced them both at the same time.

After discovering that fear and anxiety could occur simultaneously, I began to notice that my ability to identify both fear and anxiety in response to countertransference and somatic countertransference began to improve. Furthermore, I began to notice that the general fear and anxiety that I experienced as a dance/movement therapist-in-training decreased. My diminished experience of fear and anxiety can be attributed to several factors: Fear of negative evaluation, increased sense of self-efficacy, and further education.

Fear of negative evaluation. I believe that performance anxiety and a fear of negative evaluation, which is common in interns (Hayes & Gelso, 2007; Ronnestad & Skovholt, 2013; Ronnestad & Skovholt, 2003), may have resulted in difficulties with identifying situations of countertransference and somatic countertransference at the start of the study. At first, I was often monitored during the sessions that I facilitated by one or more experienced therapists on staff. In some cases, I was leading sessions with four other therapists in the room that were observing my work as well as helping to maintain management of the milieu. For a while this was slightly unnerving, especially as a new dance/movement therapy intern. As I adjusted to my work being observed by one or more therapists at a time, I no longer felt as much pressure or anxiety in their presence. I eventually became used to being observed, which I believe contributed to my decrease in anxiety.

Increased sense of self-efficacy. The hospital census increased after my first few weeks of beginning this study, which resulted in my leading more dance/movement therapy groups on my own without additional expressive and mental health therapists being present in the room. Being given opportunities to lead dance/movement therapy groups on my own gave me a sense of self-efficacy as I felt the staff trusted me to lead groups without additional support. When leading dance/movement therapy groups, I experienced less overall performance anxiety and I

was able focus more on my clients. This is consistent with literature on clinician development and performance anxiety. Ronnestad and Skovholt (2003) suggested that decreases in acute performance anxiety led novices to focus more on their clients rather than themselves during sessions.

Further education. By my fourth and fifth weeks of the study I was nearly finished with the required coursework of my degree as well as my supervision hours. As a result of having practice identifying situations of countertransference and somatic countertransference on a number of occasions with the help of my supervisors, fellow cohorts, and additional staff members at the hospital, I began to develop a more systemized and personalized schema, or system of beliefs, related to my experience of both countertransference and somatic countertransference.

I noticed that I processed countertransference and somatic countertransference from the bottom up. This means that I first recognized the presence of visceral sensations, associated with countertransference and somatic countertransference before cognitively identifying the experience as such. After identifying visceral reactions associated with countertransference and somatic countertransference, I was able to cognitively recognize the experience of countertransference and somatic countertransference as it was occurring. This schema aided me in identifying the onset of both of countertransference and somatic countertransference during group therapy sessions.

Process of Awareness

The schema was represented by certain embodied and physiological responses that I had towards my clients during moments of countertransference and somatic countertransference. When reflecting on these situations during my embodiment sessions, my embodied response was

often enclosed or became concave. At times I crossed my arms or legs in response to countertransference and somatic countertransference. Additionally, I noticed certain physiological responses such as shallow breath, increased heart rate, nausea, tapping my heel, muscle tension, clenching my jaw, and perspiration. I differentiated experiences of somatic countertransference from my own fears and anxieties by examining the onset of these embodied and physiological responses. If the onset appeared to be rapid and I could not identify a reason for these feelings I would question if they were occurring as a result of something outside of me. I would then begin to observe if I was mirroring the movement of my clients or noticed physiological sensations that other clients had reported during the check-in. If this was the case I could assume that the embodied and physiological responses I was having were a result of somatic countertransference. Once I identified that these embodied and physiological responses were in response to somatic countertransference, I used them as cues to assist me in identifying the presence of anxiety and fear in response to countertransference.

I identified my experience of anxiety and fear in response to countertransference by remaining aware of the embodied and physiological manifestations of fear and anxiety that I experienced. As I continued to mindfully attend to my embodied and physiological responses to fear and anxiety, I began to notice a pattern with which I became aware of symptoms of countertransference and somatic countertransference. When leading dance/movement therapy sessions, I first became aware of my visceral response to fear and anxiety. Often what I noticed viscerally when experiencing fear and anxiety were tightness in the chest, shallow breath, increased heart rate, nausea, tapping my heel, muscle tension, clenching my jaw, perspiration, and feeling jittery. Sometimes I left sessions feeling sick to my stomach or had a headache. As a result of my tendency to process information from my environment from the bottom up, I

typically recognized somatic countertransference first when working with clients. I identified if the embodied and physiological feelings of anxiety were a result of countertransference by mindfully attuning to my clients and noticing if I was embodying any of their postures, movements, or physiological sensations they reported or presented with during check-in. For example when I was tapping my heel in a session I felt odd as this is not a movement or habit of my own and was able to identify it as somatic countertransference. When I looked to the left of myself I identified a client doing the same movement who also happened to present as anxious throughout the group. From these physiological manifestations of somatic countertransference I identified feeling anxious as well. Feeling anxious alerted me to the possible presence of countertransference. I was then able to use countertransference as a means of identifying projections the clients were placing upon me. As I discovered what their projections were, I was then able to attribute my feelings of anxiety to a known source, and in so doing I could name a fear.

