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# Stuck in Somatic Countertransference: A Heuristic Study

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STUCK IN SOMATIC COUNTERTRANSFERENCE: A HEURISTIC STUDY

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in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Department of Creative Arts Therapies

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## **Abstract**

This heuristic research study explored how somatic countertransference in my own body, as a clinician, is related to my freeze response when working with clients in a behavioral health hospital. Primary questions that led the research, included: what does somatic countertransference feel like in my own body as a clinician, what happens in my body during a stress response of freezing, and, how can I modulate through my stress response to become regulated in session? These curiosities led to my ultimate research question, how can I, as an emerging dance/movement therapist, modulate through my freeze response while experiencing somatic countertransference with patients in hospital programs for mental health? Data were collected in the form of journal entries, watercolor paintings, and embodied writing and were analyzed, with the aid of a research collaborator, through Moustakas' approach to heuristic research. Findings indicated how the freeze response and somatic countertransference are connected in my body through feelings of anxiety and fear. Also, I explored the use of body based coping techniques to assist in modulating through my freeze response in order to be fully present with the group. Lastly, I discovered how to be connected physically, mentally, and emotionally in my body during dance/movement therapy group facilitation. I found an increased understanding of my own somatic countertransference symptoms. The process I created for myself to modulate out of a freeze response may assist other novice dance/movement therapists understand how to regulate their bodies in a group session, creating a fuller experience for all parties involved in the group process.

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## **Chapter One: Introduction**

Stepping into a role as a therapist is no easy feat. Students are educated and practice countless hours of clinical work in the classroom before taking the leap into practicum and internship work. In the Dance/Movement Therapy & Counseling program at Columbia College Chicago, students learn the history and purpose of dance/movement therapy (DMT), cultural competencies, how to lead DMT groups, and the proper techniques of counseling. This education prepares the budding therapist for real world experiences and provides new perspectives in the therapeutic relationship between patient and therapist.

Starting my role as a DMT intern, I noticed right away the difference between the classroom experientials and leading DMT groups in a behavioral health hospital. As a student, I had a safety net if I ever fell. I knew my classmates were acting and roleplaying during experientials and they would help me out if I were to ever get stuck. I had faculty guiding me through the process of leading groups and giving me feedback on my progress. I had the opportunity to try different ideas and test them out to see if they would be successful or not. I had the opportunity to fail and the opportunity to learn from my mistakes. I did not realize how much I took this for granted until I began working in an inpatient setting with actual people dealing with actual issues.

### **Problem**

As an intern, I knew I would be working in real life situations, where people are in high stress, crisis mode seeking help to relieve some of the emotional pain they carry with them daily. Until I was actually in the hospital, I did not fully understand what that meant. Working closely with a variety of diagnoses, I quickly realized something inside me was different than when I was leading groups in the classroom. I began noticing body-based anxiety, racing thoughts,

second-guessing myself, and—at times—wanting to run out of the room or crawl out of my skin when leading groups in the hospital setting. I noticed these feelings in different groups with a variety of patients. I also noticed additional body cues that felt extremely foreign to me. With all of these visceral symptoms, my mind felt like it was not able to process and connect with a single thought; so much was happening in my mind. So many times, I experienced feeling that my voice was frozen in my throat. I would try and speak but nothing would come out. My body was on hyper drive, feeling like I needed to get up and leave the room. Yet, my muscles were locked in place, and I could not physically move. At times, I also experienced extreme shifts in my levels of energy: I would go from feeling alert and present to fatigued and confused from just walking into a group room with patients present. I knew this was an issue, but I did not know how to change it or what was even happening to me.

I brought my concerns to supervision and explained my symptoms to my supervisor. She labeled my experiences as somatic countertransference. This phrase was familiar to me. We briefly learned about it in the DMT program. Somatic countertransference has been defined as the bodily felt responses and reactions that occur in the therapist during the therapeutic process in response to bodily felt sensations of the client (Bernstein, 1984; Pallaro, 2007). I was curious to understand more about somatic countertransference and how it could interrupt body regulation for me as a DMT intern. Feeling dysregulated in a therapy session led to me not feeling present in the group and not utilizing my skills as a DMT intern to my best potential. Being stuck in the experience of somatic countertransference made me feel like I was not providing adequate care for the patients and not providing them with a cohesive therapeutic relationship. I did not understand why I was experiencing a freeze when I was met with somatic countertransference brought on by my experience with patients. Why did my body and voice stop moving when it

became flooded with information and different experiences of the group? I wanted to learn more about this feeling and again spoke with my supervisor. We discussed the idea of feeling like a deer in the headlights and how that is impacting my ability to lead a group and linked this feeling to the fight, flight, or freeze response, also labeled as the stress response. The original fight or flight reaction to a threat was coined by Cannon (1927), and described the actions in response to a perceived harmful event or threat. Barlow (2002), adapted this theory, adding the idea of *freeze*. When either fleeing or fighting dangerous stimuli, freezing may take place in the body, likely causing ineffectiveness or immobility (Barlow, 2002).

Connecting these two ideas together at first did not make sense to me. Why am I having a stress response when leading a group? I thought I was prepared for this. I had the educational background and the drive to become a dance/movement therapist. It was my dream to get to this place, so why was I experiencing the group as a perceived threat? Thinking about my experiences this way created frustration and doubt in my mind. I knew I had to shift to a different thought process and explore the reasons behind my responses. Choosing to research and collect personal data on this topic led to the creation of this thesis. I sought to learn what somatic countertransference feels like in my body as a clinician, what happens in my body during my stress response, and how I can modulate through my stress response to become regulated in session. I hoped to accomplish a better understanding of why I freeze in sessions when somatic countertransference arises and how to regulate myself during these times. Exploring new ways to minimize the stress response in my body will allow for me to become a more effective dance/movement therapist.

## **Value of the Study**

This research will deepen my understanding of how somatic countertransference enters my body and the reactions that come from that experience. Researching my experience will create a dialogue for other emerging dance/movement therapists experiencing similar situations. This may validate others' experiences with somatic countertransference and create different perspectives about how to manage the stress response. I hope to build on the research that explores somatic countertransference and how that contributes to the state of hyperarousal in a clinician. By combining existing research with my lived experience, I may create new perspectives for others regarding this issue. My intent is to help myself, other emerging dance/movement therapists, and established clinicians to understand why we might be feeling temporarily disabled or in a freeze response during a session. As I act as a research participant and explore how I am able to modulate my body back to a regulated state, I may assist others struggling with this concept. Contributing a self-study to the body of work will expand the research on the topic by giving a first-person example of the process of modulation from freeze toward regulation.

## **Theoretical Framework**

I approached this research with a narrative therapy and solution focused approach. "Narrative therapy emphasizes the importance of storytelling and focusing on client's strengths and goals, as well as supporting clients in formulating plans for future action and change" (Ivey, D'Andrea, & Ivey, 2012, p. 159). Using narrative therapy to articulate multiple viewpoints and focus on the positive impact that my story held helped me to develop the possibility of change (Ivey et al., 2012). Finding the positives and seeing multiple perspectives in a single story allowed me to find growth in my development as an emerging dance/movement therapist. Using

the characteristic of narrative therapy, I externalized the issue by separating myself from the somatic countertransference and stress response. This helped me to see the issue in a variety of different perspectives and identify possible solutions for the future (Ivey et al., 2012).

Combining narrative therapy and a solution focused therapy approach narrowed my results and helped me to change my focus from what is not working (freezing while experiencing somatic countertransference) to what will work (modulating through the freeze response and allowing my body to regulate to better facilitate the group) (Madigan, 2011). As I discovered resources within myself and created a toolbox of skills to help manage my visceral symptoms, I had the opportunity to expand my therapeutic repertoire and potentially assist others who are experiencing these same symptoms.

### **Research Question**

How can I, as an emerging dance/movement therapist, modulate through my freeze response while experiencing somatic countertransference with patients in hospital programs for mental health?

## **Chapter Two: Literature Review**

The purpose of this literature review is to focus on somatic countertransference and how it relates to the trauma response of freezing in a DMT session. This literature review also covers fear and anxiety and how they also contribute to the freeze response. I was drawn to this topic to deepen my understanding of my work as an emerging dance/movement therapist and explore new literature that could help to support my journey. I am motivated to learn more about modulating out of the freeze response and how that can be beneficial for both therapist and client. The content of this literature review has been grouped into several specific categories. This review will examine: transference, countertransference, and somatic countertransference; the fight, flight, freeze response—also known as the stress response; fear and anxiety; professional development; and the mind-body connection. There is a vast research bank of information when it comes to these specific topics. I will be highlighting a small percentage of literature in these researched areas. Connecting these topics will create a deeper research base for my study and bring new light to previously studied topics.

On my journey of becoming a dance/movement therapist, I have found myself wondering about how to incorporate the mind while increasing my use of the body. As I deepened the process and gathered more information on the mind-body connection, I found new inroads through researching different responses to somatic countertransference and the benefits of this research for both client and therapist. Researching the literature about freeze responses and understanding the body of knowledge on this topic helped me to have a deeper understanding of how the somatic countertransference I experience in groups initiates a freeze response in my body and to explore approaches or research indicating ways to modulate out of that response.

## **Transference, Countertransference, and Somatic Countertransference**

### **Transference**

In determining where the idea of somatic countertransference came from, I noted that Freud (1912) used the term *transference* to “refer to the patient’s reproduction of past relationships in the current relationship established with the therapist” (Dosamantes-Beaudry, 2007, p. 75). If the clinician reminds the patient of someone in their past or a current relationship they have, the patient has the tendency to unconsciously project feelings onto the therapist (Freud, 1912). Dosamantes-Beaudry (2007) stated, “Ideally the analyst should be a blank canvas upon which the patient could project his innermost feelings and wishes” (p.75). This concept of transference can have both positive and negative effects on the therapeutic relationship. Transference can either provide a reparative opportunity to a broken relationship or create unconscious tension within the therapeutic relationship. Being aware of transference in a session and bringing awareness to the transference energy in the room may help the patient as well as the therapist deepen the healing process and allow space for growth and trust to be built in the therapeutic relationship.

Not only can patients have this reaction affect their relationship with the therapist, conversely, the therapist can also feel the effects of this unconscious projection of feelings and emotions. Exploring the literature about countertransference will deepen the understanding of how somatic countertransference came to be a part of the literature as well.

### **Countertransference**

The phenomenon of countertransference layers onto the idea of transference. Countertransference is a complex psychoanalytic concept. Freud (1912) identified that countertransference occurs when a therapist transfers emotions onto a patient. This is usually an

unconscious response to the transference of a patient, who is projecting thoughts or feelings for others onto the therapist. Sandler, Dare, & Holder (1973) explored the idea of countertransference and elaborated on Freud's concept suggesting, "...the most useful view of countertransference might be to take it as referring to the specific emotional responses aroused in the analyst by the specific qualities of his patient" (Ross, 2000, p.453).

