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I DON'T KNOW: AN ARTISTIC INQUIRY SELF-STUDY OF CLINICAL DECISION
MAKING IN DANCE/MOVEMENT THERAPY

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Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

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in

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Abstract

The purpose of this artistic inquiry self-study was to engage in an embodied, in-depth process of exploration regarding how I engage in clinical decision-making. My research question was: “how do I, as an emerging dance/movement therapist, approach the clinical decision-making process?” Data was recorded through written journaling and video recorded improvisational movement. Journaling and movement were elicited through the visualization of a moment in a dance/movement therapy session in which I was caught off guard and needed to make a clinical decision. Such moments provoked anxiety and a freeze response that interfered with effective clinical intervention. Data was analyzed through dialogue with a research consultant, and through creative synthesis, resulting in a choreographic piece.

Findings indicate that my freeze response to clinical decision making was a two-cycle process. Findings indicated that this freeze response happened when a supervisor was observing, or a client brought up intense material and my inner-critic interfered with intervention. The cycles were identified as follows: Cycle A: 1. Exploration, 2. Fear and self-doubt, 3. Perceived or imagined disapproval, 4. Shedding, 5. Resentment, 6. Distancing and grounding and Cycle B: 1. Autopilot, 2. Anger and rebellion, 3. Shedding/dissociation/loss of identity/perceived approval. The use of autonomy and inner-wisdom, hope, and self-regulation were themes generated that interfered with the cycle and generated more positive feeling states.

Future research on exploring autonomy, hope, and self-regulation in relation to clinical decision making and intervention may help to manage clinician anxiety. It is my hope that these insights will positively influence my effectiveness as a clinician and allow my future clients to experience safety and trust in having a self-regulated and decisive clinician.

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Chapter One: Introduction

During my journey as an emerging dance/movement therapist and mental health clinician, I noticed a pattern emerge while leading individual and group sessions. I would enter into a therapeutic relationship with clients easily and nonverbally attune with ease. That was a skill that came naturally to me – attuning with the person across from me and empathizing with their experience. However, when the time came to make a decision for the benefit of the client's treatment, I would freeze up, especially when being observed. My words would not come out. Emotions would flood my mind. I felt a loss of control. My body would feel tense – as if a dam was about to burst.

This feeling was familiar, and I recognized it emerging in times of inner conflict: in times where I did not have the same opinion or experience as the other person I was interacting with. It was a feeling that has always emerged in times of intimacy, in personal and professional interactions. However, this reaction did not only happen in times of direct conflict with another; it happened in times when I assumed that either the client, group members, or supervisor who was observing had certain expectations of me. Personally, it happens when I believe another person has certain expectations of me and I need to meet them – as if I *should* be acting a certain way. To clarify, this process happened both with literal observation from direct supervisors, but also happened internally within my mind as my inner-critic would speak up. In this study, I will be specifically analyzing the process that happens when in relationship and feel that someone is observing my actions – whether a supervisor observing a session or a client observing my work organically by being in session with me. Furthermore, this reaction happened much more strikingly and intensely in times of direct observation from a supervisor. It interfered with the process of deepening the therapeutic relationship and entering meaningful process with clients because I was no longer acting from a centered place and bringing myself into the relationship. I

was simply catering my thoughts and behaviors to what my projected expectations of the other person were, which undermined my autonomy as a clinician and created a style of clinical intervention that was not authentic and non-challenging to the client, as I was attempting to placate them and remove any conflict from the relationship. As a dance/movement therapist, I have become more attuned to body-felt senses as well as internal processes that may spark these physical sensations. Because of this awareness, I realized that this pattern had both physical and emotional components.

A specific memory of a time when this pattern emerged was in supervision class. A classmate introduced a case from her internship and we role-played a session in front of the class where I was the therapist and she was the client. The client expressed strong emotions of fear and overwhelm. When I attuned to the client, I became overwhelmed. I knew I needed to make a decision to intervene and therapeutically interrupt her in order to either introduce potential methods of self-regulation or bring awareness to her current dysregulated state. However, I froze. My eyes widened, my breathing stopped, my chest and torso became tight and tense. I couldn't speak and looked toward the instructor for guidance. He encouraged me to continue and try again, but I immediately felt that overwhelm of emotions come out in the form of tears. Since this was a safe environment with minimal professional pressure, I let the tears flow and realized that the freeze response happened when I became flooded with another's emotions as well as my own fear. It was the moment I realized my mind and body needed to explore this pattern more extensively in order to transform further into a more effective clinician.

This pattern of freezing, defined in this study as a state of behavioral inhibition that prevents active reaction to the occurrence of a stressful event (Bracha, Ralston, Matsukawa, Williams, & Bracha, 2004; Volchana et al., 2011), in the face of clinical intervention and

decision making is significant because the ability to take chances in session, and attune while holding boundaries between self and other are fundamental to the therapeutic process. I engaged in this exploration to develop a deeper understanding of why I freeze, how to continue being with a client when this response happens, and how to cope with this response. I believe that finding my inner-strength and identity while continuing to attune to clients will benefit both myself as a clinician and the client on their forward journey toward healing.

The purpose of this embodied artistic inquiry is to explore my experience of clinical decision making, defined as a continual process of assessing clients and then selecting effective interventions based on the assessments that are made (Laiho et al., 2013). My interest in this study is to gain a deeper insight into decision making processes to support my development as a dance/movement therapist. Understanding my relationship to decision making, specifically in relationship to clients and supervisors, will allow me to compassionately grow toward letting this freeze response go so I can engage more fully with clients without allowing my past experiences with conflict and differentiation of self and other interfere. It will also allow me to create practices and ways of coping with this freeze response, so I can work through it and feel grounded and rooted in my professional identity as a therapist.

The easiest way that I express myself and learn about myself is through movement and choreography, as it allows me to express things I do not yet have words for. Using artistic means of data collection and analysis allowed me to tune in deeply to my own experience of clinical decision making from an embodied perspective, not simply from a cognitive perspective. The use of movement provided a platform to express, contain, and regulate strong emotional responses (Krantz & Pennebaker, 2007). Since this freeze response was deeply internal as well as body-based, movement was an effective way to deepen the process of understanding my own

physical, mental, and emotional processes in a way that came naturally and easily to me as a dancer and as a clinician.

Theoretical Framework

As a clinician and researcher, I use a combination of dance/movement therapy theories and counseling theories that stress the importance of relationships with self and others as well as emphasize a client's strength and resilience rather than their weaknesses or illnesses. Relational cultural theory (RCT) focuses on forming relationships that foster growth and active participation from everyone involved (Jordan & Dooley, 2000). Openness to influence and emotional availability are important factors in growth-oriented relationships (Jordan & Dooley, 2000). Because this research into my decision making includes clients and supervisors, it easily relates to RCT. I also utilize a framework of person-centered and strengths-based therapy in which I focus on the resilience of the client, instead of any illness. This research aims to describe a process that happens when I approach a decision in a clinical setting from a nonjudgmental lens. Although negative emotions, such as fear and anxiety, are present in the moment, there is an adaptive reason that this pattern developed and there is a way to rewrite this pattern using my strengths. I also utilize Trudi Schoop's approach to dance/movement therapy in which I try and enter the inner-world of a client as well as utilize some drama and humor in a session (Levy, 2005). Entering the inner-world of a client allows the therapist and client to deepen knowledge of their processes. This was reflected in my process, as I entered my own inner-fantasy world of what happened in the instant of the freeze and utilized drama to create a narrative from my data.

The following chapter will review literature regarding decision making processes. The literature will define and discuss aspects of decision-making processes that can affect decision making outcomes, such as affect, cultural bias, decision making in relationship or autonomously, stage of professional identity development, and the overlap between dance/movement therapy

and decision making. Literature will also describe the freeze response and how this response affects decision making. Finally, the next chapter will discuss the need for therapists and helping professionals to understand their decision-making strategies and processes, as biases may impinge upon effective clinical treatment.

Chapter Two: Literature Review

A considerable amount of literature is available on the topic of clinical decision making in counseling and has been since the beginning of the profession. This literature review will focus on processes that underlie clinical decision making, such as utilizing intuition and analysis, as well as factors that impact decision making like affect, cultural bias, physiological response, and experience and ability to make autonomous decisions. The topic of affect is represented quite extensively in literature relating to decision making in clinical and managerial settings (Dane & Pratt, 2007). Established research has revealed that not only does affect have an impact on decision making, but emotion regulation skills can relieve the potentially negative effect that emotions can have on decision making. Furthermore, themes regarding how to cautiously and responsibly utilize one's body cues and affect in decision making processes presented themselves in literature and will be discussed.