Image #1 shows how I began to use embodied and physiological responses to bring awareness to the presence of countertransference and in so doing translate the anxieties I felt into nameable fears that the clients were projecting onto me.

Image 1

Process of Awareness



It is important to point out that this image exemplifies my process of becoming aware of somatic countertransference, anxiety, countertransference, and fear and not the order in which any one of these occurred. Although there was a particular order in which I tended to become aware of each one of these factors, I often experienced more than one of them simultaneously. This process of awareness merely served as a tool that I was able to use in order to identify feelings of anxiety and fear, in response to countertransference. Approaching therapy from this process of awareness improved my understanding of somatic countertransference, as a dance/movement therapy intern and aided me in making effective clinical decisions, which allowed me to further connect with my clients and allowed my clients to further connect with one another during the therapeutic process.

The following summary of a session illustrates how I used this schema to facilitate an adolescent dance/movement therapy session. I started this session with a brief check-in. During the check-in, I noticed that many of the clients appeared quiet and withdrawn. At first I assumed this to be the case because it was a morning group and sometimes the clients are very tired. However as the check-in came to a close I began to notice physiological sensations that I was confused by. I began to notice my heart was beating faster and I was beginning to perspire. I knew that these physiological responses were not related to my own performance anxiety because by this point I was used to leading the adolescent groups and had been working with that population for months. I also knew it wasn't related to any anxiety I may have been feeling in my personal life as I could not identify anything I was anticipating or feeling worried about. As a result, I knew that the physiological responses I was having were the result of something occurring externally in my environment and therefore were the result of somatic countertransference. I recognized that these physiological sensations were related to feelings of

anxiety I was having. I knew that these feelings of anxiety were related to countertransference because I could not attribute them to performance anxiety. This led me to question why the clients were withdrawing from me. Initially I thought it was because they were tired or feeling resistant but then I began to question if they were withdrawing due to feelings of anxiety. I questioned what fears they might be projecting onto me. Looking around I noticed that many of the clients were new to the program and wondered if they might be projecting their fears of connecting to others onto me. I asked if any of the clients were new to the program and the majority of them were. I was able to name the fear that was causing the clients to withdraw. The clients were afraid to open up because for many of them it was their first week in the partial hospitalization program and they were not familiar with one another. This communicated to me that the clients did not feel safe connecting to one another so I choose interventions that would encourage clients to connect with one another in a safe way. I choose movement experientials that encouraged clients to practice social skills such as making eye contact, engaging in conversation, and physically rotating their bodies and reaching out towards one another.

The movement intervention I used to develop social skills began with all participants seated in a circle. I grabbed a ball and asked each of the group members to pass the ball to one another in no particular order. Once a group member received the ball they were asked to say something about themselves. I purposely left this vague so that group members would not feel forced to say anything they did not feel comfortable sharing with the group. This experiential encouraged participants to reach out to one another as well as converse with one another by sharing something about themselves with the group. While I initially found that clients were sharing one sentence about themselves at the start of the experiential, I noticed that the client's responses began to lengthen. When some clients received the ball they were sharing for minutes

at a time. I also began to notice that the clients' affect brightened. The group members were looking at those who were sharing and responding to the stories as evidenced by laughing if the story was funny or offering words of support if the story was serious or sad.

I found that this experiential encouraged clients to form connections with one another and it also resulted in the five good things of Relational Cultural Therapy (RCT) (Miller, 1988). Clients demonstrated increased energy and zest as evidenced by their brightened affect and laughter that occurred during the session. Clients demonstrated having a sense of self-worth by sharing stories they felt had meaning. They demonstrated an increased motivation to take action by fully engaging in the experiential. They demonstrated increased knowledge of themselves by identifying through verbal processing that it is easier to open up to others once you learn a little about them. Lastly clients demonstrated a desire for more connection by continuing to not only share longer stories as the group went on but also by responding to what other group members had shared (Miller, 1988).