According to Pope, Sonne, and Greene (2006), counselors who do not practice the idea of becoming self-aware may ignore their feelings of countertransference and then model the idea of minimizing issues present in the room, thus resulting in modeling poor behavior by avoiding difficult topics and negating the impact of the therapeutic process. Ignoring the countertransference and creating an elephant in the room causes voids in the healing process. Countertransference is not necessarily problematic when it comes to managing emotions and feelings towards a patient, it can become an issue when those feelings are ignored (Pope, Sonne, & Greene, 2006). The phenomenon of countertransference needs to be brought into the awareness of the clinician and addressed in order to establish a healthy therapeutic relationship between therapist and patient.

Racker (1968) described two different types of reactions of countertransference: concordant countertransference and complementary countertransference. Concordant countertransference are reactions of the clinician to feel empathically with the patient's thoughts and feelings, whereas complementary countertransference reactions occur when the therapist feels transformed into a negative aspect of the patient's self (Dosamantes-Beaudry, 2007). For example, if the therapist feels a reaction of concern and deep empathy for the patient while experiencing countertransference, that would be considered concordant countertransference. On the other hand, if a therapist feels irritated or frustrated with the patient after the patient stated an

issue that stirred countertransference in the therapist that would be complementary countertransference. Within the literature, there seems to be disagreement about where countertransference originates. One side believes it is an exchange resonating in the therapist, where the therapist is reminded of someone through the patient. Other research explains the phenomenon as the patient experiencing transference, creating an unconscious shift in the therapist, which in turn causes the therapist to feel the effects of countertransference. Seeing the effects of countertransference on a body level leads the research process to examining the effects of somatic countertransference.

### **Somatic Countertransference**

Forester (2007) noted that, in the fields of body-based psychotherapies, therapists work with somatic countertransference daily. It is part of training, daily life, and ongoing practice. However, it has not been the focus of writing or research that incorporated Freud's psychoanalytic ideas until recently by Dosamantes-Beaudry (2007), Eckberg (2000), Holifield (1998), Pallaro (1994), Siegel (1984), and Stromstead (1998). Thus, Forester stated, "There is accordingly a great need for somatic therapists to contribute writings on somatic countertransference" (2007, p. 126).

Dosamantes-Beaudry (1997) used the term somatic transference to refer to the somatic reactions a patient has towards their therapist and somatic countertransference to "...the somatic reactions a therapist has toward her patient at a particular moment during treatment" (p. 522). Orbach (2003) described somatic countertransference as connecting the innermost core of the client to the safe container of the dance/movement therapist. In this view, therapists' bodies are considered transference objects for patients, creating the "...intersubjective subjective experience of therapy" (Orbach)... (Young, 2017, p.98). Forester (2000), stated that somatic

awareness is "...an essential key for monitoring somatic countertransference" (p. 73). Stone (2006) described somatic countertransference as metaphorically similar to a tuning fork. She stated that the therapist's responses to the client could help aid the therapist in attuning to the client's emotions. Bernstein (1984) was the first to coin the term *somatic countertransference*: "She noted the necessity to be aware of and embody the patient's somatic unconscious so as to aid the patient in the process of cathecting, metabolizing, and integrating split-off parts of the self, as well as revealing the patient's resistances and defenses" (Pallaro, 2007, p. 186). Forester (2007) added to the literature stating, "...somatic countertransference is the effect on the therapist's body of the patient and the patient's material" (p.129). She also adds clues for recognizing countertransference reactions in the body, such as shifts in feelings, moods, or thoughts occurring on a continuum from simple sensations to sensory experiences incorporating cognitive responses. Some of these experiences may appear to embody something that belongs to the patient and other times, a somatic reaction may be from the patient's material evoking the therapist's material (Forester, 2007).

Somatic countertransference is more than a feeling or intuition. It is a visceral reaction in the body, mind, and spirit of the clinician in response to the client. Some common sensations associated with somatic countertransference, include: dizziness, pain, hunger, fullness, claustrophobia, fatigue, and restlessness (Pallaro, 2007). Though clinicians often report that undetected somatic countertransference 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). Vulcan (2009) highlighted the importance of the therapist being aware of their own body, including: sensations, images, feelings, and thoughts, as a means of providing information about the client's process.

Just like the idea of countertransference being grouped into two categories, somatic countertransference can also be classified as two different reactions: concordant and complementary (Pallaro, 2007; Racker, 1968). Dosamantes-Alperson (1987) stated she brings awareness to "...bodily-felt reactions to complementary countertransference reactions to determine the emotional developmental level achieved by a given patient and to assess the kinds of movement experiences that are likely to facilitate emotional growth" (p.212). Schore (2003) stressed the notion that a clinician must be able to differentiate between the patient's material and the clinician's own material. The clinician must also be able to exercise the capacity to think reflectively and recognize the countertransference bodily signals that may cause discomfort (p.97). Schore (2003) stated, "Only by sensing and paying attention to one's own counterregulatory reactions to the patient's dysregulation" (p. 98) can the therapist access information for the patient's benefit, hold unexpected bodily sensations, and thus model a self-regulating capacity for the patient" (Pallaro, 2007, p.186).

In many verbal therapists, there is a feeling of shame or embarrassment when experiencing bodily felt reactions towards their clients causing the therapist to not share their experiences and process such information in a supervisory environment (Beard, 1992; McDougall, 1989; Rutter, 1989). This, in turn, creates a problem where the therapist's somatic experiences are ignored or minimized. Over time, these experiences build up tension in the clinician's body and the stress of the somatic countertransference gets in the way of the therapeutic relationship between patient and therapist (Forester, 2007).

The therapist who ignores the bodily felt sensations of somatic countertransference can often times feel an increase in vulnerability towards the bodily experiences. This increases the impact these sensations have on the therapist during sessions with continued somatic

countertransference (Forester, 2007). When a clinician becomes more than just affected by the patient's material, there is the potential of the therapist becoming traumatized by the bodily felt experiences of somatic countertransference. When the clinician is unable to process through those pieces of the material, it can negatively impact the patient, the clinician, and the course of therapy (Forester, 2007). Forester (2007) noted, "Therapist's use of their body awareness and somatic countertransference are crucial sources of information in clinical work. When attended to, they can inform the process of therapy and reduce the likelihood of the therapist suffering from vicarious trauma" (p.130).

Exploring the literature about transference, countertransference and somatic countertransference lead to the exploration of the stress response. Learning about how body reactions can trigger different unconscious responses needed to be reviewed, in order to comprehend what my body was trying to tell me during dance/movement therapy sessions and to deepen the understanding of where the freeze response I was experiencing was coming from.

### **Fight, Flight, or Freeze**

Since the early 1900s, the fight or flight response has been well known in psychology. First coined by Cannon in 1927, the fight or flight response—or the acute stress response—was created to describe the key behavioral factors of an animal dealing with a perceived threat: instinctually fighting or instinctually fleeing. Researchers have extrapolated the fight or flight concept into anxiety research. Barlow (2002), for example, added the freeze response to a perceived threat. The fight, flight, or freeze response is also referred to as the trauma response (Barlow, 2002). Gallup (1977) was one of the first researchers to add the idea of freeze to the acute stress response, describing the freeze response as "...tonic immobility, which includes motor or vocal inhibition, with an abrupt initiation and cessation" (p. 292).

Martin (2016), stated:

The fight or flight response is a sequence of internal processes that prepares the aroused organism for struggle or escape. It is triggered when we interpret situations as threatening. The resulting response depends on how the organism has learned to deal with threat, as well as on an innate fight or flight 'program' built into the brain. (para. 3)

There are multiple factors that contribute to the stress response. The stress response is activated in the brain. The external stressful stimulus is sent to the brain via the senses. The information is sent to the amygdala, the area of the brain that processes emotional matter. When the amygdala interprets the information as dangerous, it will send a distress signal to the hypothalamus, also located in the brain. From the hypothalamus, a distress signal is sent throughout the entire body through the nervous system either creating a fight, flight, or freeze response (Harvard Health Publishing, 2018). Porges (1995) introduced the Poly-Vagal Theory describing how the vagal nerve in the brain is connected to the parasympathetic control of the heart, lungs and digestive system. According to Porges (1995), the vagal nerve is activated when the fear responder becomes inhibited.

Immediately following the signal of danger, the body releases hormones such as adrenaline into the blood stream. Heart rate and blood pressure increase, pumping blood into the muscles, heart, and other vital organs, in turn causing increased breathing rates. Airways in the lungs open wider, allowing for more oxygen to be absorbed into the body. Thus, higher oxygen rates are sent to the brain, increasing alertness in all senses. Sight, sound, smell, taste, and touch become intensified as the body undergoes this instantaneous reaction to a threat. Meanwhile, epinephrine triggers the release of blood sugar (glucose) and fats from temporary storage sites in the body. These nutrients flood into the bloodstream, supplying energy to all parts of the body

(Harvard Health, 2018). These changes happen in the blink of an eye. Most of the time, people are not even aware that their body is undergoing a stress response until after everything is said and done and the stimulus is gone or the event is over. The three responses to a threat are fight, flight, or freeze. The vast literature on these responses focuses on these main ideas.

### **Fight**

In the primitive nervous system, this reaction of fight occurs when there is a stimulus perceived as dangerous and the body goes into survival mode. In this almost instantaneous reaction, whether accurate or not, the body will sense it has the power to confront the stimulus. The body will release hormones from the sympathetic nervous system and gear up for battle (Martin, 2016). In today's world, the fight response tends to lead people to stand their ground, defend their position, attack, and resist the idea of compromising (Hart, 2013).

### **Flight**

In a flight response, the brain senses it does not have the capacity of fending off the noxious stimulus and gears the body up to flee the situation instead of fighting. The nervous system still pumps hormones into the body, creating the energy needed to run away from the situation (Martin, 2016). Nowadays, most people will not encounter a bear outside of their habitat or try to escape the clutches of a sabre tooth tiger. However, these ancestral responses are still in action in the human body. Today, the reactions in a stressful situation might be giving up, giving way, retreating, or moving on (Hart, 2013).