As a developing clinician, I have observed, through self-reflection, a need to understand my own process of decision making. Courses within the graduate program of dance/movement therapy and counseling at Columbia College Chicago emphasize the necessity of clinicians developing keen self-understanding. Through learning this importance, I have gained curiosity about my own inner processes. I have also noticed that my decision-making process is often informed by somatic, body-based sensations as well as affective reactions I have in the moment – anxiety, fear, and a freeze response. There is little literature available about how the body influences decision making, but those that are available speak of the importance of listening to the body and creating self-awareness around their own reactions to decision making situations in which the decision is ethical, or highly emotionally charged for the clinician.

This research study will examine my unique process for decision making so as to understand how to develop a strong clinical identity in which I can confidently make decisions, and identify and regulate body cues that arise in clinical situations when a decision must be made.

Common Decision-Making Strategies: Intuition and Analysis

Clinical decision making is a process of identifying possible courses of action and the potential consequences of each (De Bortoli & Dolan, 2015). The Cognitive Continuum Theory conceptualizes decision making by organizing cognitive processes of decision making into a continuum ranging from intuitive cognition on one end, to analytical cognition on the other (De Bortoli & Dolan, 2015). This model describes intuition and analysis as completely dissimilar. Analysis is defined as a rational, step-by-step, logical, conscious process that produces a clear and defensible answer to a problem. Intuition is defined as a process that is holistic, affective, preconscious and effortless. It integrates information without insight into the process of integration (De Bortoli & Dolan, 2015); the information is integrated without conscious analysis or awareness. While these descriptions of intuition seem clear and accurate, they are much disputed in the literature. Another, perhaps less clinical definition is that intuition is “a feeling of knowing with certitude on the basis of inadequate information and without conscious awareness of rational thinking” (Hodgkinson, Langan-Fox & Sadler-Smith, 2008, p. 6). Many similarities exist among the definitions of intuition compiled by Hodgkinson et al. (2008) which were well summarized by Dane and Pratt. Their definition included four key characteristics of intuition: “intuitions are affectively charged judgments that arise through rapid, nonconscious and holistic associations” (Dane & Pratt, 2007, p. 40). This is the definition I will be using for the purposes

of this study. Analysis, however, seems to be clearly defined above and was not disputed in the literature.

Clinical decisions or tasks come in two categories, suggests Dane and Pratt (2007): judgement tasks and intellectual tasks. Intellectual tasks are those with a definite criterion for success, while judgement tasks are those that require moral, subjective reasoning. For instance, an example of an intellectual task is a math problem or the task of balancing a budget. An example of a judgement task would be the decision of whether or not to intervene with talk therapy or dance/movement therapy in a session with a client. This task cannot be proven to be correct or incorrect based on a set system of regulations or rules. It is shown that the use of intuitive decision making may be more effective in judgement tasks than rational analysis (Dane & Pratt, 2007). In clinical decisions involving human behavior, it is not desirable to be anything other than subjective (Robson, Cook, Hunt, Alred, & Robson, 2000). For instance, each client should be seen as an individual, with individual needs and a treatment plan that is tailored to those needs. Therefore, for the purposes of this literature review, we can assume that most clinical decisions referred to are judgement tasks that may benefit from intuitive judgement.

Although Dane and Pratt (2007) suggest that intuition may be more effective than rational analysis when making decisions that require moral, subjective reasoning, other researchers have found that the use of intuitive judgement is best paired with thorough analysis and reflective analytical judgement (Dane & Pratt, 2007; De Bortoli & Dolan, 2015; Fox, Hagedorn & Sivo, 2016; Miller, Spengler & Spengler, 2015; Robson et al., 2000; Shallcross, 2016). For instance, Fox et al. (2016) emphasize the importance of retroactive self-analysis in novice therapists to ascertain what pattern of behavior they were reacting to when making a decision to reduce the amount of biases and heuristics – or shortcuts to decision making - used. It

is suggested that mental health clinicians act as scientist-practitioners by not relying solely on “gut-level instincts, which are strongly associated with heuristics and biased judgements” (Miller et al., 2015, p 564). Clinician and professor Jeff Cochran teaches his counseling students to not act on first hunches – but to see if that hunch persists as more information is gathered – as an initial intuitive judgement may be laden with biases if sufficient clinical experience has not been acquired (Shallcross, 2016). This begs the question of what factors influence the ability to trust one’s intuitive judgement at any stage in clinical experience. The theme of sequencing intuitive judgements with post-decision analytical-evaluative self-reflection ties into the next point for this literature review: how does a clinician hone their intuitive judgement? What factors influence how intuitive judgement processes occur? How can a novice or expert clinician mindfully and consciously avoid harmful heuristics and biases using a non-conscious process such as intuitive judgement?

Influences in Decision Making

Affect

Emotions are crucial to the intuitive decision-making process; because emotions are not seated in rationality, they are closely associated with intuiting processes (Dane & Pratt, 2007). The literature offers considerable data regarding clinician mood state and clinical effectiveness and judgement accuracy. For instance, Dane and Pratt (2007) suggest positive mood leads to increase of intuition and decrease in rational approaches to decision making. More specifically, basal ganglia are engaged through positively affective stimuli, which is the same as the mechanism used for intuitive judgement. Positive affect enables individuals to think more flexibly (Raglan & Schulkin, 2014). In Raglan and Schulkin’s 2014 study regarding mindfulness, mood, and clinical decision making, clinicians with negative mood states such as negative

anxiety, anger and sadness made different clinical decisions on a similar case than they did when in a positive mood state. Thus, it suggests that clinician mood sub- or unconsciously influences decision-making.

Earlier findings regarding emotions and decision making have found that that a 'cool head' prevails when making decisions, such as a study in financial decision making found that individuals with lower intensity of emotion performed better in decision making tasks (Naqvi, Shiv, & Bechara, 2005). However, many recent studies have found that intense emotions can be beneficial to decision making. Individuals who had more depth and awareness of emotional experiences during the decision making process could experience positive effects on decision making performance. Those with higher intensity of emotions showed higher decision-making performance (Dane & Pratt, 2007, Seo & Barrett, 2007). Further, those with higher emotional awareness during times of decision making tend to be more successful in regulating those feelings and the influence they have on decision making (Barrett & Gross, 2001; Seo & Barrett, 2007). In contrast to the view that intense emotions cause better decisions, this information furthers the findings so that intensity of the emotion can indicate better decision making, but only if the decision maker has emotional awareness and the ability to regulate their emotions. Those who were better able to differentiate and regulate their emotions experienced fewer biases that could potentially negatively impact decision making (Seo & Barrett, 2007). Essentially, ignoring one's feelings during the decision-making process, the common strategy in the topic of affect in decision making, is not as effective as utilizing one's emotions, differentiating them, and regulating them so they do not influence one's behavior.

Interestingly, however, Seo and Barrett (2007) found that there was only benefit to decision making outcomes when decision makers differentiated between their negative emotions,

not positive ones. One explanation for why this is true, is that the body and mind are more active in regulating negative feelings than positive ones (Oatley & Johnson-Laird, 1996; Pratto & John, 1991). This means that when clinicians experience negative emotions, they are more likely to regulate them – taking time to determine what feeling state they are in when making a decision will result in increased regulation of negative emotions and a better outcome.

Expected Emotions. When making a decision, especially if it is important and has significant potential positive or negative consequences, people imagine what potential emotional outcomes are associated with each decision. However, these predictions are often unrealistic (Loewenstein & Lerner, 2003; Schwarz, 2000). The intensity of the expected emotions is another factor in decision making (Schwarz, 2000). For instance, if a therapist is in a session with a client in crisis, the consequences of a decision will be more emotionally charged than if the session was with a client who was stable and exploring ways to reduce stress. Under the influence of intense emotions, such as highly pressured situations like having a client in crisis, people can often feel out of control or act against their own self-interest (Schwarz, 2000). This means that people often cannot clearly assume their expected emotions correctly, especially when under the influence of highly intense affective states.

In the example with the client in crisis above, the therapist may believe if the intervention is effective, she will feel relief, self-efficacy, joy, and confidence in her abilities. However, if the intervention is not effective, she believes she will feel shame, sadness, loss of confidence in her abilities, and despair for failing her client. Although the assessment of expected emotions while making decisions can be effective, attempts to predict future feelings are often wrong and can result in suboptimal decisions (Loewenstein & Schkade, 1999), especially when those expected emotions are the sole basis upon which a decision is made (Loewenstein & Lerner, 2003).