I found that by using this schema and further understanding both the cognitive and visceral manifestations of countertransference and somatic countertransference that I was able to choose effective interventions. These findings are congruent with conclusions that have been made by other psychotherapists who have studied the embodied experience of somatic countertransference and countertransference (i.e. Pallaro, 2007; Stone, 2006; Rothschild & Rand, 2006; Wyman-McGinty; 1998). Others have suggested that the therapist's physiological and embodied responses to clients may aid individuals in identifying moments of unidentified countertransference and empathy as well as compassion fatigue, vicarious trauma, and burnout (i.e., Ross, 2000; Rothschild & Rand, 2006). Other embodied and dance/movement therapists have also suggested that embodied as well as physiological responses may be a potential

resource for identifying moments of countertransference and somatic countertransference sooner and aid a therapist in accessing their client's pre-verbal emotions (Ben-Asher et al., 2002; Pallaro, 2007; Ross, 2000; Rothschild & Rand, 2006; Wyman-McGinty; 1998).

The Choreography Process

I noticed a change in myself as an intern, based on the information I had gathered during the weekly improvisational movement sessions. I decided to convey these changes by creating three separate sections in choreography. The first section of the piece was perhaps the most physically and emotionally taxing section. I performed this section for the first time on May 17, 2014 at Manifest Urban Arts Festival Dance/Movement Therapy and Counseling Department performance entitled "Harmonic Lattice". The first, second, and third sections of the piece were performed in a collective show along with two of my dance/movement therapy peers on March 13, 2015 titled "Moving the Untold: Bringing Forth Marginal Voices". We choose this title as each of the topics we presented on are issues that are rarely discussed or explored. We each showed pieces that were choreographed to reflect the different results that each of us had derived during the study of our various thesis topics. The title of my piece is "Journey Through the Unknown" (<http://youtu.be/OFxGgQZnTxs>).

Section 1: The unknown. The first section of this piece was very painful to both choreograph and perform from both a physical and emotional standpoint. It was representative of the beginning of this process when I was still navigating how to identify and process feelings of fear and anxiety in response to countertransference and somatic countertransference as well as distinguish between feelings of fear and anxiety. As an intern, I felt very lost in response to these feelings and experienced a diminished sense of self-efficacy during my first months as an intern and during the first few weeks of this study. During the first few weeks of the study, I had

difficulty pinpointing moments of fear and anxiety that were related to unidentified countertransference and somatic countertransference. This caused me to become more emotionally and physically exhausted. I noticed that physically my body felt tired and sore following weekly embodiment sessions. Emotionally I felt stressed and frustrated at the negative impact that both fear and anxiety in response to countertransference and somatic countertransference had on my decision making.

The stress of clinical decision making as an intern can be very debilitating as is the stress of making mistakes, which is a very real aspect of being an intern as well as a therapist. I was able to examine and process these feelings safely with the help and support of my supervisors, faculty, cohort, friends, family and the dance/movement therapy consultant who collaborated with me on this study. Through embodying these experiences with my dance/movement therapy consultant and further exploring how these experiences related to my research questions, I was able to begin using my embodied responses to further identify and process the fear and anxiety that was the result countertransference and somatic countertransference in a healthy way.

During my first few weeks of the study, I often embodied my experience of unidentified countertransference and somatic countertransference. Rarely during these first weeks of the study was I able to identify my experience of countertransference or somatic countertransference when it was happening during dance/movement therapy sessions that I lead. I assume this to be the case largely due to the fact that as a student I not only experienced anxiety in response to countertransference and somatic countertransference but I also experienced performance anxiety as a result of being a novice. This contributed to the initial difficulty I had when identifying instances of countertransference and somatic countertransference. I was however able to identify the experience of countertransference and somatic countertransference in hindsight

through journal entries and then process these experiences through improvisational movement with my dance/movement therapy consultant during weekly embodiment sessions.