### **Freeze**

In recent years, the term freeze has been added to the acute stress response and the acute stress response has been termed either a fear response or a trauma response. In a freeze response, the body is ultimately frozen in fear. This has been studied in pan-mammalian species

throughout the world. According to Brancha (2004), “The freeze response corresponds to what clinicians typically refer to as *hypervigilance* (being on guard, watchful, or hyper-alert). This initial freeze response is the stop, look, and listen response associated with fear” (p. 448). Rothschild and Rand (2006) theorized the freeze response occurs in the presence of a fearful object when the parasympathetic nervous system and the sympathetic nervous system are triggered at the same time. The activation of both nervous systems results in the body becoming overwhelmed, resulting in momentary paralysis noted in the freeze response (Rothschild & Rand, 2006). There are disputes on how the response is triggered; however, the freeze response itself can be described as the “...tonic immobility, which includes motor or vocal inhibition, with an abrupt initiation and cessation” as aforementioned (Gallup, 1977, p. 292).

In the stress response, the idea of a threat is presented in the literature. Van der Kolk (1989) states that traumatization occurs when the both internal and external resources for a person are inadequate to cope with an external threat. Physical and emotional maturity play important roles in managing the stress response to an external stimulus (van der Kolk, 1989). Understanding ones own maturity in managing stressful stimuli is beneficial to deepening the understanding of the intensity of a personal stress response. A human reaction to a threat can be both fear and anxiety; therefore, it is important to research the literature presented on fear and anxiety to deepen my understanding of what is happening to my body during dance/movement therapy groups and whether it is anxiety, fear or both.

### **Anxiety and Fear**

The experiences of fear and anxiety are similar, but research has shown that they originate differently. Experiencing anxiety and experiencing fear are often accompanied by somatic symptoms, such as: muscle tension, shortness of breath, accelerated heart rate, shaking

or trembling, upset stomach, and tightness throughout the entire body (Ankrom, 2018).

Knowing that both emotions can set off a stress response, it is important to understand the origins of each. Although not all the literature agrees, Ankrom (2018) explains the major difference between fear and anxiety is that fear is a response to a real threat, a concrete object or situation, whereas anxiety is a response to an imagined or an interpreted threat.

### **Fear**

The emotion of fear is triggered when individuals feel that they are in danger. In an earlier study on fear, researchers identify one of the fundamental functions of this emotion:

A fearful reaction to dangerous things is one of the most fundamental of human experiences. The emotional experience of fear almost certainly has deep evolutionary roots and still serves the useful function of compelling individuals to vigilantly avoid those things. (Sadock, Sadock, and Ruiz, 2015, p. 637)

Fear can be crippling and lead the body to a trauma response. Fear is one of the most primitive human expressions still alive today. Fear can lead to anxiety or anxiety can lead to fear. The two emotions can be interwoven, but they are two separate entities (Ankrom, 2018).

### **Anxiety**

According to Sadock, Sadock, and Ruiz (2015), anxiety is a "...diffuse, unpleasant, vague sense of apprehension" (p. 624). Anxiety grew to be very well known in the twentieth century, largely due to Freud's stance in the media and psychoanalytic therapists using Freud's techniques in sessions with patients. During this time, anxiety was not conceptualized as an illness, rather just a part of human existence (Horwitz, 2013). With research being conducted on anxiety and the understanding of how anxiety can affect people differently, this idea that anxiety was not associated with mental illness started to shift. In an epigraph from Freud, he stated,

“There is no question that the problem of anxiety is a nodal point at which the most various and important questions converge, a riddle whose solution would be bound to throw a flood light on our whole mental existence” (Horwitz, 2013, p.118). During the 1950s and 1960s, the labeling of distress as anxiety led to the demand for relief from anxiety symptoms through medications. Using therapy mixed with prescribed medication became the modern way to treat feelings of stress and discomfort (Horwitz, 2013).

At times it is difficult for a novice therapist to distinguish between the two feelings of fear and anxiety because many times they experience them simultaneously (Batko, 2015). Establishing a connection between somatic countertransference and the feelings of fear and anxiety within the literature lead to the exploration of how the body is impacted when exposed to these somatic symptoms. Reviewing the literature on vulnerability helped to strengthen that connection.

### **Vulnerability**

Vulnerability can be defined as “capable of being physically or emotionally wounded” (Merriam-Webster’s Collegiate Dictionary, 1999). Rothschild and Rand (2006) wrote, “all emotions are contagious” (p. 9), both the pleasant and unpleasant ones can be absorbed by patient or clinician, impacting the emotions of the unsuspecting person unconsciously resulting in either transference or countertransference (Rothschild & Rand, 2006). Having the emotions of fear or anxiety present creates a vulnerability in the body to take on more stress, especially in a novice therapist. Skovholt & Ronnestad (2003) stated:

The beginning counselor/therapist is highly vulnerable. Professional self-worth closely coexists with client improvement. The novice is often not fully aware of this self-focus

strand in the unrealistic expectation of ‘If the client really gets better, expresses appreciation, or likes me, I’m really good at helping.’ (p. 53)

The literature on vulnerability related to emerging therapists introduced the idea of an additional piece of anxiety that comes with the role of new clinician. Performance anxiety in particular has been studied in novice counselors.

### **Performance Anxiety**

Since anxiety became labeled as a disorder in the mid-twentieth century, multiple categories of anxiety have been extrapolated. Performance anxiety can be a major player in the beginning of a novice therapist’s career. Kelly (2011) explains that a reaction to pressure is a matter of interpretation. Psychologist Sian Beilock stated in an interview about performance anxiety, “The more supportive and friendly an audience is, the more self-aware we as performers get” (Kelly, 2011, p. 2). Beilock also explains that when the mental pressure becomes too great, the tendency to choke is greater, creating more anxiety and stressful encounters in the environment surrounding the novice therapist. Skovholt & Ronnestad (2003) noted that many therapists just starting off feel overwhelmed early in their careers, “They lack the professional confidence that buffers the experience of anxiety when difficulties are encountered. The anxiety of self-consciousness, which leads to focusing on oneself, makes it more difficult to attend to the complex work tasks” (p. 47).

Novice therapist anxiety can impact the quality of work the counselor contributes to the session. New clinicians may be aware of their own anxiety and try to hide it instead of optimally focus on the patient (Skovholt & Ronnestad, 2003). The combination of fear and anxiety in a novice therapist has the ability to seriously heighten stress levels and create a stress response in the body (Ankrom, 2018; Kelly, 2011; Skovholt & Ronnestad, 2003). Performance anxiety can

seem much higher to the novice professional at the beginning of their development as a therapist. In addition to anxiety, literature indicates emerging therapists work through a variety of emotions and feelings throughout the start of their professional work.

## **Professional Development**

### **Novice Therapist**

Stepping into the role as a novice therapist can be overwhelming to some. Mullenbach stated in a personal conversation with Skovholt, “The requirements for the novice to access, integrate, synthesize, and adapt information are exhausting” (Skovholt & Ronnestad, 2003, p. 45). As the beginning therapist steps into their first role helping people they are met with the harsh reality that the work may be much more difficult than anticipated. The standards for therapeutic practices can be ambiguous, as are the techniques and training (Skovholt & Ronnestad, 2003). The role of novice therapist comes with vulnerability and fragility (Skovholt & Ronnestad, 2003). Descriptions of having an unbalanced professional self relate to that fragile state of being. Stepping into a new professional role, the new clinician feels both enthusiasm and insecurity (Skovholt & Ronnestad, 2003). “Creating a practitioner-self, a term similar to that of Ellwein, Grace and Comfort... involves vigorous internal construction work, as well as external effort of trying on new clothes and new ways of being in the world” (Skovholt & Ronnestad, 2003, p. 50).

Novice clinicians will experience a variety of moods and emotions, such as: enthusiasm, insecurity, elation, fear, relief, frustration, delight, despair, pride, and shame (Skovholt & Ronnestad, 2003). Each individual is unique and each beginning therapist will respond to these experiences in his or her own way. Inevitably, becoming a practicing therapist involves stressors. Rodulfa et al. (year) found that in comparison with professionals, practicum students

and interns in psychology experienced significant stress related to a variety of very specific client behaviors that confused them, such as the client's lack of motivation or crying in a session (Skovholt & Ronnestad, 2003). The novice will experience countertransference and react emotionally to these encounters. Part of their reaction to the patient comes from the therapist's own body knowledge/body prejudice. The literature indicates understanding these concepts will allow for a stronger therapeutic relationship between client and therapist.

### **Body Knowledge/Body Prejudice**

The discovery of mirror neurons by Rizzolatti, Gallese and their colleagues has opened the discussion for the origin of empathy (Marsh, 2012). Mirror neurons are a type of brain cell that respond equally when we perform an action and when we witness someone else perform the same action (Moore & Yamamoto, 2012). Moore & Yamamoto (2012) noted, "While all humans possess the same perceptual mechanisms, these can be used in diverse culturally dictated ways" (Moore & Yamamoto, 2012, p.45). They go on to explain,

In addition to perceptual learning, culture dictates how the body is to be used. How one eats, how one sits, how close together or far apart people stand. By now it is well documented that these actions differ along cultural lines. (pp. 46-47)

Knowing one's own culture and being self-aware of one's own movement preferences helps to keep assumptions and movement interpretations about a patient at bay.

Body knowledge encompasses more than a physical skill of knowing the body, "It involves the mind, feelings and sensory-motor systems" (Gantz, 2015, p.13). Gantz (2015) broke down body knowledge into four stages:

**Stage one: Kinesthetic awareness.** Emphasis is on awareness of the body, sensations and perception focused on the subjective inner life—becoming grounded in the non-verbal realm, generating a felt sense.

**Stage two: Movement observation/analysis.** Moving and observing movement using the principles and terminology of Laban Movement Analysis.

**Stage three: Body reaction/prejudice.** Recognizing how another's movement may trigger a response in the observer (self).

**Stage four: Continuous kinesthetic empathic inquiry.** Establishing a mode of inquiry based on kinesthetic empathy. (Gantz, 2015, p.15)

Determining a clinician's own body knowledge/body prejudice eliminates certain judgments in the therapeutic movement relationship and creates a deeper connection rooted in empathy to create areas of healing for the patient.

### **Therapeutic Movement Relationship**

Young (2017) wrote,

The therapeutic movement relationship (TMR) can be traced to the beginnings of dance/movement therapy (DMT), introduced by Marian Chace as one of her four core concepts... and continues to be pivotal to the enactive, embodied, intersubjective framework... within the field. (p. 93)

The therapeutic relationship or the therapeutic alliance can be identified as the transference relationship to the genuine interpersonal relationship (Freud), the human relationship or the connection between therapist and patient (Horvath, 2005). Through the lens of interpersonal neurobiology, Siegel (2012) noted that the development of human interactions and relationships can directly impact the emotional well-being through the ability to both shape the development

of the brain and facilitate integration of the mind. The literature on the mind-body connection explores the ideas and importance behind establishing this connection within one's own body.