Retroactive Emotional Assessments. Another way that decisions are made, besides anticipating expected emotions after the decision, is to reflect upon past decisions and the emotional outcomes of those decisions. However, memories of emotional experiences post-decision are often fraught with biases (Kahneman, Fredrickson, Schreiber, & Redelmeier, 1993; Loewenstein & Schkade, 1999; Schwarz, 2000). Many experiments have been conducted regarding the accuracy of decision related emotions after the decision has been made. There is a tendency to believe that the actual emotional consequences of the decision made were similar to what you predicted – whether or not this is the case (Loewenstein & Schkade, 1999). For instance, after someone makes a decision, they may say “I knew I would feel sad...,” even though they told a colleague that they believed they would feel excited before the decision was made. This lack of accurate memory of pre-decision predictions creates the inability to correct for prediction errors in the future (Schwarz, 2000).

Furthermore, post-decision emotional reflection often is only indicative of the peak intensity of emotions as well as the emotions present at the end of the arc of emotion, regardless of duration (Kahneman et al., 1993; Schwarz, 2000). An experiment was done by Kahneman et al. in which participants dipped their hands in cold water for two different time intervals. In the first interval, they dipped their hands in very cold water for 60 seconds. In the second interval, they dipped their hands in the very cold water for 60 seconds, then in slightly less cold water for an additional 30 seconds. After those two experiences, the participants were given a choice between the two options, and most chose to experience the 60 seconds of very cold water with 30 additional seconds of slightly less cold water. This is supportive of the theory that post-decision memories are mainly indicative of emotions at the peak (pain in this case), and at the end of the emotional arc (less pain) and disregard duration of emotional effects (Kahneman et al., 1993). To

summarize, the lack of memory of duration of affective components of decisions often causes people to make suboptimal decisions, such as a voluntary exposure to a longer duration of pain (Schwarz, 2000).

Cultural Factors

Emotional factors are not the only ones that affect decision making processes. It is important to investigate cultural factors when making clinical decisions as to avoid heuristics and biases which may come up unconsciously in intuitive decision making and lead to perpetuations of oppression (Hays, Prosek, & Mcleod, 2010). A mixed methodological analysis of culture and its relationship to clinical decision-making showed that clinicians with higher self-report of cultural competence and awareness of one's own cultural biases made clinical decisions that did not adhere to the common bias regarded in the study: clients within oppressed groups receive more severe diagnoses (Hays et al., 2010). It is important for counselors and trainees to be able to self-reflect upon their own biases to correctly assess clients' presenting issues. Another finding of this study is that participants' awareness of social justice issues is related to positive prognosis of clients. While this is solely a correlation, it begs further research into how cultural competence and clinical decision making interact to reinforce or lift common biases. Hervey's literature (2007) supports this notion and suggests that it is imperative for clinicians to become aware of their ethical blind spots in order to increase ethical sensitivity.

Discussed above is the literature's emphasis on recognizing cultural biases in relation to client's cultural identifiers, but it is also important to acknowledge one's own cultural identifiers and how that makes their intuitive decision-making process unique. While it would be convenient to codify a system regarding how clinical counseling decisions must be made, that is simply not effective for fields relating to human behavior (Robson et al., 2000) or with human

practitioners! Individuals within the field of counseling each demonstrate a unique process of decision making similar to that displayed by artists, in subjectivity, individuality, style and creativity of process (Maxwell, 2010). To make decisions intuitively is to show one's artistry and individuality – which inherently display cultural bias through aesthetic, and may impact clients (Maxwell, 2010).

Autonomy and Identity Development

As developing clinicians enter the field, intervening with clients for the first time without direct supervision, I recognize there is a parallel to the exploration of autonomy that happens in childhood. As clinicians continually reflect upon elements that influence their personal and professional identities, they establish differentiation among mentors and peers (Moss, 2017). This process of development and exploration leads to the development of autonomy and competence within their field (Moss, 2017).

Children who are developing their personal identities go through Erikson's stage of autonomy vs. shame and doubt (McLeod, 2018). Clinicians parallel this stage when entering the field and facing critical opportunities to explore their professional identity, and assert and illustrate independence from supervisors and peers. The ability to explore independently and make one's own mistakes and still feel a secure base is crucial in this stage (McLeod, 2018). If children are criticized or not given opportunities to assert themselves, the child, or beginning clinician, may not develop self-esteem and confidence. They may experience, as Erikson's stage suggests, shame and doubt in their own choices and abilities.

Beliefs that new clinicians often have can influence self-confidence in decision making as well. New counselors often have a faulty belief that they should be able to create amazing results (Skovholt & Ronnestad, 2003). Oftentimes, novice clinicians falsely believe that each session

and intervention should create a miracle in the life of the client. They often feel anxiety and pressure to be as skillful as more experienced therapists (Proti, 2016). Novice clinicians also learn through experience but have little knowledge of what enough empathy or skill looks like (Moss, 2017). This can create a sense of self-doubt when, in the reality of clinical life, outcomes are more often than not, subtle and gradual. In the same vein, novice counselors idealize mentors and supervisors and gradually see them as more realistic and human. Before realizing this, they often feel as if there is too much to know and blame themselves or their training for feelings of clinical inadequacy (Proti, 2016; Skovholt & Ronnestad, 2003).

While clinician confidence can be influenced by relationships with supervisors and expectations of clinical work, Bandura's (1977) work suggests that past performance experience is the strongest contributor to perceived self-efficacy. Furthermore, the level of perceived self-efficacy has been found to affect the amount of effort expended and the degree of persistence, which are both significantly related to performance (Bandura, 1977). This means that if a novice clinician experiences positive performance evaluation by themselves or others, they will likely feel more self-efficacy, thereby increasing future performance.

Furthermore, clinicians with high levels of expressed confidence in accuracy of judgement appear more credible to clients and colleagues due to a phenomenon named the confidence bias (Miller et al., 2015). In a study by Miller et al. (2015), clinician confidence was correlated with judgement accuracy – higher levels of clinician confidence correlated with higher levels of judgement accuracy. However, this must be believed with reservation, because a behavioral loop can be formed between positive affect associated with a correct intuitive judgement and likelihood to make the same intuitive judgement again as a heuristic (Dane & Pratt, 2007).

The Body's Role in Decision Making

Within identity development comes awareness of one's somatic reaction in relation to therapeutic work. While there is not substantial research regarding this topic, research regarding embodied ethical decision making is available. Ethical decision making is inherently an embodied process. It is a heuristic process that requires an individual's free and full participation to be meaningful (Hervey, 2007; Jungers & Gregoire, 2016). Dance/movement therapists have begun to compile research relating to embodiment, defined by Thomas Csordas as attending with or attending to the body (Hervey, 2007), in relation to ethical decision making. Embodied approaches to clinical decision making consist of noticing shifts in bodily states when confronted with a specific decision. This embodied response to clinical decision making in an intuitive sense is often referred to in literature as a gut feeling (De Bortoli & Dolan, 2015; Miller et al., 2015; Robson et al, 2000). One study has been done in which individuals were asked to play games where the rules were not told to them (Bechara, Damasio, Tranel, & Damasio, 1997). When the players felt they had a hunch about how the game worked, they often showed skin conductance changes from a monitor on their palms. This illustrated that gut feelings cause or precipitate the knowledge and integration of information as fact – “the body may *know* and be transmitting information outside of conscious awareness” (Dane & Pratt, 2007, p. 47). Thus, the body may be able to integrate information from internal and external stimuli in order to make a decision before consciously being aware of the information. This study parallels the process that happens in a therapy session in which a client or group of clients shares information with the therapist and group, and the therapist may intuitively and physically feel they know what to do next to intervene without going through conscious analytical process to verify their gut feeling.

Another term used frequently to express intuition is a felt sense (Shallcross, 2016). In an interview, Lori Chapin, a professor of counseling, remarked that intuition is a bottom-up process, meaning that the body creates physiological emotions and sensations that communicate to the conscious brain (Shallcross, 2016). What's more, integration of information itself is related to the body. The right brain processes information through images, body sensations, and affect, which is also involved in the intuiting process (Olendzki, 2014). Chapin suggests that counselors "have to listen to their brains AND bodies" (Shallcross, 2016, p. 7).

Dance/movement therapists can intuit physical body knowledge from their clients through a process called somatic countertransference. Somatic countertransference is defined as "the bodily felt responses and reactions which occur in a therapist during the therapeutic process in response to the bodily felt sensations of a client" (McCarty, 2015, p. 3). In this situation, intuitive decisions are made based on bodily information coming from their clients. McCarty (2015) found that attuning to her own body and discerning what sensations were created by somatic countertransference allowed her to create clinical interventions that were more effective for her clients.