In choreographing this first section of the piece, I found that my movements tended to be rather isolative. I demonstrated postures that were often closed off by either crossing my arms or my legs and I found myself often gazing at the floor. I also noticed that many of my movements were more passive during the first few weeks of the study but gradually became tenser and at times forceful. I found that I experienced a lot of anger and frustration in conjunction with my feelings of fear and anxiety in response to countertransference and somatic countertransference and this was demonstrated in my movement. I often became frustrated and angry with myself that I was not able to perform the way I wanted to. As I became more aware of countertransference and somatic countertransference, I began to recognize that many of the clients I worked with felt anger towards themselves as well. Often they were frustrated by their fears and anxieties as well. I responded to these instances of countertransference and somatic countertransference with embodied responses that fluctuated between strong forceful movements and more passive movements. I also found myself constantly changing levels. I had dramatic shifts from being low to the ground to standing then being thrown to the floor again. I found these movements to be reflective of how unidentified countertransference and somatic countertransference can often complicate the therapeutic relationship and give rise to emotional highs and lows within both the client and the therapist. I choreographed this section to reflect the emotional complications and challenges that arise when navigating through feelings of fear and anxiety in response to unidentified countertransference and somatic countertransference within a dance/movement therapy session.

The first time that I performed this section at the Manifest Urban Arts Festival in 2014, I experienced the choreography that I embodied on a whole new level. I was already experiencing general performance anxiety prior to performing the piece and ended up channeling much of this into my embodied portrayal of fear and anxiety in response to countertransference and somatic countertransference. As a result, I found that I was exerting myself throughout the performance more intensely than I had during previous rehearsals. I found that the performance anxiety that I was experiencing gave me the adrenaline to experience these embodied responses more powerfully than I had when I was choreographing. I also found myself to be truly present throughout the experience of the performance. I felt as though I was truly re-experiencing some of these intense physical and emotional responses that I had towards some of my clients.

After the performance I experienced a feeling of relief. The process of performing this experience and being seen was extremely therapeutic for me. I felt as though I held on to a lot of the embodied responses I had experienced with my clients prior to entering into this study. Exploring these emotions in response to countertransference and somatic countertransference provided me with a healthy outlet from which to express the feelings I was experiencing. The opportunity to perform these experiences allowed me to express these feelings in a safe place and allowed me to find closure with some of the more painful and intense experiences I had endured during my time as an intern.

The day after my performance I was extremely sore and felt much of the physical pain more deeply than I had throughout the course of the study. I believe that the opportunity to perform this work allowed me to find a deeper connection with the clients that I had worked with and provided me with an embodied understanding of how countertransference and somatic countertransference manifest in myself. While this first section demonstrated the emotional and

physical manifestations of fear and anxiety within myself in response to countertransference and somatic countertransference I wanted to elaborate on the middle and final weeks of the study.

Section two: Unraveling. As I reached the third and fourth weeks of this study, I began exploring how to use countertransference and somatic countertransference as a means of further empathizing with and understanding my clients. I choreographed this second section of the piece by exploring my embodied experience of identifying moments of fear and anxiety in response to countertransference and somatic countertransference. I explored using countertransference and somatic countertransference as a means to mindfully empathize with my clients and further understand their situations. By exploring how to mindfully attune to my clients, I protected myself from symptoms of compassion fatigue, “A general term applied to anyone who suffers as a result of serving in a helping capacity” (Rothschild & Rand, 2006). Furthermore, I established a healthy boundary between my clients and myself. Healthy boundaries are defined as the physical distance a therapist maintains which allows the therapist to reside in the comfort zone and feel protected while working with their clients (Rothschild & Rand, 2006). A therapist may further maintain healthy boundaries through choosing clothing which makes them feel comfortable or protected, tensing certain muscles or areas of the body where they feel more vulnerable, and actively choosing moments throughout a session to ground when clients are recounting traumas (Rothschild & Rand, 2006). I established healthy boundaries by exploring different ways of embodying boundaries. I engaged in common boundary setting techniques throughout sessions by remaining grounded through breathing deeply, stretching, and firmly pressing my feet into the floor. My embodiment during this stage of the piece also involved movement that fluctuated between open and closed postures. I explored through movement how to safely open myself up to my clients in order to further empathize but I also explored

recognizing when to set a boundary through movement in order to remain safe and present with my clients. As I began to further understand how to recognize fear and anxiety in response to countertransference and somatic countertransference I began to base my clinical interventions off of the connections I was making with my clients.

Section three: The culmination. In the final section of the piece I choreographed the process of mindfully attuning to the presence of somatic countertransference and countertransference so that I may make relevant and effective clinical decisions and movement interventions. Many of my embodied experiences of fear and anxiety in response to countertransference and somatic countertransference often stemmed from a lack of connection between the client and myself and the client with other clients. I found that if I could actively choose a theme that related to the fear and anxiety I was experiencing in response to countertransference and somatic countertransference, the group was more likely to engage in the intervention.