### **Mind-Body Connection**

Part of the mind-body connection was examined by Hackney (2002). She believed creating total body connectivity within the self is the intention behind the mind-body connection. Hackney (2002) described total body connectivity as "...the whole body is connected, all parts are in relationship. Change in one part changes the whole. Acknowledging relationship between the parts of the body brings the possibility for both differentiation of the parts and integration of the whole" (p. 39). According to Weinberg (2018), research in the field of mind-body medicine is finding connections between emotions and imbalances in the body. Therapeutic experiences such as mindfulness, meditation, and yoga, can help to bring balance back into the body and promote inner harmony between mind and body (Weinberg, 2018).

The mind-body connection is created on both a chemical and physical level. The mind incorporates more than just the brain. Mental states, thoughts, emotions, beliefs, and outlooks on life are connected within the umbrella of the mind. Different mental states can have either positive or negative impacts on biological functioning. According to Weinberg (2018), "This occurs since the nervous, endocrine, and immune systems share a chemical language, which allows constant communication between the mind and body through messengers like hormones and neurotransmitters" (p. 1). Stromsted (2007) discussed the importance of body-oriented psychotherapy and stated the process of bringing awareness to the body allows patients to feel more whole and explore more creative ways of living.

Finding the mind-body connection or reestablishing a severed connection between the two begins with breath (Hackney, 2002). Hackney (2002) stated, "Breath brings life and

movement. Breath is a physiological support for all life processes and, hence, all movement. Breath enlivens” (p. 41). Breath is automatic but can also be influenced by consciousness, feelings, and thoughts. It can bring in mindfulness and help bring a person into the present moment by connecting with one’s internal state, bringing awareness to the mind-body connection (Kabat-Zinn, 2005). Breath is the first movement pattern of total body connectivity and creates a platform of integration between body and mind (Hackney, 2002). Breath connects the inner world and outer world of a person. Breath creates a lively interplay between a person’s “inner connectivity and outer expressivity” (Hackney, 2002, p.34).

### **Conclusion**

The concept of freezing becomes salient for me when, as an emerging dance/movement therapist, it is necessary for me to use my body as a tool for understanding and managing all aspects of the session (Vulcan, 2009). I must enhance the process of therapy by tuning in nonverbally. In DMT, the therapist’s body becomes susceptible to many different kinds of energy while tuning in to and monitoring the room. It is the job of the DMT practitioner to bring the implicit to the explicit and explore nonverbal communication styles (Hackney, 2002). It is no wonder that a dance/movement therapist can then pick up on others’ energies and emotions, resulting in somatic countertransference (Orbach & Carroll, 2006). But what happens when clinicians have too much awareness of somatic energy, both their own and that of others? How can they regulate themselves to be effective therapists when overcome by impeding energies? That is to say, what sends me, as an emerging dance/movement therapist, into a trauma response of freeze when navigating somatic countertransference, and how can I manage that response?

## Chapter Three: Methods

### Methodology

My chosen methodology is a heuristic study utilizing qualitative methods for data collection. Moustakas (1990) looked at the processes that assisted the internal exploration of the researcher, allowing the person to discover something for themselves and about themselves. I infused this methodology with a transformative paradigm, giving me the opportunity to build the knowledge base of the community to reflect the power and social relationships in society to help find ways to improve society (Mertens, 2005). I chose this methodology to discover something within myself in order to become a more effective dance/movement therapist. In doing so, I may also help others who freeze in sessions with patients. A heuristic study allowed for me to deepen my understanding of how my mind and body work together, so I can translate my findings for others in the field. The purpose of this study was to bring awareness to somatic countertransference and how that can impact the trauma response. Using myself as a participant allowed for me to fully embody the experience and reflect on what is happening before, during, and after sessions. This led me to reflect on how I can self-regulate more effectively in session.

### Methods

**Population.** I was the sole participant in this study. I am an emerging dance/movement therapist intending to work in a mental health facility. Already in sessions with patients, as an intern, I have felt the effects of somatic countertransference and felt very sensitive to kinesthetic energy in a space. I noted being very susceptible to others' feelings and emotions, and I needed to work on boundary setting in order to keep myself safe in the process of managing somatic countertransference.

**Setting.** I used my experiences of somatic countertransference in sessions at a behavioral health hospital and journaled about the process after group sessions with patients. I also used my home as a place of reflection and processing after the journaling process.

**Data collection methods.** Moustakas (1990) articulated six distinct phases in a heuristic study: Initial Engagement, Immersion, Incubation, Illumination, Explication and Creative Synthesis. I utilized these stages throughout my research process focusing on phases one through three in my process of data collection and the final three phases during my data analysis of my research. The first stage of Engagement is when a clinician has thought about or has been engaged in an idea for some time. In my case, my research question has been percolating since I started my internship at Linden Oaks and noticed that I sometimes feel disoriented and fatigued in certain groups. I became curious about why this was happening and started researching somatic countertransference. I also noticed that when I became disoriented, I froze in the group. I was not able to think clearly or respond to group members when I froze. This engagement of somatic countertransference and feeling frozen in the group brought me to the next step of the process.

The next step is Immersion, where I was immersed in the research question of why I freeze when I experience these bodily sensations. I collected data in the immersion stage by journaling my experiences in groups, writing down as much detail directly following the group as possible so everything was still fresh. I tracked body felt sensations and noted how I felt before, during, and after a group, to document any shifts of energy I had come across and/or picked up from the group. These journal entries highlighted the setting of the groups and my initial responses to any somatic countertransference, so I could return to these groups more accurately later in my process.

I used watercolor painting in my home to reflect any sensations, movements, images, feelings, or thoughts that came up for me while processing the exchanges of energy from the group at the hospital. I chose watercolors because I feel comfortable in this medium and the way the colors blend and move together relates to my creative process of blending old thoughts with new ideas. I also documented any residual energy that had stayed present with me during the reflective process. I chose to not document movement phrases because I know I will be too critical in analyzing my own movement and the creative process will be lost. Using a different modality—like watercolors—provided me with a different approach to the data and allowed for me to find different pathways of bringing my implicit feelings into the explicit and see my process on paper. To explore more understanding of the groups during which I feel somatic countertransference, I created journal entries of embodied writing where I reflected on the groups in question and noticed if any themes or symbolism came up for me to help process my journal entries and connect my art making and writing together. In my embodied writing journal entries, I deepened my thoughts from my original journal entries to elicit more responses that might not have been initially present.

The final step of my data collection process is Incubation, when I took a step back and implicitly analyzed data and reflected on what came up for me. These were different feelings and sensations surrounding somatic countertransference and the trauma response and how those internal feelings connected to the research question (Cruz & Berrol, 2012). During incubation, “...the inner workings of the tacit dimension and intuition continue to clarify and extend understanding on levels outside the immediate awareness” (Moustakas, 1990, p. 29).

**Data analysis methods.** Continuing with Moustakas’ (1990) organic approach to heuristic research, I then analyzed the data collected in this study. In Moustakas’ approach to

research, he presented a six-step method starting with Engagement, Immersion, and Incubation as stated in the data collection section. In the next step, Illumination, I began the process of analyzing the data collected from journaling and art making. The Illumination stage is where new understandings of the data can be developed and brought into the conscious mind. During this stage, I met with my research collaborator to explore emergence of possible themes and create new perspectives of the data that had been collected. Appendix B holds the collaboration agreement for my research collaborator and myself, to establish a mutual understanding for our time together.

Following Illumination, I returned to my notes and journal entries for the fifth step of Explication. Here, I revisited the data and analyzed again to make sense of the information in a more profound way, seeking different ideas or potential themes that I had not noticed from the first round of analysis. This step created more opportunities for the unconscious to become conscious and allowed for more ideas to be developed. Revisiting the data helped to solidify my findings.

The final step of Moustakas' heuristic research approach is Creative Synthesis. Here, I took all of the collected data that I meticulously analyzed and related it to the present field of knowledge surrounding somatic countertransference and the trauma response. Using this approach, I explored the creative synthesis of visual art making using watercolors and documented how those generate a deeper understanding of my process of experiencing other phases of my freeze. I created one final reflective piece of artwork, Appendix A, that pulled from the themes and emerging ideas from data collection, allowing for my personal experience to help others with similar experiences find a connection to a more articulated example of somatic countertransference and freezing (Cruz and Berrol, 2012).

## **Validation Strategies**

I utilized the idea of triangulation as a validation strategy. Creswell (2013) stated, "...in triangulation, researchers make use of multiple and different sources, methods, investigators and theories to provide corroborating evidence" (p. 251). Having a way to validate my data collection was very beneficial to the analysis process. Using different samples of the same interactions with somatic countertransference created a deeper understanding of the phenomenon. I used journal entries, art making, and embodied writing as sources of data.

Having a research collaborator to provide feedback on my collected data provided another set of eyes on my project to help pull themes from my work and act as a point of reference when I sought guidance during data analysis. I asked my research collaborator to serve in the role of the peer debriefer. Creswell (2013) refers to Lincoln & Guba's description of the role of the peer debriefer as "...an individual who keeps the researcher honest; asks hard questions about methods, meanings, and interpretations; and provides the researcher the opportunity for catharsis by sympathetically listening to the researcher's feelings" (p.251).

## **Ethical Considerations**

Considering this is a self-study and journal entries were written in a public environment, I did not use patient names in entries and kept my work with me at all times. I typed the entries on my password-protected personal computer.

I had a research collaborator with whom to dialogue about the process and work through Moustakas' steps. Keeping beneficence in mind, I created a written agreement that outlined the process and collaboration between us. This ensured all parties involved had a clear vision of the collaboration process and a full understanding of the researcher/collaborator relationship. This was my project and I took ownership of the process. My main hope for my research collaborator

was to receive assistance in finding themes in journal entries and receive feedback on how to keep my research ethically sound. See Appendix A for agreement.

## **Chapter Four: Results**

At the beginning of this research study, I set out to answer the question, how can I as an emerging dance/movement therapist modulate through my freeze response while experiencing somatic countertransference with patients in hospital programs for mental illness? After documenting 20 groups where I experienced somatic countertransference in various ways, I compiled my findings into three categories: symptoms of somatic countertransference, effects of the freeze response, and different ways I was able to overcome my responses to the group. Several themes arose during data analysis of my journal entries and art making, all of which fell into one of these three categories. Some of my collected data overlapped categories, meaning I experienced more than one category in certain groups I was leading. I made certain to collect as much data as possible through each group and to analyze the possible themes and outcomes of each piece of data. Sifting through my personal experiences allowed me to connect these themes in various ways. This chapter highlights the main themes I extracted from my data.