While body sensations and felt senses are one way to observe clinical intuition, movement is another. Warren Lamb created a Movement Pattern Analysis system in which he analyzed the movements of factory workers to increase effectiveness (Hervey, 2007; Maxwell, 2010). He later created a system to identify the steps of an individual's own unique decision-making process – identifying that each person has physical and embodied reactions and processes by which they make decisions (Hervey, 2007). Each clinician has their own patterns of decision making, which must be thoughtfully reflected upon to ensure that intuitive judgements are made accurately.

Freeze Response

Among embodied reactions to clinical situations, some clinicians experience a freeze response in high-stress moments with clients. The freeze response is often discussed in the literature as a response to trauma, defined as “a state of behavioral inhibition that prevents active reaction to the occurrence of a stressful event” (Bracha et al., 2004; Volchana et al., 2011). While situations in which clinicians make decisions in session are rarely traumatic, the nervous system can react in similar ways, especially when situations activate stress and anxiety. During a freeze response, the dorsal vagal complex will activate, causing a drop in heart rate, reduction in metabolism, and difficulty breathing (Van Der Kolk, 2015). This overwhelm of the body and mind can even cause awareness of self and other to shut down – even no longer registering physical pain.

Another characteristic behavior of this response is immobility (Gallup, 1977; Moor, Ben-Meir, Golan-Shapira, & Farchi, 2013; Rolls, 1999; Van Der Kolk, 2015). Often a human’s emotions will seem so intense that this freeze response will be activated and maladaptive behaviors such as freezing or fainting will be produced instead of active escape or fight reactions (Rolls, 1999). This response also seems to be so strong that even rational reasoning capacities are unable to be activated, and humans still find themselves exhibiting these ineffective behaviors (Rolls, 1999). Animals exhibit this freeze response as well – such as a deer when it sees the headlights of a car or sees a human walking near. When an animal freezes, it engages in an active, purposeful attempt to avoid initial detection by a predator (Gallup, 1977). While this response is adaptive for those experiencing acute or chronic trauma, the problem arises when a patterned response develops and occurs when an individual is in a safe environment.

Dance/Movement Therapy and Traumatic Response

Polyvagal theory is an organizing principle that explains the evolutionary function of the autonomic nervous system. It underlies the fight/flight/freeze adaptation that people experience when in dangerous or threatening circumstances (Porges, 2010). Some dance/movement therapists utilize the polyvagal theory to inform their practice by viewing the primitive behavioral strategies present when faced with unsafe events as adaptive instead of negative and unhelpful. This view of the fight/flight/freeze response offers respect toward the body's natural instincts and celebrates those responses as a service of survival (Gray, 2017). Polyvagal-informed dance/movement therapy (DMT) emphasizes the importance of state-shifts for those in the fight/flight/freeze arousal state. This state-shift can only occur when the body is involved in treatment (Gray, 2017). Utilizing this strengths-based view of the fight/flight/freeze response while using the body's wisdom to create physiological, emotional, and psychological change is a clear match for the modality of dance/movement therapy, as it utilizes the body's wisdom to create change. For instance, if a client experiences a freeze response to stressful situations, the therapist could help the client utilize the adaptive increase in energy and pause to recognize body sensations such as tension, heat, rapid breathing, or urge to run, and let the body experience new ways of being. The client could slowly deepen their breathing and decrease shoulder tension until the body is no longer frozen.

Conclusion

The literature shows that clinical decision making is a process that is influenced by many factors. Intuitive judgements are affective, fast, nonconscious, and holistic in nature. Intuitive decisions are best made in tasks that are judgement based, without clear criteria for success. These tasks include clinical decisions for mental health treatment that therapists encounter daily. The use of intuitive judgement is often dismissed as inherently biased or heuristic in nature.

However, it has been found to be more cognitively efficient than structured analyses. Clinicians must also be aware of the influence of affect on decision making. Affect can enhance the effectiveness of clinical decision making as long as the clinician has awareness of their emotions at the time of the decision. Ability to regulate emotions that are present when making a decision also diminishes the effects of biases and heuristics. Additionally, cultural competence and self-reflection of personal history is necessary to reduce any reinforcement of oppression. Finally, the body is used in intuition by use of bottom-up processing where body felt senses are processed later at a conscious cognitive level. Knowledge of one's bodily reactions, such as the freeze response, to a certain situation may influence the decision-making process.

The purpose of this study is to explore my process of clinical decision-making. My hope is that the exploration, through movement and journaling, will illuminate patterns that arise and support my work as a dance/movement therapist, as well as illuminate potential strategies to use when the freeze response occurs in a clinical situation in order to push through and provide effective care for clients. Thus, this study may allow other clinicians to uncover their own decision-making processes and find ways to push forward in the face of stress and anxiety. My research will answer the question: How do I, as an emerging dance/movement therapist, approach the clinical decision-making process? This research will also investigate how the factors above influence my decision-making, and specify which feelings generally emerge when I freeze during a session.

The following chapter will discuss the methods of my research. I will describe in detail my process of embodied artistic inquiry self-study, as well as why this methodology was chosen. Descriptions of the procedure, data collection, analysis, and validation strategies are also detailed in the next chapter.

Chapter Three: Methods

This artistic inquiry self-study took place over the course of eight weeks. Data were collected in the form of written journal entries as well as video recorded improvisational movement. Video recorded embodiment sessions occurred weekly and were overseen by a board-certified dance/movement therapist (BC-DMT) and Laban movement analyst who acted as a research consultant and external auditor throughout the course of the study. I used the movement that was derived during embodiment sessions to choreograph a piece that aesthetically reflected the themes that arose using creative synthesis.

Methodology

This study used an embodied artistic inquiry self-study methodology. This methodology was first introduced to dance/movement therapy research by Lenore Hervey (2000). “Embodied artistic inquiry is defined as research that (1) uses artistic methods of gathering, analyzing, and/or presenting data (2) engages in and acknowledges a creative process and (3) is motivated and determined by the aesthetic values of the researcher” (Hervey, 2000, p. 7).

Artistic inquiry fit best with this study’s purpose because my personal relationship to clinical decision making is an embodied one. When faced with a clinical decision or crossroads, I exhibit symptoms of the freeze response, defined in this study as a state of behavioral inhibition that prevents active reaction to the occurrence of a stressful event (Bracha et al., 2004; Volchana et al., 2011), and cannot easily continue effective treatment until that anxiety has gone down. Rothschild & Rand (2006) theorized that the freeze response occurs in the presence of a fearful object when both the parasympathetic and the sympathetic nervous system are aroused simultaneously. In this case, since the response has happened repeatedly in sessions during decision making, the fearful object was the decision itself. Clinically, I needed to research what

happened in that moment of decision to learn about this pattern, so I can understand why it happened and move forward in offering effective treatment. Since this freeze response is an embodied and deeply personal experience, artistic inquiry was an appropriate methodology because it utilized artistic and personal means of collecting data and analyzing data (Hervey, 2000).

I learned through my fieldwork and time in classes that I process information from a bottom-up perspective. Daniel Siegel (2012) describes that the right hemisphere of the brain integrates horizontally – meaning that it integrates knowledge across modalities (such as sight, sound, and touch) and can attain complex contextual information with which to create a vivid representation of the information being taken in. Using artistic means of gathering and analyzing data before vertically integrating the information using language and categorization, the function of the left-brain (Siegel, 2012), allowed me to utilize my strengths. As someone who utilizes the right-brain and integrates information horizontally before utilizing the left-brain to analyze through words, I was able to create an authentic and meaningful experience during data collection and analysis that more accurately mirrored my own experience of information integration as a clinician in sessions. Using artistic methods of collection and analysis also allowed me to experience transformative shifts in perspective that would not have integrated as well into my professional development had I used a non-artistic or non-embodied method of collection and analysis.

Finally, as a dancer since childhood, dance and movement are integral to my emotional expression and processing. Using dance and movement data allowed data to be authentic, meaning the data collection, analysis, and results were expressed in a way that was representative of my reality, worldview, and subjective ways of knowing (Hervey, 2000). Artistic inquiry

allowed me to create a final, aesthetically representative and expressive work that was performed as an answer to my research question.

Participant and Setting

I was the sole participant of this artistic inquiry self-study. I was a 24-year-old, Caucasian, cis-female residing in Chicago, Illinois and was a graduate student in dance/movement therapy and counseling. Through my graduate program and practicum experiences I learned that I exhibit a freeze response that causes me to become flooded with emotions and unable to speak when confronted with the opportunity to make a clinical decision in a therapy setting, especially if the content presented to me by a client was unexpected, intense, or if I was being observed by a supervisor.