As a result of this finding, much of my choreography during this third section of the piece involves reaching out toward others and allowing for somatic countertransference to happen mindfully. I then used the information that I received through somatic countertransference to identify the presence of anxiety. The presence of anxiety often prompted me to question whether or not I was experiencing countertransference. If I could identify the presence of countertransference I could also identify a specific fear that the anxiety I was experiencing was related to. I routinely entered into this process during my last weeks of my internship and found that I did not only find deeper connection with my clients but deeper connection with myself. I was able to use the mind body connection to engage in a process of awareness that benefited my clinical decision-making skills. As a result, the choreography that I created in this final section

highlighted the strengthened mind body connection I found within myself. I felt an increase in self-efficacy and I felt empowered despite experiencing fear and anxiety in response to countertransference and somatic countertransference. I recognized that these feelings indicated I was making connections with the clients and that I had the tools to use those connections to make effective clinical decisions regarding my clients.

The Final Performance

The final performance “Moving the Untold: Bringing Forth Marginal Voices” took place on March 13, 2015 at Columbia College Chicago. I performed my piece in its entirety at the second showing. Prior to the performance, I experienced a bit of performance anxiety much as I did prior to my performance at Manifest. What changed was my perspective on this piece. I am a shy person and I have often shied away from openly demonstrating some of my more raw and intense emotions. Most of the performances I have done have not gone in as far depth as this piece. I honestly worried a lot before performing this piece in its entirety. I worried about what people would think of me and what they would think of the topic. I worried that it might be perceived as disturbing and I worried that the feelings I had would be something that no one else in the audience could relate to. Despite all of these fears that I had about showing the piece itself I felt that it needed to be shared for the same reason that I had chosen this topic. Fear and anxiety in response to countertransference or somatic countertransference are real experiences that novice therapists have experienced but do not always report or seek guidance on out of fear or shame. During this process I found that normalizing this experience made it easier to cope with and provided me with a feeling of empowerment.

When I performed the piece, I felt my adrenaline pumping. I felt so many physiological responses I previously had to my clients more intensely than I had before, particularly shortness

of breath and perspiration. During the performance I felt vulnerable and exposed. It was challenging to get through this performance knowing that once I performed it for others it could never be unseen. I hoped this performance would provide others with the validation that feelings of fear and anxiety were a normal part of my process and through self-exploration I was able to use these feelings to the advantage of my clients to better their treatment and improve my therapeutic skills.

After the performance I remember feeling in shock that it was over. I was relieved that I had made it through the performance. Unlike Manifest, after this performance there was a question and answer session as well as time to meet with those who had seen the performance afterwards. During this time, I received feedback from friends and family that I had not expected. Many of them had validated my experience and discussed similar experiences they had with their clients. Others discussed that they saw a different side of me and a true representation of personal growth. It was at this moment that I began to feel that this experience was not something to be ashamed of. This experience provided me with the confidence and empowerment that I needed to manage feelings of fear and anxiety in response to countertransference and somatic countertransference as well as improve upon my clinical decision-making skills as a dance/movement therapist.

Limitations

As a result of this being a qualitative self-study, generalizability was not a goal. More evidence, and research in regards to countertransference as well as somatic countertransference, is necessary in order to determine how my findings relate with other therapists, both dance/movement therapists and non-embodied therapists alike, when engaging in the therapeutic

relationship. Also, findings may differ based on the population that a therapist is working with and additional differences in personal background.

Additionally, there were moments in which I could not capture my movement, which occurred during sessions with absolute accuracy due to the fact that videotaping sessions would violate the confidentiality of the clients I worked with. These embodied responses could only be observed after therapy sessions and recorded during embodied movement sessions or in writing through journal entries. Also there was a period in which I responded to the journal entry data I had collected after two weeks rather than the end of the corresponding week in which the data was collected. This may have slightly altered the data as a result of an unavoidable inconsistency that occurred during data collection.

Future Questions for Exploration

Though beyond the scope of this study, other research questions, which may be applicable in the future, might include: How do I integrate Schoopian technique into the interventions I use when identifying the presence of countertransference and somatic countertransference related to fear and anxiety? How may anxiety be defined in relation to becoming a novice therapist? How are fear and anxiety, in response to countertransference and somatic countertransference, experienced in novice dance/movement therapists versus other new clinicians? Are dance/movement therapists more aware of feelings of fear and anxiety related to countertransference and somatic countertransference due to their specified understanding of the body and somatic responses to the environment? How do the approaches of a dance movement therapist compare to other therapeutic professionals in experiences of countertransference and somatic countertransference when making a clinical decision? Is the schema that I discovered in

my own process of awareness useful for others in understanding their own process of awareness or clinical decision making?