### **Somatic Countertransference Symptoms**

To fully understand my symptoms of what I labelled somatic countertransference, I brought more awareness to my own body's reactions and documented each shift in a variety of ways: journaling, art making, and embodied writing. After analyzing the data, I noticed some common themes in my symptoms of somatic countertransference. My artwork reflected these sensations as well. In art, color is not assigned to emotion or feeling. However, for the purpose of research and deepening my own implicit feelings, I found it beneficial to assign certain color to my art making and create a color key to represent different feelings, energies and emotions I experienced in the different groups. The color key assisted my own understanding of my experiences in the group by identifying similarities and differences within the same color

scheme. Orange represented anxiety, yellow signified joy and happiness, green demonstrated groundedness, blue was breath, purple represented confusion, and black signified a freeze during session.

### **Shifts in Energy**

Through this process, I realized I am sensitive to shifts in energy related to emotions, feelings, alertness, and groundedness. I noticed I picked up different energy in each group I am a part of. Before entering a group, I would take a minute to check in with my body. How am I feeling? What is my mood? How is my energy: am I tired, alert, or energized? I would focus on what was mine before I took a step into the group room. Multiple times, I noticed changes in my own energy levels. I would walk into a group and feel like my energy was being pulled from my body.

Stepping into the room, I felt a swarm of new energy surrounding my body. I felt a buzzing in my brain and my balance became unsteady. It felt like my energy was being drained from my body.

This feeling of being stripped of my own energy was a common symptom of my experience with somatic countertransference. I noticed this shift in many different groups with different populations. The strongest shift in energy levels consistently occurred during a support group I helped lead. There were a variety of people with a variety of diagnoses present in this weekly group. In this group, people had been diagnosed with bipolar I, recurring depressive episodes, borderline personality disorder, and anxiety. I articulated this energy shift in my artwork (See Figure 1). The crossing brush strokes indicated feeling unsteady. The colors blended together, creating a muddy effect. I related this to the idea of blending my energy with others.



Figure 1  
Watercolor Artwork

Another type of energy shift that appeared in several groups I documented was a push-pull energy.

I felt dizzy. The energy felt like a magnet being turned off and on and my body felt like it was pushed and pulled in my chair. I tried to block the energy, but I did not know how.

For the remainder of the group, I felt this push-pull sensation.

Along with this push-pull energy came other somatic symptoms. I experienced dizziness, nausea, light headedness, feeling unbalanced, and feeling uncoordinated.

I feel the energy pierce through and hit me in the chest and head. I feel unbalanced and the push pull energy is very strong. As I sit, I become nauseous from the dizziness I am

experiencing. I feel so defeated and uncomfortable in my body and the group has not even begun.

I discovered there is a connection for me between these somatic symptoms and when I feel another energy source in the room. The energy I sensed created a reaction and a body response for me that felt foreign and interrupted my flow of energy, resulting in discomfort and confusion. The confusion I experienced occurred both on a body level and on a mind level. My body created tension where it usually would not hold on to tension, for example in my hands, feet, and chest. I also became disoriented at times and unable to process dialogue with patients when feeling these foreign energies. My mind felt foggy and confused as I tried to figure the best way of working through these symptoms. In my artwork for this journal (See Figure 2), I painted a tornado in purple representing my dizziness and confusion that resulted in anxiety and a freeze response.

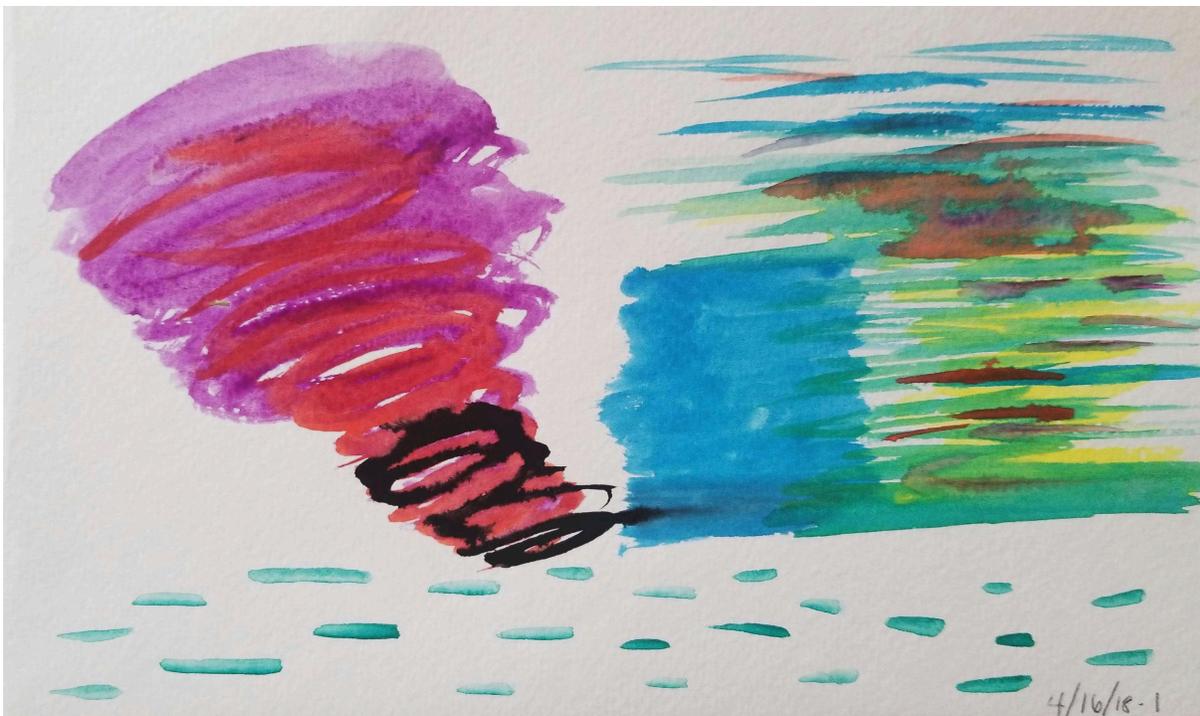


Figure 2  
Watercolor Artwork

## **Shifts in Feelings and Emotions**

Not only did I experience shifts in my energy during DMT groups, I also noticed an additional layer of symptoms: a shift in my own feelings and emotions. The shifts in energy can be triggering of an array of different emotions. At times I documented feeling intimidated by a certain energy—vulnerable, disgusted, angry, nervous, disrespected, ridiculed, and hesitant. All of this stemmed from just coming into contact with a new or different energy.

Something feels different at the start of this group. I feel vulnerable and nervous to say the least! I invite the patients to the group and I am met with silence and glares. Patients ask me who I am and why am I there. ‘Where’s the other dance therapist?’ One patient asks and follows up with, ‘you’re just an intern.’ I have never met this patient before. I feel myself shrink back and have the urge to apologize but I shake off that exchange as best as I can before the group starts. He enters the group room and finds a seat in the corner. I can feel his eye contact is piercing a hole in whatever groundedness I had. I am scared, intimidated but try to keep smiling as I start the group.

These layers of feelings and emotions can be seen in the artwork representing this journal entry (See Figure 3). I did not use my normal color-coding for this piece. This group was different for me and felt very dark and heavy. I used black and blue to represent those deeper feelings for me. The brush strokes are representative of the energy I felt piercing my body from that specific patient.



Figure 3  
Watercolor Artwork

### **Anxiety**

Anxiety is a common human experience. Many people know how their bodies react when experiencing anxiety. I was no exception to that. Anxiety is a naturally occurring sensation in my body. Before entering my internship, my personal signs of anxiety included nervousness, body tension, racing thoughts, increased heart rate, and a bouncing knee. I knew what my own anxiety felt like. However, experiencing others' anxiety was a new sensation for me.

As I sit down in this room and scan the group, I have a moment of panic. I think to myself, "What's going to happen, where is this going to go? Is this my anxiety or someone else's?" It feels different than my own. I feel like this energy can be identified

as anxiety, but I have never experienced it in this way. I feel a tingle in my neck and shoulders that does not come with my own anxiety. I also feel light headed and that my neck is locked in place creating tension down my spine.

Identifying that I have never experienced anxiety in such a way before led me to believe that I picked up on others' anxiety in the room. By reflecting on this idea and bringing it into my awareness, I was able to document other times this energy exchange occurred in my body during my research process. In my reflective artwork, I used orange to represent anxiety. Looking through each piece, I noticed that anxiety is present in much of my documentation. I noticed a trend that the anxiety was heavier in the beginning of my research than towards the end of my study.

Other times I experienced anxiety, I felt other layers of emotions and sensations as well. I picked up new energy and it combined with my own energy creating uncomfortable and foreign feelings within my body. During this stage in my research it was difficult for me to distinguish between my own feelings and the emotions I was picking up from the group, ultimately leading me to experience nervousness and anxiety in the group.

### **Positive Somatic Countertransference**

Not all my experiences with somatic countertransference were disorienting, nauseating, and anxiety-increasing experiences. I also documented groups that provided positive feelings and energy for me. Some of the symptoms of this countertransference were the feeling of a light energy, seeing the color yellow, and feeling bright, calm, and grounded. I felt these shifts most frequently in the older adults group I co-lead weekly.

I always look forward to this group. The energy is always comforting and soft with this group of patients. They are older adults and I feel like my energy blends well with them.

How can I take this energy and bring it into my other groups? I feel my heart vibrating and radiating, and I can release the tension in my stomach and hands.

Looking at the painting created from this journal entry (see Figure 4), I noticed there was a great sensation of grounding happening in this group, as well as happiness and calm energy. The colors came together in a way that is different from the rest of my artwork. There was an even flow with the brush strokes and there seems to be a blended yet separate energy being depicted. In the same group setting the following week, I experienced similar sensations.



Figure 4  
Watercolor Artwork

This group always brings me peace and excitement to lead. I step in and feel my heart warm and open. I feel centered and do not have negative thoughts racing through my mind.

### **Freeze Response Symptoms**

Along with discovering my symptoms of somatic countertransference, I also wanted to deepen my understanding of my freeze response. I was curious to explore the events or situations that caused these responses in my body, as well as to dissect what a freeze looks and feels like in my body. Understanding the feel of these responses ultimately helped me to identify what happens in my body more quickly and allowed me to manage my symptoms during a DMT group. I was able to extract symptoms from my journal entries as well as create artwork describing the feel of a freeze. I documented my freeze responses in black paint.

The main symptoms of my freeze response were loss of breath connection and increased tension in my body. This journal entry highlighted the common reaction I had in a freeze response.

Feeling ill-prepared I enter the room and my anxiety increases. I freeze. My breath stops. My muscles are tense and my eyes are scanning the room but taking nothing in. My voice feels trapped in my throat. I feel like I do not have the ability to speak, and my mind becomes blank.