Data collection sessions took place in the private practice space of a board-certified dance/movement therapist and counselor and research consultant in Chicago, Illinois. Data analysis and the creation of choreography were completed at Columbia College Chicago dance studios as well as at the private practice space.

Data Collection

Data was collected alongside a board-certified dance/movement therapist and counselor as a research consultant through the form of improvisational movement and written journaling. I collected data four times over the course of eight weeks. My first session was an introductory session, then data was collected the next four sessions, and finally, after I analyzed data by creating choreography, I had a validation and closing session – making a total of six sessions over the course of eight weeks. For the purposes of this study, I will regard the first data collection session after the introductory session to be the *first session*. The introductory session was a way to introduce the research consultant to the topic and method as well as familiarize

myself with the space. The closing session was for the research consultant to assist in adjusting movement qualities and choreography to better reflect the themes discussed in data collection sessions and finally, validate my findings. Data collection sessions lasted 60-75 minutes and included orientation to the topic through a 5-10-minute grounding meditation, 20-minute movement improvisation, 10-15-minute journaling, and discussion for the remaining time. The research consultant was present throughout each of the 60-75 minute sessions.

One week was taken off between the first and second data collection sessions due to a scheduling conflict, however, this week acted as a period of incubation (Moustakas, 1990). Incubation is defined as a period which allows for understanding and clarification of material “on levels outside immediate awareness” (Moustakas, 1990, p. 29). A substantial amount of data was collected during the first collection session, which was integrated during the incubation period. The data collected surrounding my decision-making process had deep roots and personal implication, which created a heaviness and intensity for me around this research. In turn, this incubation period offered a way for me to process through the personal implications of the data before coming back and viewing the research from a clinical perspective. I was able to come into the second collection session with a renewed perspective of the research question and data collected. During this incubation period, I purposefully did not think about the data or research question, which, as Moustakas (1990) suggested gave me a deeper understanding of the phenomenon being observed in the research.

During the grounding meditation beginning each data collection session, I recalled an experience in a dance/movement therapy session I led where I exhibited a freeze response, which was experienced as anxiety, inability to speak, inability to make a decision, fear, and body tension when confronted with a clinical decision to be made. This recollection was introduced to

recreate a physical, mental, and emotional experience just before freezing at the point of decision making. It was important that the data was collected just before the freeze response because when a true freeze response occurs, it causes arousal levels to reach outside the window of tolerance – meaning the nervous system is overactive – causing disruption in one’s thinking or behavior (Siegel, 2012). My research consultant noticed that I was reaching the point where my arousal was outside my window of tolerance during the beginning of the first session, making my movement come less easily. We decided to modulate by only allowing me to reach the edge of my window of tolerance, instead of outside of it. To do this, the research consultant looked for body and movement cues that I was outside my window of tolerance such as inhibition of movement, muscle twitches, rapid breathing, and extensive muscle tension.

During the first session, a theme of autonomy emerged, detailed further in the Results chapter. The research consultant and I decided that in subsequent sessions, I would indicate when my improvised movement and journaling portions of the collection session had come to a satisfactory close instead of abiding to the strict time limits set in my research proposal; thus, strengthening my own personal ability to make decisions, as well as ensure that adequate improvisational movement and journaling data was collected. The indicator that data collection was finished was when I had collected enough data to see trends repeat themselves several times. This happened after the third and fourth sessions – I no longer was generating new data, and the existing data had exhibited clear, repeated themes. If the process of creativity in session felt strained, this would have been indicative that no more data would be meaningful for this topic.

Improvised Movement. Improvised movement was recorded with my computer’s webcam. I began in a position where I felt grounded, which was different each session. After the research consultant led me through a grounding meditation and body awareness exercise to focus

my attention inward to my mind, body, and spirit in the moment – then into the recalled experience of anxiety and freezing in a group, she turned on the camera. I chose not to use music, as I did not want to be influenced by the mood created by it. Occasionally, the research consultant would spontaneously offer up directives if I appeared to be too deep into the freeze response where movement became difficult. She also offered up words and directives, intuitively, which offered opportunities for me to deepen my experience.

Journaling. Journaling consisted of sensations, images, feelings, and thoughts (SIFT) that were salient throughout the movement improvisation. Using a SIFT (Siegel & Bryson, 2012) lens for journaling ensured that my data would be rich and descriptive of the inner, subjective experience. I kept a lined notepad and an assortment of writing utensils in the studio with me to use after the movement improvisation. Each time, I would recall my experience on the paper, translating my embodied experience into language. My journaling data included written words, narrative, and illustrations that reflected my experience during the improvised movement.

Data Analysis

I used the process of setting choreography to analyze my data through creative synthesis, creating, as Moustakas stated, “an aesthetic rendition of the themes and essential meanings of the phenomenon” (1990, p. 52). The data collection was witnessed by a research consultant and themes were determined through verbal dialogue and cooperative process through movement and writing. I synthesized the data by extracting salient themes from discussion with the research consultant, journaling, and movement data. The process of choreographing was done alone at a Columbia College Chicago dance studio. I watched my movement data video recordings and re-read my journaling and notes from discussion with the research consultant. I created the performance piece by improvising movement in response to the recently reviewed data. As I

continued to move in response to those themes, a narrative and repetitive structure developed. After creating that structural narrative, I utilized my knowledge of Laban Movement Analysis (LMA), a system created for the observation and description of movement, to create aesthetic distinction and solidify the meaning of the analysis in order to accurately portray themes to the audience. The creation resulted in a physical and artistic expression of my inner sensory and emotional process during the moment of clinical decision making and intervention. The process of art making through movement created meaning of my data through purely artistic and aesthetic means (Hervey, 2000). Furthermore, to clarify my results, LMA terminology was used throughout the data analysis process.

After creating the piece, I met with the research consultant one more time to discuss how my piece appeared to aesthetically represent the themes generated by the movement data, journaling, and discussion. We discussed moments within the choreography when my themes needed to be emphasized and the research consultant offered movement coaching using LMA to create that emphasis. I used the coaching information to adjust my choreography once more before the performance. This final choreographic piece was performed at the Student/Faculty Dance Performance, “What Would Marian Say?,” on July 18, 2018. The piece was entitled “the watcher and the inextinguishable inner flame” (See link provided in Appendix A).

Validation Strategies

The first validation strategy for this research study was the use of a research consultant as an external validator during data collection and analysis. The research consultant helped me explore and address the freeze response that occurs when approaching a clinical decision, as well as different ways this freeze response showed up in my movement data. The research consultant also helped validate my theme generation by watching my movement data and dialoguing with

me during the sessions. Finally, the research consultant helped me attune to my aesthetic preferences when finalizing my choreography as well as ensure that my final product was aesthetically portraying my themes to the audience and aligned with my data and the original research questions posed.

My second form of validation was a resonance panel discussion comprised of three dance/movement therapists, including one Laban movement analyst, four weeks after my performance. Each panel member had a background in movement analysis as well as a year or more of supervised clinical experience, giving them insight into their own embodied clinical decision-making processes. I asked for critical feedback regarding themes apparent in my choreography. The feedback session was semi-structured. I presented my research question and data collection and analysis process as well as themes that arose. We viewed the choreography using a recording of the performance and the panel spontaneously gave feedback as to where they noticed themes were present and how the aesthetics of the piece were reflective of themes I generated. The group also offered questions for me regarding meanings within my results. This process deepened my understanding of my themes and created new insights into themes I had originally missed.

Chapter Four: Results

As a result of my embodied artistic inquiry self-study of my clinical decision-making process, I discovered themes within my journaling and movement, as well as through creating choreography during data analysis. This section will present those themes and how they answer my research question. Although the feelings and movements became somewhat exaggerated through movement and journaling, it is of note that the process I explored was an internal one that would not necessarily be noticed by those observing or in the therapy session when the freeze response being studied occurred; therefore, the descriptions of each stage are also a symbolic representation of my own internal experience. The primary research question I explored was: “how do I, as an emerging dance/movement therapist, approach the clinical decision-making process?” A cyclical pattern emerged, which is explained in detail below as well as other embedded themes related to the cycles.

Process of Decision Making

While embodying the space where I freeze in a therapy session during clinical decision making, I recognized that a cycle was repeating itself in each data collection session. For example, memories that came to mind which triggered this response during my data collection included an older client who brought up the topic of death and another client making self-deprecating jokes about his physical limitations. Despite the knowledge that fixing things was not the most therapeutic, I became frozen when brainstorming which response was the right one for that moment. I deeply wanted to help, but also because of my fear of rejection or causing harm. Memories such as the above examples created physical sensations and impulses for me to move in certain ways, which offered a more in-depth way to delineate this feeling into a structured process. The process was not simply a cycle, but more like a spiral outward as seen in Figure 1.