Conclusion

When I first began this study, I looked at feelings of fear and anxiety as debilitating and inhibiting towards the therapeutic process. Through this study, I discovered that deepening my understanding of fear and anxiety could be useful to the therapeutic process. By mindfully attending to my experience of fear and anxiety and the relationship to countertransference and somatic countertransference within the therapeutic relationship, I was able to further connect with my clients. Furthermore, I was able to choose effective clinical interventions based on the connections I was making with my clients. Approaching this study through Relational Cultural Theory (RCT) empowered me and made me a better clinician as I learned how to use the experience of fear and anxiety in response to countertransference and somatic countertransference to inform my therapeutic practice rather than inhibit it. Understanding countertransference and somatic countertransference from an RCT framework not only allowed me to forge stronger connections with my clients but it allowed me to form a stronger connection to myself. I identified how I personally become aware of the presence of countertransference responses and used this information to further connect with my clients and enter into a process of mutual empathy. This information allowed me to choose clinical interventions that were relative to the present needs of my clients which ultimately made my interventions more effective and made the treatment more effective.

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Appendix A: Definitions of key terms

Anxiety

General feelings of unease or discomfort, which cannot be linked to a specific source or situation. These feelings are in anticipation of an event rather than in response to the immediate onset of an event as is the situation of fear (Bourke, 2005).

Cathartic Experience

A process in which a client openly expresses their emotions in order to gain a deeper “understanding of and appreciation for the psychological forces that impact their lives” (Ivey, 2007, p. 246).

Clinical Decision Making

A continual process of assessing clients and then selecting effective interventions based on the assessments that are made (Laiho, et al., 2013).

Compassion Fatigue

“A general term applied to anyone who suffers as a result of serving in a helping capacity” (Rothschild & Rand, 2006).

Countertransference

The reactions experienced by a therapist in response to the patient’s own infantile wishes, projections, and object relations the patient places on the therapist (Freud, 1910; Pallaro, 2007).

Fear

A situation in which an individual has an identifiable source of discomfort or unease (Bourke, 2005). These feelings are also in response to the immediate onset of an event rather than the anticipation of an event as in the case of anxiety (Bourke, 2005). Bodily responses, which are

instigated upon arousal of the sympathetic nervous system, may be to fight, flee or freeze depending on the situation (Bourke, 2005 & Clarkson, 2002).

Freeze

Paralysis that is often experienced with muscles that either slack, like when a mouse is caught by a cat, or stiffen, like when a deer is caught in headlights (Rothschild & Rand, 2006, p. 102).

During freezing an individual may have an almost dissociative experience in which there is “an altered sense of time and space, reduced registration of pain, and dampened emotions” (Rothschild & Rand, 2006, p.102).

Healthy Boundary

The physical distance a therapist maintains which allows the therapist to reside in the comfort zone and feel protected while working with their clients (Rothschild & Rand, 2006). A therapist may further maintain healthy boundaries through choosing clothing which makes them feel comfortable or protected, tensing certain muscles or areas of the body where they feel more vulnerable, and actively choosing moments throughout a session to become mindful of the here and now when clients are recounting traumas (Rothschild & Rand, 2006).

Improvisational Movement

“a process of nonverbal free association during which the individual permits his body to move spontaneously and unguardedly (Schoop & Mitchell, 1974, p. 143)”.

Mirroring

The ability to, “kinesthetically and visually experience that which the patient was experiencing and trying to communicate (Levy, 2005, p. 24)”. It has been referred to as, “...Participating in another’s total movement experience, i.e., patterns, qualities, emotional tone, etc. (Sandel, Chaiklin, & Lohn, p.100). A dance/movement therapist engages in mirroring by fully

embodying all aspects of the client's total movement experience including the client's affect, respiration pattern, gestures, postures, muscular tension, movements, and vocal intonations (Rothschild & Rand, 2006; Sandel, Chaiklin, & Lohn, 1993).

State Anxiety

“A therapist factor that seems theoretically central to countertransference, but that has not been examined empirically” (Hayes & Gelso, 1991, p. 285).

Somatic countertransference

Bodily felt responses and reactions which occur in a therapist during the therapeutic process in response to the bodily felt sensations of a client (Bernstein, 1984; Pallaro, 2007).

Transference

Transference is the process in which the client is “literally transferring the thoughts and feelings they have towards others onto the therapist” (Ivey, 2012, p. 210).

Appendix B: Tables

Table 1

Process of Awareness