The artwork associated with this freeze response (See Figure 5) indicated the feeling of being trapped within the freeze response with increasing anxiety. There was no breath support in this painting or much movement from the brush strokes. I really wanted to capture the essence of the moment of freezing in this piece.

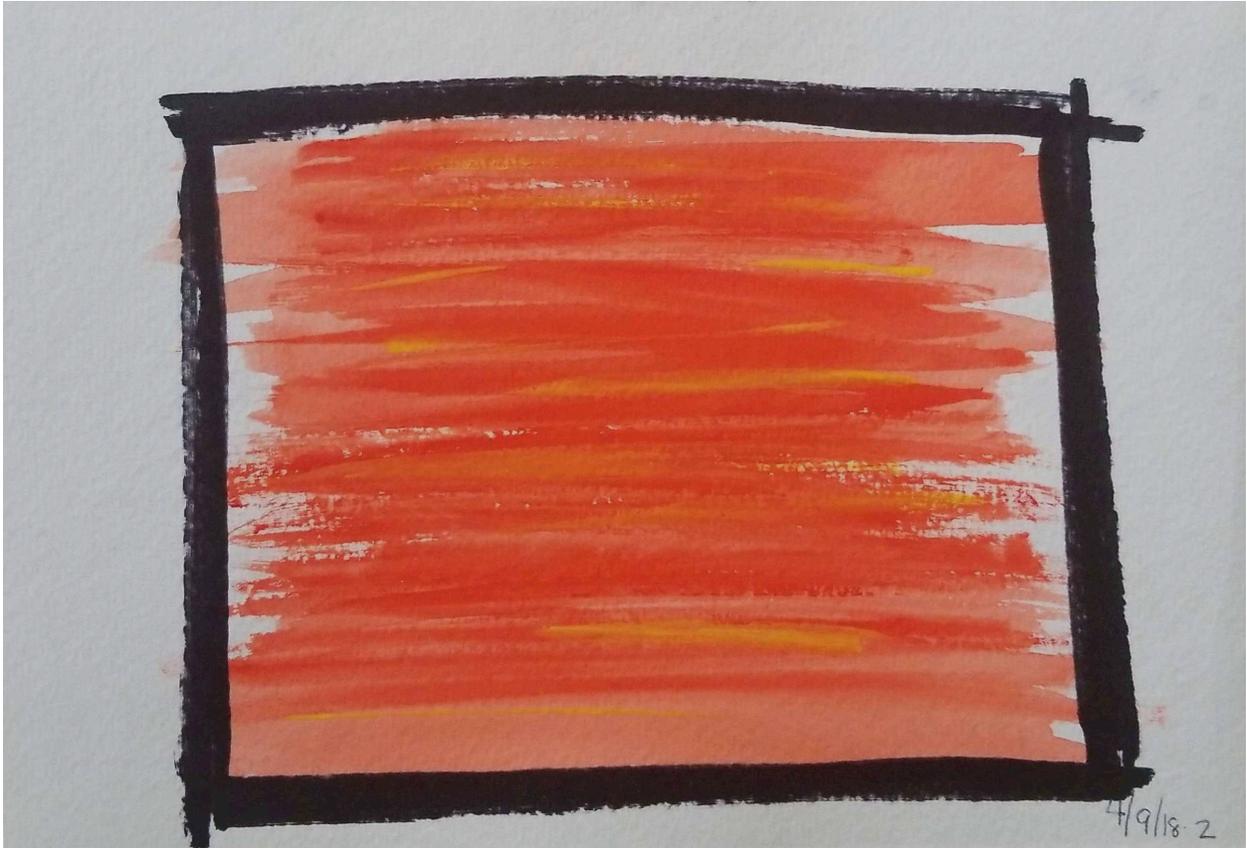


Figure 5  
Watercolor Artwork

Other symptoms that arose in my journals were a panicked inner dialogue and feeling like I have lost the ability to speak. Some freeze responses had my thoughts racing through my mind. When this happened, I did not know what to do, and I felt lost in my own mind. This resulted in the inability to use my voice.

My body just wants to get up and get out of this room, but nothing moves. My brain is telling me, 'Get out! Get out!' But I stop. I know I cannot leave. To start this group, I must say something. 'Say anything! Use your words!' There is a bubble in my throat, and it feels like my voice is unplugged from my body. My muscles in my arms and shoulders are tense and my neck feels like it is locked in place. I know I am freezing, and the anxiety of another freeze brings more panic to my body. I have to stop this pattern.

This journal entry was from the same group as the push-pull energy for somatic countertransference symptoms (See Figure 2). The swirling tornado of purple and orange (confusion and anxiety) shifted into a freeze response, and I lost my feeling of grounding. Analyzing other artwork, I noticed that was a similarity across the board. If confusion and anxiety were present in the painting, then a freeze response was imminent.



Figure 2  
Watercolor Artwork

Another piece of significant information came from analyzing both my somatic countertransference and my freeze responses: the two were, in fact, connected. If I experienced an adequate amount of somatic countertransference that created discomfort and confusion in my body, a freeze response occurred. The next step in my process was to explore how to get out of that pattern and overcome these reactions.

## **Overcoming Somatic Countertransference and the Freeze Response**

As aforementioned, I created this research project to help myself and other emerging dance/movement therapists modulate through the freeze response when it is associated with somatic countertransference stemming from an exchange with a patient. Through trial and error, I have come across several techniques that have helped me to overcome the initial freeze in a session with patients.

### **Body-Based Techniques**

Finding a connection with my breath is a body-based technique that has been successful for me modulating myself out of the trauma response. During a freeze response, I often do not breathe or have very shallow breaths. I have found that taking a deep cleansing breath helped to regulate my system and allowed me to become unstuck from the freeze sensation. Figure 2 demonstrated the entire reaction sequence quite well. It first showed the somatic countertransference into a freeze. The blue paint represented the breath I take to overcome the freeze that allowed me to continue with the group. That breath was my main support to reestablish my mind-body connection.

I have also noticed that focusing on my connection to the earth has helped create an escape from a freeze response. I have used the same ideas I tell the patients I work with. “Notice how your feet are on the floor. The chair supports you, and—if needed—place your hands on your head.” Do not forget to practice what you preach! Taking my awareness to the body helped me to take the stress of a freeze response out of my head and allowed my body to help itself overcome feeling temporarily disabled in a session due to that stress response. Physical grounding of the body created a shift in focus that lasted long enough to create a shift in the mental processing of a freeze.

## **Attuning and Accepting**

Paying attention to the external world around me has also helped me to overcome somatic countertransference and the freeze response. Focusing on the needs of the group and listening to what they say created a pathway out of the freeze for my body and mind. In a documented group, I experienced vibratory energy, very different than my own. It created anxiety and led to a freeze response in me as the clinician. Patients were voluntarily standing and dancing in this group, and I became panicked because many of the patients were older adults with fall risks. I was concerned I was not following the rules.

A voice enters my mind and says, 'stop and look what is happening.' They were happy; they were safe. I started connecting with the patients and it became a big dance party.

Pushing away that dialogue was the best thing I did for this group. They were ready and willing to explore movement. Attuning to the group and listening to what they needed provided such a positive atmosphere for the patients. I'm glad I didn't stand in my own way for this group.

Creating a safe and positive environment is what I strive for as an emerging dance/movement therapist. Allowing myself to go with the flow and facilitate that type of atmosphere created a break in my own freeze and self-doubt. It was quite spectacular to witness the organic development of that group.

Bringing awareness to my needs and the needs of the group in the moment helped to create a safe and harmonious group experience for all in attendance. I realized that each group is different; each group has a combination of different energies and my reaction to those will be different every time. When overcoming a freeze response brought on by somatic countertransference, it has also been helpful to allow myself to be ok with the fact that each

group is different. I realized I do not have to force the group to be something it is not. This acceptance has been crucial for me. As a novice dance/movement therapist, I realized many times my expectations for a group are set too high. Attuning to the group and accepting where they are at in their recovery: physically, mentally, emotionally, and spiritually, has helped me not only in a freeze response but in other areas of facilitation.

### **Confidence and Connection to Self**

In order to overcome my freeze response due to somatic countertransference, I had to discover my inner confidence to lead groups and create a therapeutic environment to promote healing and connections with patients. Several layers of discovery have unfolded during this process for me.

I first realized I was lacking confidence in a group of adolescents I was leading. I was nervous to lead this group to begin with; both supervisors were going to observe me in this group. I did not have a clear plan of what to bring to this group and my time was running out. I had to think quickly and began just throwing out ideas to the group. I mentioned movement-based games, experientials that had been successful in the past, but nothing seemed to pique their interest. I could tell I was losing the group. The energy was high and chaotic in the room. My freeze response was setting in, and I scanned the room for anything I could use in the moment.

[My supervisor] asks me in front of the group, “Aren’t you a dance teacher?” The energy, the mood, the chaos of the room shifts to curiosity as I step into my role I have created over the past 12 years. Miss Katie enters the room, confident, bubbly and with a touch of sass. The adolescents want to learn a dance! They are focused and their self-confidence is expanding before my eyes. It was a beautiful moment of growth for both patient and therapist.

Connecting my teacher self with my therapist self with my true self allowed me to safely explore where my confidence lives within me. I was comfortable in my role as a dance instructor and learned how to be more confident in my role as a therapist. When I learned that I can create a connection within my body to integrate parts of myself, it opened endless opportunities for growth and potential for success in overcoming freeze responses. While moving from my teacher self, I did not experience the effects of freezing or the anxiety that comes from somatic countertransference.

This realization of combining my already confident parts with my emerging dance/movement therapist self was a pivotal moment in my data collection process. I made note of this experience and reminded myself how I was successful in the process. Reflecting on this adolescent group, I pushed myself more and discovered more parts of myself that can be integrated into my therapist self. I realized I could use humor and be successful, as well. Patients responded to my lighthearted approach when I entered the room in such a way, and they were able to trust the process more directly when I was open and leading from a true part of myself. Finding more ways to integrate my true self with my therapist self led to a deep connection with my confidence and created a balanced environment in a DMT group. This solicited healing as opposed to freezing. I found myself writing in many journal entries, “confidence is key.”

Analyzing the data I was able to collect in these groups provided a deeper understanding of what feelings and emotions I was experiencing when leading a dance/movement therapy group in a hospital setting. I was able to clarify for myself what I was actually experiencing and how to create a more grounded and fluid approach to my facilitating. Throughout the process of

data collection and data analysis I found new ways to help modulate through my freeze responses.

## **Chapter Five: Discussion**

The research question for this study was: How can I, as an emerging dance/movement therapist, modulate through my freeze response while experiencing somatic countertransference with patients in hospital programs for mental illness? After documenting my lived experiences and analyzing the data collected, I found connections and themes throughout my documentation. The results of my data were stated in the previous chapter. After reflecting on the results and finding connections between themes that arose throughout my personal process, I found valuable ways to modulate through the freeze response I encounter when experiencing somatic countertransference.