The data revealed a first cycle (cycle A) that explained where my freeze response came from, and a second cycle (cycle B) in which cycle A became ingrained and unconscious. It was clear that cycle A, when repeated enough times, turned into a more automatic version – cycle B. Below I will describe each cycle and stage within each cycle: Cycle A: 1. Exploration, 2. Fear and self-doubt, 3. Perceived or imagined disapproval, 4. Shedding, 5. Resentment, 6. Distancing and grounding and Cycle B: 1. Autopilot, 2. Anger and rebellion, 3. Shedding/dissociation/loss of identity/perceived approval. The relationship between the cycles can be seen in Figure 1.

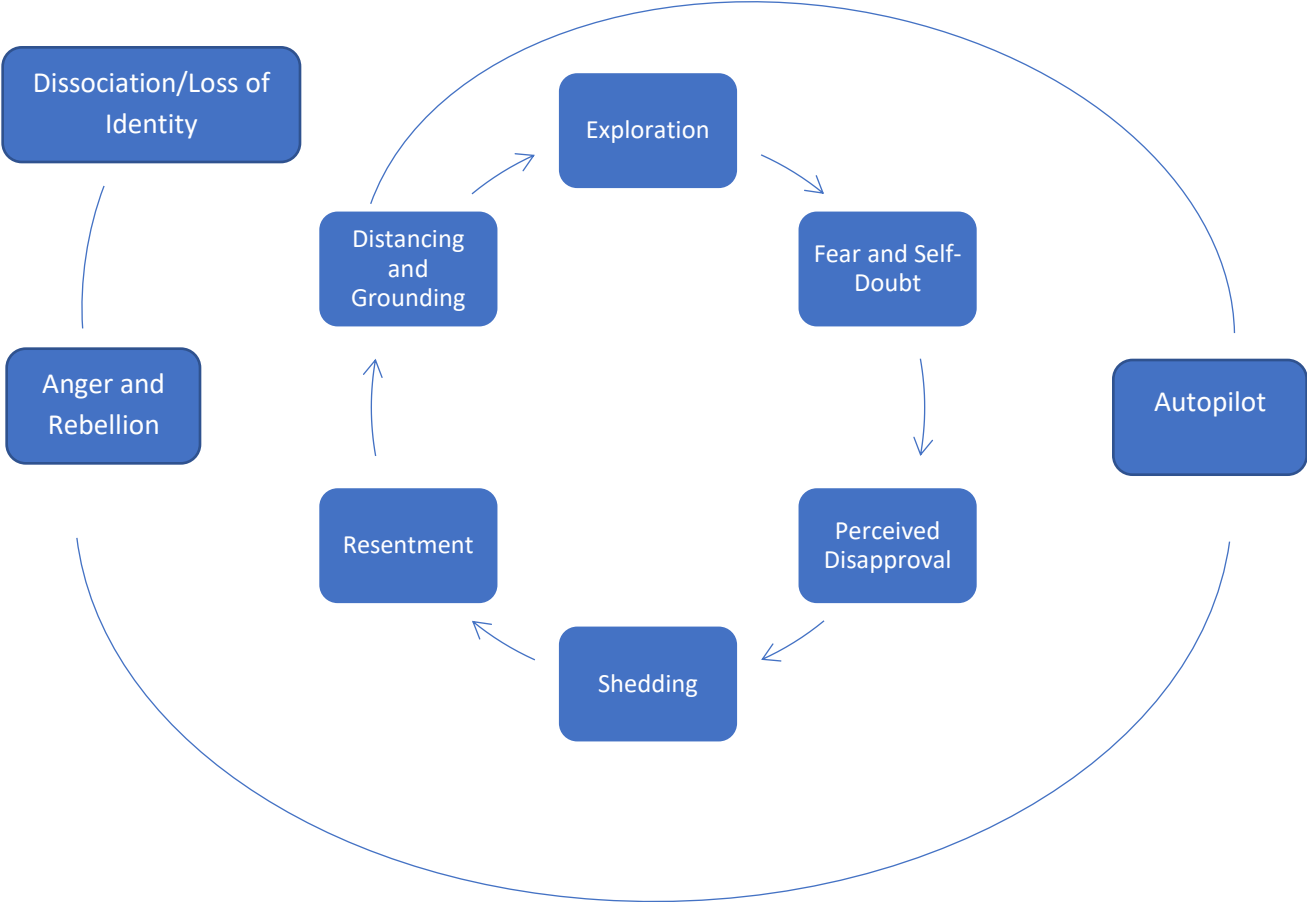


Figure 1. The inner cycle beginning at Exploration represents cycle A, the outer spiral represents cycle B.

Cycle A: The first cycle was experienced as a six-part process that happened immediately when a decision was to be made. Each stage represented a feeling state, body-felt reaction, and behaviors, images, and memories I experienced in data collection sessions when recalling a clinical situation in which I felt this freeze response during a decision. The choreography from 0:00-4:31 of the piece I created represented this cycle repeating three times. I will describe each stage in detail.

Stage 1: Exploration. This stage of the cycle included movements that extended from my core to my distal ends – reaching away from center and into the environment and back toward center. In my choreography, this was characterized by exploring the small area in front of me while laying down, with my fingers, as if they were walking away and back to center. This stage was also demonstrated by me utilizing far reach space and extending limbs outward while spinning, with a smile on my face.

This stage felt child-like at first, as if my inner-child reminded me of the freedom that one can experience when uninhibited. I felt a strong sense of curiosity with almost no sense of fear. My soul felt light as indicated by the smile on my face and ease of movement. I utilized the LMA effort quality of free flow almost exclusively and utilized acceleration. An image came to me of my younger self dancing freely in a wide-open field with no inhibition and the sun shining on my face. I felt no shame or doubt, only freedom and curiosity. Each time the cycle continued, this stage brought up the sense of an older character or inner-self. The first round of the cycle, I felt young and small, but during the third cycle I felt attuned with my womanhood and sensuality, choosing to explore with a fuller range of LMA effort qualities. In the second data collection session, I utilized my hips and spine in slow swaying movements and explored tactile and kinesthetic touch with my own body, bringing about a feeling of sensuality and feeling like I

owned my body. The research consultant added that this phase looked like the dance of a woman who has found her voice, is owning her rights as a woman and is expanding and making room for herself where she used to feel small. I felt as if I had the will to make my own decisions and felt feminine wisdom manifesting through my slow and swaying movements. In my third data collection session I wrote “when I felt like myself, I felt like water and air; very grounded and elemental.” This feminine wisdom and grounded, rooting feeling was an anchor that created a feeling from which I could explore safely – translating to experimenting with interventions and taking risks with clients in session without fear. For instance, if that inner flame was present within me during session, I would feel safe to offer interventions that were unexpected or new to me with the understanding that at any moment, I was still safe to return to my inner flame and lead session from that place again, even if the risk-taking intervention was unsuccessful.

Each time I explored, I felt a flame in my chest and saw images of fire. The fire inhabited my chest and solar plexus. It felt like the classic phrase – I had fire in my belly. I felt motivated, curious, and focused. The fire within me did not feel destructive, but simply like it was my trueness amplified and was leading me toward growth and freedom. During my first data collection session, this energy was red and orange, but I hadn’t identified it as fire. In subsequent sessions, an interplay between fire and water began to emerge in my mind’s eye. As I will mention later in cycle A: stage 4, and cycle B: stage 1, this fire encountered a few different conditions that attempted to extinguish it. However, the image of fire within my chest and belly was consistent through the length of my data collection process.

My heart felt open and vulnerable in this stage. In my second data collection session “I felt the urge to carve slowly and open my heart toward clients. When my heart was open, I was vulnerable to criticism of “me” and not of the tools I was using in session.” Similarly, in this

session I mentioned “my heart isn’t enough, my mind has to lead.” During this exploration, I was opening my heart, but there seemed to be a slight unconscious fear looming behind the free and open feeling. This stage was drenched in a sense of purity and free-spirited joy without worry and without fear. Although there was this occasional sense of looming fear in anticipation of the next stage, it was neither overwhelming or difficult to put aside.