### **The Process**

I established a process that interrupts the cycle that occurred during groups of feeling an uncomfortable, disabling shift in energy. This process started before even walking into the group room to meet with patients. I first made sure to notice what my body felt like before walking into the room. By bringing awareness to my original feelings, I was able to notice more rapidly what shifted in my body and how the shift affected my ability to lead the group. I began to lead from my true self. When, in fact, a freeze response occurred in my body, I brought awareness to the situation. This freeze response included feeling my body tense up, my anxiety increase, my breath become shallow and dysregulated, and my mind disconnect from my body. My mind also went blank, and I was unable to speak during a freeze response. During this reaction to the somatic countertransference in the room, I would tell myself, “you are having a freeze response right now” and accepted that as part of the process. Bringing that awareness and identifying the response in my body allowed for me to start the modulation out of the freeze.

The next step in my unfreezing process was very impactful yet very simple: breathe. Taking a deep breath allowed me to reconnect my breath to my movement and gave me a chance to shift out of the freeze. I would take a deep breath in through my nose and feel my ribcage expand, bringing awareness to subtle movement in my body. This breath would also impact the feeling in my brain. I could feel the breath reconnecting my thoughts in my mind and cleansing out some of the energy associated with the somatic countertransference I was experiencing. I found that, in the beginning of my research, I felt a lot more anxiety and panic during a freeze response. Allowing myself to accept it and go with it—instead of resisting it—lowered my anxiety and fear around having a freeze response. I let go of the resistance and tried not to push through, accepting the freeze as information about the group. I asked myself, “What is the freeze and somatic countertransference trying to tell you as the therapist?” Approaching the response with curiosity instead of fear opened up my window of tolerance (Siegel, 2012), creating less extreme freeze responses in my body.

Approaching the somatic countertransference and freeze in my body with curiosity allowed for my confidence to grow, as well. By eliminating or even reducing the fear around the freeze and replacing it with intrigue, I opened the door for me to explore why this feeling was happening in the first place. Speaking to the group and seeing what was going on for them allowed me to get a better sense of the energy or the feelings I might be picking up from the group. Even speaking to the fact that I felt a shift when I walked in and I was curious about it helped to keep my freeze response to a minimum. Deepening my connection to my confidence with the idea to approach the freeze with curiosity also allowed me to feel more connected to my authentic self and feel more grounded in the group. I wrote in many journal entries, “Confidence is key.” I believe that shifting fear to curiosity allowed for my confidence to grow and help

integrate the parts of myself that I want present in a group. The open, grounded, caring, curious, attuned, humorous, light-hearted therapist that I have been dreaming of becoming was able to enter the room.

With my confidence growing through this process, the last step in modulating out of the freeze response was to gain positivity. My positivity first started as a positive thought after dragging my way through a tough freeze response. I told myself I was capable of doing that and that I was proud of myself for managing such a visceral response to somatic countertransference. It felt good to note that in a journal entry and look back on those kind words to myself. I wrote, “I want to create a positive environment for my patients, shouldn’t I be doing that for myself as well?” As I brought in some self-appreciation and patience for myself, I opened the door for more confidence to grow and freeze responses to lessen in intensity.

Overall, the process of exploring my freeze responses due to somatic countertransference created a deeper understanding of group dynamics and exchanges in energy. I realized that I should not be afraid of these moments. They have actually taught me a lot of information about facilitating therapy. The modulation out of the freeze response that I have found to work for myself is: bringing awareness to freeze, breathing, approaching with curiosity, connecting to my confidence, and finding positive words and feelings to take away from the experience (See Figure A below).



Figure A  
Process of Freeze Modulation

## **Limitations**

Like all studies, there were limitations to my research. I conducted a self-study, meaning I was the sole participant in the data collection process. My experiences likely differed from other researchers because each individual has different responses to somatic countertransference and different feelings in a freeze response. It is also possible for different responses to occur with different populations and settings. My research was conducted in a behavioral health hospital in the suburbs of Chicago. I would be interested to see what the outcome would be with a different population with different emerging dance/movement therapists.

In addition, there are limits to a qualitative data collection process. There is room for error or missed opportunities to gather all the data when journaling from memory. I was not able to write and journal during the group, so all of my data is from revisiting my experiences and embodying my responses through writing, artwork, and embodied writing. Some of my artwork and journal entries did not deepen my understanding of my responses to somatic countertransference. Having collected information from 20 groups through journal entries, watercolor artwork, and embodied writing, I was not able to utilize every piece of data collected. Some data did not reflect a theme that seemed related to my research, and, in others, I was not able to fully articulate my experiences through writing and painting.

## **Summary**

To begin this research study, I set out to deepen my understanding of how I responded to others' reactions to me, and how my body-felt responses affected my ability to conduct a DMT group. I was experiencing a lot of moments of freezing in my groups, and being unable to speak was becoming an issue. I wanted to contribute to the body of research by exploring my personal experiences and finding themes to help myself and other emerging dance/movement therapists

understand the feelings of somatic countertransference and freezing. I also wanted to help myself and others find the ability to modulate out of the freeze response, in order to better facilitate the group they are with. Through my research, I found a better understanding of my own personal experiences with somatic countertransference and the freeze response. I learned how to manage my symptoms of each and use them to my advantage. I was able to replace some fear and anxiety with curiosity and deepen my confidence and connection to my authentic self. Using reflective journals and a narrative therapy approach allowed for me to examine the story that was being told, I was able to take away the main themes, and create connections to the literature. Examining my process from start to finish has given me the opportunity to strengthen my development as a clinician. I went from walking into the room and panicking to being able to modulate myself through a freeze response by bringing in awareness, breathing, allowing for curiosity, giving space for my confidence, and nourishing my mind and body with positivity. This experience and insight can grow into future research for the field.

This research could expand to other areas connected to the freeze response, not only somatic countertransference. Researchers could also explore somatic countertransference and freeze responses in other emerging clinicians, not just dance/movement therapists. This research could be replicated with seasoned dance/movement therapists and document their experiences with somatic countertransference over years of experience. This may shed light on whether or not anything has shifted for them and how they have learned to manage their symptoms after years of experience. Conducting this research study has benefited my transition from dance/movement therapy intern to a novice professional dance/movement therapist. I am now more aware of how others affect my own energy and how to approach those shifts with curiosity instead of anxiety and fear.

## References

- Ankrom, S. (2018, May 4). The difference between fear and anxiety. Retrieved from <https://www.verywellmind.com/fear-and-anxiety-differences-and-similarities-2584399>
- Barlow, D. H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic*. New York: Guilford Press.
- Batko, C. (2015). How fear and anxiety in response to countertransference and somatic countertransference impacted the clinical decision-making of a dance/movement therapy intern. Unpublished master's thesis, Columbia College Chicago, Chicago, IL.
- Beard, K. D. (1992). Somatic knowing with the psychosomatic patient: An answer in kind. *Dissertation Abstracts International*, 53 (9-B) 4943. (UMI No. 9302939).
- Bernstein, P. L. (1984). The somatic countertransference: The inner pas de deux. In P. L. Bernstein (Ed.) *Theoretical Approaches in Dance/Movement Therapy* (Vol. 2, pp. 321-342). Dubuque, IA: Kendall/Hunt.
- Brancha, H. (2004). Does fight or flight need updating? Retrieved from [https://www.researchgate.net/publication/8367153\\_Does\\_FIGHT\\_or\\_FLIGHT\\_Need\\_Updating\\_YES](https://www.researchgate.net/publication/8367153_Does_FIGHT_or_FLIGHT_Need_Updating_YES)
- Cannon, W. B. (1927). The James-Lange theory of emotions: A critical examination and an alternative theory. *The American Journal of Psychology*, 39(1/4), 106-124.
- Creswell, J.W. (2013). *Qualitative inquiry and research design: Choosing among five approaches*. (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage.
- Cruz, R., & Berrol, C. (2012). *Dance/movement therapists in action*. Springfield, IL: Charles C. Thomas.

- Dosamantes-Alperson, E. (1987). Working with internalized relationships through a kinesthetic and kinetic imagery process. *Imagination, Cognition and Personality*, 2(4), 333-343.  
doi:10.2190/hmw8-598t-uwul-rkk6
- Dosamantes-Beaudry, I. (1997). Somatic experience in psychoanalysis. *Psychoanalytic Psychology*, 14(4), 517–530.
- Dosamantes-Beaudry, I. (2007). Somatic transference and countertransference in psychoanalytic intersubjective dance/movement therapy. *American Journal of Dance Therapy*, 29(2), 73-89. doi: 10.1007/s10465-007-9035-6
- Eckberg, M. (2000). *Victims of cruelty: Somatic psychotherapy in the treatment of Post Traumatic Stress Disorder*. Berkeley, CA: North Atlantic Books.
- Freud, S. (1912). *The dynamics of transference*. Standard Edition, 1958, 12: 99-108.
- Forester, C. (2000). *Body awareness: An aspect of countertransference management that moderates vicarious traumatization* (Unpublished doctoral dissertation). California Institute of Integral Studies, San Francisco, CA.
- Forester, C. A. (2007). Your own body of wisdom: Recognizing and working with somatic countertransference. *Body, Movement, and Dance in Psychotherapy*, 2(2), 123-133.  
doi:10.1037/e609212012-006
- Gallup, G. G. (1977). Tonic immobility: The role of fear and predation. *The Psychological Record*, 27 (S1), 41-61. doi:10.1007/bf03394432
- Gantz, J. (2015). Cultivating body knowledge. *Magazine-Journal of the Mind/Body Arts and Sciences*, 17(3), 12-16.
- Hackney, P. (2002). *Making connections: Total body integration through Bartenieff fundamentals*. New York, NY: Routledge.