Stage 2: Fear and self-doubt. After feeling freedom and lack of inhibition in my movements for a period of time, I would sense myself being watched by someone in the room – in these visualizations it was a supervisor, often very suddenly. From this point on, I will reference the person witnessing me as the *watcher*. This immediately caused me to stop breathing entirely for a short period of time, then to breathe shallowly. I experienced tightness in my chest and shoulders. My eyes widened and I imagined a deer in the headlights. I felt a heightened self-awareness, tinted with self-criticism. I had thoughts like “oh no, I got caught,” “what did I do?” and “what do you want from me?” I felt the desire for approval, validation, and praise from the person observing. It was as if I had been caught doing something wrong. This flooded me with shame and self-doubt. My flow became heavily bound and I physically froze. My muscles became tense and I felt the urge to run accompanied by a frustrating inability to do so.

When I felt like I was caught doing something wrong, my mind suddenly went blank and my head felt somewhat dizzy and disoriented. It was as if I had lost my footing and grounding a bit in my exploration, then was interrupted, which was disorienting. In my first session I wrote “[I felt] fear that I was doing something wrong or incorrectly” ... “as if, at any moment, [the watcher] would jump in and attack me or tell me I was doing a terrible job or that I’m hurting others. I felt an almost instant dissociation when the anxious situation was introduced.”

The fears I felt were fear of disapproval by the watcher, fear of abandonment by the watcher, and fear of disappointing the watcher. I projected expectations onto the watcher and when I realized I was being observed – exiting stage 1 and entering stage 2 – I would feel shame and experienced a switch from freedom and curiosity to fear and inhibition. I felt that in order to gain the watcher’s approval, I had to act differently than was my natural inclination. A journal entry from the first session expressed this notion: “I felt fear of disapproval from [the watcher] which made me put myself away, pushing away who I truly am to be something [the watcher] would approve of.” This thought brought feelings of shame – as if who I am was not good enough and my own judgements could not be trusted. This notion will be explained further in stage 4.

Stage 3: Perceived or imagined disapproval. This stage was filled with self-doubt, projecting expectations upon the watcher, and was very brief. As mentioned earlier, I felt fear of disapproval from the watcher as soon as I felt seen by them. These fears seemed to manifest in hypersensitivity to cues of disapproval from the watcher. In my first data collection session, I experienced this so quickly, it happened almost instantly and unconsciously as evidenced in my journaling by only stating “I thought they would be mad” before journaling more about the subsequent stages. In my choreography, this was represented by the transition between each abrupt pause with my arms raised above my head and when I was dragged, by my projected expectations from others, across the stage backwards toward the watcher. This transition was almost unnoticeable in my own process; a resonance panel member suggested this stage after feeling it was something initially unnoticed by the research consultant and me. I automatically began to enter stage 4 after stage 2, but the reason and mental thoughts appearing between these two stages included things like “I’m sorry” and “I know I did something wrong.” These thoughts

indicated the desire for approval, as well as the shame present when I assumed that I had done something that the watcher disapproved of. In the movement data, this part was very subtle and often was more evident in the journaling section and the content was similar to the phrases stated earlier that were negative and illustrated feelings of guilt, shame, and self-blame.

Stage 4: Shedding. In order to dissipate the fear, anxiety, tension, and shame that were brought up in stages 2 and 3, I began to feel the need to shed parts of myself that I assumed were being disapproved of. In the first data collection session, I experienced an image: “I felt a pull of energy being pulled out of my right ear as if my face was being pulled off and a wave of energy crashing over my head and pushing my red/orange energy out, like extinguishing a flame or knocking over a building.” I felt a loss of identity and loss of will. It was as if I was emptying myself of everything I felt so fully in stage 1 based upon assumptions about the expectations of the watcher.

Movements were present in the second session where I would move my arms and hands as if I was plucking feathers out of my body. Each feather seemed to represent those qualities of myself that I deemed the watcher would disapprove of. A motif of my choreography that was repeated three times was me wiping my hand across my face as if I was removing anything that characterized me as myself, plucking out of my heart, and ripping out my vocal chords as if I was removing my ability to speak. There was a conflicting sense of passivity and weightlessness in my movement contrasting a sense of resistance and tension. I had thoughts of “if it will make you happy, I will get rid of this part” which was a statement present in my journaling from sessions one and four. I felt sadness, desperation, and hypervigilance of the watcher, self-critical shame, and abandonment of the self in order to please others.

I felt very attuned to the watcher and felt the need to absorb their needs and become what I believed they wanted. As if I was a vase – I emptied myself of my own essential parts and waited for myself to fill back up with what they wanted of me. I also felt a need to look toward the watcher after plucking each part of me away – “is this better?” and “am I ‘good’ now?” I felt desperate to rid myself of that sense of shame by contorting myself into something I thought the watcher would approve of.

Stage 5: Resentment. After shedding parts of myself, I began to feel anger directed toward the watcher for indirectly making me dispose of parts of myself. This anger was soft and was felt through a subtle nauseous feeling in the pit of my stomach. I felt a subtle grimace on my face, my nostrils flared, and jaw clenched. The research consultant and I developed the concept of a burden on my back creating physical and emotional heaviness. It felt like something was pulling me down or pulling me toward what I thought I had to do – in my choreography, this burden pulled me toward stage right at the end of each section. I felt as if my will had been taken away and I simply had to obey the unspoken orders of the person observing, which was against the wishes of the inner-child and inner-flame that was exploring in stage 1, causing resentment.

Stage 6: Distancing and grounding. After resentment built, I felt the need to run from the watcher and re-center myself. In the choreography, this was represented as moving away from the side of the stage where the watcher was housed. The overwhelm of anxiety and intrusion I felt when trying to adhere to the watcher’s perceived expectations was too much to bear in that moment, and I needed to create physical distance. Other times, like in my third data collection session, I moved away and imagined a wall put up between myself and the watcher in order to feel comfortable enough to re-center and ground into who I am and what decision I wanted to make. Once the wall was up, I felt relief. I also felt guilt. I felt, although I was able to

re-center, that I was somehow being rude or ungrateful to the watcher. This guilt showed up in that session, especially, because I was imagining a moment when my supervisor was watching me. As a resource for clinical knowledge, I wanted to be constantly connected to them. So, when I put up the wall I felt some sense of missing out. However, the burden from stage 5 was so heavy, I felt my only choice to feel grounded was to distance using that image of a wall.

Another part of this stage that showed up in the first data collection session was a stronger use of weight, and presence of anger. I distanced from the watcher and kept the resentment that built in stage 5. I wrote in my first journaling session: “I felt like I was saying ‘HA’ to my supervisor. I was saying no to the ‘shoulds’ that I projected they put on me. I wanted them to know that they couldn’t control what I did. I felt like a toddler or teenager rebelling against what my parents wanted me to do. There was some spite with my distancing.” This spite grew as the cycle continued. The first time through the cycle did not elicit this resentment, however as the cycle repeated, the resentment and anger seeped into stage 6 more.

This stage would often end with the transition from feeling off-center and out of control into feeling grounded and attuned with my inner-child and inner-flame. I would either revert to my inner-child and feel prepared to explore freely or feel grounded in my womanhood and feel able to make decisions independently.

Cycle B: Repetition of pattern. This cycle is an iteration of cycle A. After cycle A repeated enough times, it became automatic and no longer was as delineated – becoming cycle B. Some stages from cycle A were combined automatically, and others were more exaggerated and intensely felt in cycle B. The purpose of distinguishing the two cycles is to bring awareness to the changes that occur to the cycle with it is repeated and becomes habitual and automatic in cycle B.

Stage 1: Autopilot. This stage became evident as I choreographed and analyzed my data. In my conversations with the research consultant, a pattern was identified. In cycle A above, stages 1-4 were distinct stages with their own awareness and surrounding emotions. However, as this cycle continued, stages 1-4 became merged into an automatic reaction to being observed. Instead of processing confusion and resistance to feeling shame, doubt, and fear, I would enter an autopilot stage where shedding happened automatically, and I did whatever I thought the watcher wanted me to or expected me to. This stage included dissociation from my inner-flame. I imagined, in my second data collection session, raindrops trying to extinguish the inner-flame that was my integrity and will. This caused me to feel, as I discussed with the research consultant after the second data collection session “without color, without taste, without smell, without feeling.” There was a sense of resignation. A thought that entered my mind was “fine, I’ll do whatever you want.” I felt as if I was conforming to another person’s will and ignoring my own.