- Hart, P. (2013, May 23). Stress recess: The fight or flight response. Retrieved from <https://releaseyv.wordpress.com/2013/05/22/stress-recess-the-fight-or-flight-response/>
- Harvard Health Publishing. (2018, May 1). Understanding the stress response - Harvard Health. Retrieved from <https://www.health.harvard.edu/staying-healthy/understanding-the-stress-response>
- Holifield, B. (1998). Against the wall/her beating heart: Working with somatic aspects of transference, countertransference and dissociation. In D. H. Johnson & I. J. Grand (Eds.), *The body in psychotherapy: Inquiries in somatic psychology* (pp. 59-84). Berkeley, CA: North Atlantic Books and The California Institute for Integral Studies.
- Horvath, A. O. (2005). The therapeutic relationship: Research and theory. *Psychotherapy Research, 15*(1-2), 3-7. doi:10.1080/10503300512331339143
- Horwitz, A. (2013). *Anxiety: A short story*. Baltimore, MD: Johns Hopkins University Press.
- Ivey, A. E., D'Andrea, M. J., & Ivey, M. B. (2012). *Theories of counseling and psychotherapy: A multicultural perspective* (7th ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Kabat-Zinn, J. (2005). *Coming to our senses: Healing ourselves and the world through mindfulness*. New York: Hyperion.
- Kelly, J. (Nov/Dec, 2011). Performance anxiety. *The University of Chicago Magazine*, Retrieved from <https://mag.uchicago.edu/science-medicine/performance-anxiety>
- Madigan, S. (2011). *Narrative therapy*. Washington, D.C.: American Psychological Association.
- Marsh, J. (2012, March 29). Do mirror neurons give us empathy? Retrieved from [https://greatergood.berkeley.edu/article/item/do\\_mirror\\_neurons\\_give\\_empathy](https://greatergood.berkeley.edu/article/item/do_mirror_neurons_give_empathy)
- Martin, B. (2016, July 17). Fight or Flight. Retrieved from

<https://psychcentral.com/lib/fight-or-flight/>

- McDougall, J. (1989). *Theatres of the body*. London, England: Free Association Books.
- Merriam-Websters collegiate dictionary*. (1999). Springfield, MA: Merriam-Webster.
- Mertens, D. M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Moore, C. L., & Yamamoto, K. (2012). *Beyond words: Movement observation and analysis*. New York, NY: Routledge.
- Moustakas, C. E. (1990). *Heuristic research: Design, methodology, and applications*. Newbury Park, CA: Sage Publications.
- Orbach, S. (2003). There is no such thing as a body. *British Journal of Psychotherapy*, 20(1), 3–16.
- Orbach, S., & Carroll, R. (2006). Contemporary approaches to body in psychotherapy: Two psychotherapists in dialogue. In J. Corrigan, H. Payne, & H. Wilkinson (Eds.). *About a body: Working with the embodied mind in psychotherapy* (pp. 63-82). London, England: Routledge.
- Pallaro, P. (1994, September). *Somatic countertransference: The therapist in relationship*. Paper presented at the third European Consortium for Arts therapies Education, University of Ferrara, Italy.
- Pallaro, P. (2007). Somatic countertransference: The therapist in relationship. In P. Pallaro (Ed.), *Authentic movement: Moving the body, moving the self, being moved: A collection of essays* (Vol. 2, pp. 176-193). London, England: Jessica Kingsley.
- Pope, K. S., Sonne, J. L., & Greene, B. (2006). *What therapists don't talk about and why:*

- Understanding taboos that hurt us and our clients.* Washington, DC: American Psychological Association.
- Porges, S. (1995). Orienting in a defensive world: Mammalian modifications of our evolutionary heritage. A Polyvagal Theory. *Psychophysiology*, 32, 301-318.
- Racker, H. (1968). *Transference and countertransference*. London, England: Hogarth Press.
- Ross, M. (2000). Body talk: Somatic countertransference. *Psychodynamic Counselling*, 6(4), 451-467. doi:10.1080/13533330050197089
- Rothschild, B., & Rand, M. J. (2006). *Help for the helper: Self-care strategies for managing burnout and stress*. New York, NY: W. W. Norton & Company.
- Rutter, R. L. (1989). *A phenomenological study of somatic countertransference and therapist type* (Unpublished doctoral dissertation). California School of Professional Psychology at Berkeley/Alameda, Alameda, CA.
- Sadock, B. J., Sadock, V. A., & Ruiz, P. (2015). *Kaplan & Sadocks synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (11th ed.). Philadelphia, MA: Wolters Kluwer.
- Sandler, J., Dare, C., & Holder, A. (1973). *The Patient and the Analyst*, London: Karnac.
- Schore, A.N. (2003). *Affect regulation and the repair of the self*. New York, NY: W.W. Norton.
- Siegel, E. V. (1984). *Dance-movement therapy: Mirror of ourselves: The psychoanalytic approach*. New York, NY: Human Sciences Press.
- Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York, NY: Mind Your Brain.
- Skovholt, T. M., & Ronnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development*, 30(1), 45-58.
- Stromsted, T. (2007). The dance and the body in psychotherapy: Reflections and clinical

- examples. In D. H. Johnson & I. J. Gran (Eds.), *The body in psychotherapy: Inquiries in somatic psychology* (pp.147-170). Berkeley, CA: North Atlantic Books and The California Institute of Integral Studies.
- Stone, M. (2006). The analyst's body as tuning fork: Embodied resonance in countertransference. *Journal of Analytical Psychology*, 51(1), 109-124.
- Van der Kolk, B. (1989). The compulsion to repeat the trauma. *Psychiatric Clinics of North America*, 12(2), 389-411.
- Vulcan, M. (2009). Is there any body out there? A survey of literature on somatic countertransference and its significance for DMT. *The Arts in Psychotherapy*, 36(5), 275-281. doi:<https://doi.org/10.1016/j.aip.2009.06.002>
- Weinberg, J. (2018, February 08). Mind-body connection: Understanding the psycho-emotional roots of disease. Retrieved from <https://chopra.com/articles/mind-body-connection-understanding-the-psycho-emotional-roots-of-disease>
- Young, J. (2017). The therapeutic movement relationship in dance/movement therapy: A phenomenological study. *American Journal of Dance Therapy*, 39, 93-112. doi: 10.1007/s10465-017-9241-9

## Appendix A. Contractual Agreement for Collaborator



### Collaborator Agreement

**Title of Research Project:** Stuck in Somatic Countertransference: A Heuristic Study  
**Main Researcher:** Katie Hochleitner

You are invited to participate in a research study to explore the phenomenon of somatic countertransference in clinicians and how it relates to the clinician's freeze response. This contractual agreement will provide information about the study and the importance of your role, if you choose to participate. This is a voluntary position in this study. If any questions are left unanswered, please feel free to ask at any time.

**Your role** in this study is a research collaborator. You are being asked to participate in this study because you are a clinician who is familiar with the phenomenon of somatic countertransference and have experienced its effects while leading a dance/movement therapy group in a hospital setting. You will be asked to provide feedback on data collected from the study, and work with the researcher to find emerging themes in the data. Further information on your role is provided in the procedures section of this agreement. The data collection of study is expected to conclude by May 2018, and writing to be concluded by August 2018.

**The Purpose** of this self-study is to begin with an understanding of somatic countertransference in the researcher's body and what it feels like in a session. Also, to explore somatic countertransference and how that relates to the trauma response of freezing with a patient. The research question intended for this study is, "how can I, as an emerging dance/movement therapist, modulate through my freeze response while experiencing somatic countertransference with patients diagnosed with mental illness?"

With this study, the researcher hopes to build on the research that explores somatic countertransference and how that contributes to the state of hyperarousal in a clinician. By combining existing research with the researcher's lived experience, they may create new perspectives for others regarding this issue. The intention of this study is to help the researcher and other emerging dance/movement therapists to understand why they might be feeling stuck or in a freeze response during a session. Contributing a self-study to the body of work will expand the research on the topic by giving a first-person example of the process of modulation from freeze to regulation.

## Procedures

If you agree to engage as a research consultant in this study, you will be asked to do the following:

- Self identify as a dance/movement therapist in a clinical setting that has felt the effects of somatic countertransference as defined by:

Bernstein (1984) first coined the term somatic countertransference by defining it as “precisely those countertransferential reactions which occur at a bodily level. She noted the necessity to be aware of and embody the patient’s somatic unconscious so as to aid the patient in the process of cathecting, metabolizing, and integrating split-off parts of the self, as well as revealing the patient’s resistances and defenses”( Pallaro, 2007, p. 185). It is more than just a feeling of intuition that a therapist might encounter. It is a visceral reaction in the body, mind and spirit connection. Some common sensations associated with somatic countertransference include dizziness, pain, hunger, fullness, claustrophobia, fatigue, and restlessness (Pallaro, 2007).

- Participate as a research collaborator with the following requirements:
  - Set specific time and meet with researcher
    - Sessions will run one hour, once a week for 2-4 weeks
    - Times will be discussed between researcher and collaborator
    - Create list of preferred meeting times
  - Review data presented in the forms of journal entries, paintings and embodied writing during meeting times
  - Work with researcher to illuminate emerging themes from data
  - Provide feedback, recommendations and express any ethical concerns throughout the study
  - Be a witness to the data analysis process
- Grant permission for portions of your feedback to be included and possibly quoted in the final presentation of the research study. You have the right to identify yourself or remain anonymous in the study.
- Agree that the intellectual property of the final presentation of this data belongs to the researcher.
- If an emergency arises and you are unable to meet at a set time, it is required to contact the researcher as soon as possible and reschedule for another time.
- Understand this is a voluntary position and compensation will not be given.

## **Confidentiality**

As a research consultant in this research study, you have the choice to identify yourself or remain anonymous to accompany your data analysis feedback.

Please initial your preferred form of identification:

\_\_\_\_ I prefer to be identified using my real name, including any other identifying information in the final presentation of this research study.

\_\_\_\_ I prefer to remain anonymous and given a pseudonym, including changing any identifying information in the final presentation of this research study.

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

1. The main researcher will keep all collaborator's information and recorded feedback will be password and firewall protected.
2. All electronic files containing personal information will be password and firewall protected.
3. Information about you that will be shared with others will respect your confidentiality choice as indicated on this consent form.
4. No one else besides the main researcher and you as a collaborator will have access to your original data.
5. At the end of this study, the main researcher may publish their findings. Your confidentiality choice as indicated on this consent form will be respected in any future publications or presentations.

## **Participation Agreement**

I, \_\_\_\_\_ agree to engage as a research consultant. I agree with my role as the research collaborator and the responsibilities that go along with that title. I will select meeting times and agree to be present in all sessions agreed upon by the researcher and myself. I understand this is a volunteer position and have had the opportunity to ask questions about the research process. I understand I will not be penalized if I decide to withdraw from the study. I understand the confidentiality of the study and have initialed my preferred use of my identity.

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Signature of research collaborator

Date

**Researcher Obligations**

Understanding you are donating your time to this study, the researcher will respect the collaborator in the following ways:

- Be on time to scheduled meetings
- Understand if collaborator participation is withdrawn, even after agreement is signed
- If an emergency arises and researcher is unable to meet at set time, it is required to contact collaborator as soon as possible and reschedule for another time.
- Reimbursement of any and all expenses that may occur for collaborator.

I, Katie Hochleitner will hold myself accountable for all obligations listed above as the researcher.

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Signature of researcher

Date