However, distinct of the shedding stage in cycle A, this was automatic because of the number of times I had cycled through cycle A before. My weight became passive, and I lacked energy. In my choreography, I used my hands to cover my face and walked very evenly across the stage as if I was being controlled. My feelings were muted, and I felt somewhat hopeless. Instead of exploring the stage as I had other times in the piece during stage 1, I went from the distancing stage (cycle A, stage 6), straight into autopilot because the burden was too heavy, and I felt discouraged by the number of times the cycle kept going. Entering the autopilot stage was energy conserving. After removing my face, heart, and voice as I had during the first three repetitions of cycle A, I no longer had the energy to re-ground and find my inner-flame again. In order to conserve energy, I put the flame away and became who I thought the watcher wanted me to be.

Stage 2: Anger and rebellion. This stage was an iteration of the resentment stage in cycle A. Instead of a soft anger emerging, the resentment built to a point where I felt the need to express the anger and rebel against the watcher, or the expectations I assumed the watcher had of me. This stage was characterized by strong use of weight in the form of stomping, throwing, wringing, and flailing my arms and legs. My jaw became tense when this stage appeared in the first data collection session and this journal entry was recorded: “I felt very grounded at one point and felt almost rebellious doing my own thing. Intervening how I wanted, not how I thought [the watcher] wanted. I remember feeling almost spiteful like I was saying ‘ha!’ when I did my own thing.” I stomped loudly and remember feeling my core engage. This stage, in contrast to the resentment stage in cycle A, felt less in control. My flow was free, and I was expressing my anger outwards, as if I finally had had enough and was “fighting against the ‘shoulds’,” as the research consultant observed.

My core was engaged, I used force in my limbs, used large kinesphere, and felt like I was flying. I traveled in space, utilizing my own mobility as well, instead of staying stable. At one point in the choreography, I paused and hit the ground then came up standing straight with my legs apart and arms out and mouthed as if I was screaming. The image of a steaming teapot came to mind in this stage – as if I had suppressed my will for so long, it came out freely and somewhat explosively.

Stage 3: Shedding/dissociation/loss of identity/perceived approval. After the rebellion and anger was expressed, I felt tired and fatigued. My body wanted to recuperate, and in order to do so, I entered a stage similar to stage 1 of this cycle, however, this time the dissociation and automatic movements did not result in anger or emotion. I felt numb, defeated, and lacking identity. In the choreography, I illustrated this section by moving toward the watcher, without

being dragged. I deliberately moved toward that side of the stage and began to wipe my hand across my face, and gesture as if to pluck from my heart, and rip out my vocal chords. That motif repeated three times; however, this third time, I continued plucking at myself, removing more and more of myself until I ended up completely dissociating and floating – giving control to the watcher, or my own perception of their expectations.

This phase felt like giving up. After going through cycle A so many times, I felt too tired and discouraged to continue repeating the cycle. Although some hope was still present – I still wanted to be able to break free from the cycle, I felt too tired at the time and recuperated by dissociating from myself and attuning to what I thought the watcher wanted. This was the point where I had realizations that I “need[ed] to find something that can break me out of the cycle and keep me in tune with my inner-flame, so I can stand strong in my decisions and feel grounded, rooted, and present with clients.” So, although I felt worn out and discouraged, there were still hopeful thoughts in my mind motivating me toward finding strategies to break the cycle.

Embedded Themes

While the two cycles of decision making were clear through data collection and analysis, there were embedded themes within the data which emerged after further analysis of the data. After reviewing all data once again, there were three embedded themes: autonomy, hope, and self-regulation. These three themes emerged as ways in which I learned to counteract the cycle so that it did not spiral out into dissociation, and instead allowed me to remain strong in grounded exploration. The way in which these three themes were uncovered, as well as the gist of the themes will be described in detail in the subsequent sections.

Autonomy and inner-wisdom. The theme of autonomy and inner-wisdom emerged in the initial data collection session and continued to be an important factor in finding a way to

stand strong in my own mind and body without giving too much power to others in a moment of decision making. In the second session, the research consultant suggested I decide when the movement and journaling portion of the data collection session was completed instead of staying with the initial timing set out in the proposal. This allowed me to tune into when I felt the movement was complete and when I had written enough – thus allowing me to practice my decision making based off my own judgement.

I became aware that when I was attuned to my inner-wisdom, I felt the sensation of my feet, heavy on the floor. I was more aware of the room and its temperature. I also felt my shoulders relax as if I was safe. I imagined an energy field expanding around me to fill almost the entire room, in which I was safe. Everything slowed down, my actions became mindful and I felt as if I was moving with intention and very little resistance. In the fourth data collection session, the research consultant said “you have permission to come out now; it is safe to come out now” to my inner-self. I enjoyed the permission but wasn’t completely sure what to do with that freedom. I slowed down and felt as though “if I moved too quickly, I’d lose the feeling.” This feeling was a warmth in my entire body, as if my body was filled with warm water. I felt my heart space connect to my belly so that my whole torso felt radiant with an orange and red flame. I felt very vulnerable, but strong at the same time. My movements were slow and steady and often in near reach space. I used free flow, but slow movements, which created a sense of hesitancy, but purposefulness. I felt as if I trusted myself and was able to manage to keep the inner-flame ablaze while with others and while being observed, as long as I stayed mindful and slow.

Hope. Hope emerged often within the last few sentences of my journal entries, as well as sporadically within my movement sessions. After noticing the cycles emerge from the data, with

the help of the research consultant, I felt somewhat discouraged, since the cycle B was a spiral. It sent me into a somewhat hopeless place, because the cycle had no points in which there was a way to remain in a healthy state in a therapy session. After the first data collection session, I journaled “I am filled with hope that this journey will help me find [my inner-child] and hold on to her, even in the presence of influence.” This statement was hope that I would develop a stronger professional identity within a session with a client whose experience differs from my own – not losing myself in empathy for them and remaining strong in my identity while dipping a toe in theirs. In my second session, I journaled “The voice that said ‘Let me be me! It is enough!’ was louder this time,” and “maybe the light inside will grow stronger and I will expand.” In my third session I journaled “I have to fill myself up and decide based on my heart, not any projection of what other people want.” And finally, in my fourth session, I wrote “it’s a tiny light” – referring to the hope inside me when I feel I’ve reached the outer edge of cycle B.

Hope, in my body, felt like a small smile on my face, activity in my chest, like a motor starting, the urge to move in the sagittal dimension, and like a heavy blanket had been removed from atop my body – like a burden had been lifted. I thought more positively as evidenced by my journal entries above. I felt strong motivation, confidence, and desire to problem solve so that this spiral would not take over my decision-making process. It was empowering, and I experienced an image of sun shining on me – as if it was a brand-new day and a new chance to create a new pattern in my decision-making process.

Self-regulation. This theme of self-regulation emerged as images of water and fire. In the cycles, the process was so habitual and automatic, that often self-regulation was not breached in any other way than by shedding the self and/or dissociating. During the second session, however, I was able to find a moment of self-regulation which broke me out of the cycle

temporarily by imagining water surrounding me becoming still, without waves, without sound. My movement became slower and more even. I journaled “The light was loud today, and I felt more assured and less in need of validation” ... “I felt like this was how I am supposed to be. It felt calm like the chaotic waves had stopped and I controlled my own water. For a moment I was big and expansive.” The image of a light being inside my chest was one that was present in each session, as well as the physical sensation of water keeping me grounded and present. In the first journal entry, I wrote about a wave crashing over me, coming from the watcher. In contrast, in the second session I controlled my own water. This was indicative of self-regulation and the ability to figuratively calm my own waters regardless of the outside conditions – differentiating self from other. It was as if the cycles were placing unnecessary blame upon the watcher, while the moments of self-regulation were filled with thoughts about how I could intentionally change my state of mind and behavior even when in the presence of someone who I thought was attempting to change who I was.

In the following chapter, these cycles and themes will be discussed in terms of their application to my professional practice of DMT and therapy. I will discuss concrete ways to stop or slow these cycles from interrupting my clinical decision making and possible coping skills to use when I reach the point of a freeze response. A reflection of the performance will also be included.

Chapter Five: Discussion

The purpose of this embodied artistic inquiry was to explore my process of clinical decision making in order to gain a greater understanding of how my freeze response plays out in session, as well as ways to combat the cycle and be more present with clients in a session. This section will answer the research question: “How do I, as an emerging dance/movement therapist, approach the clinical decision-making process?” Additionally, it will include a reflection of my performance of the cycles of decision making.

Dance Performance Reflection

The artistic and embodied exploration of my process of decision making – specifically the qualitative characteristics and narratives present within the moment of decision – involved a deep and tender sense of vulnerability. It allowed me to observe how I unconsciously respond to opportunities for decision making, especially when being observed. Through dance/movement and journaling, I was able to identify cycles that occur as well as concepts that can interrupt those automatic cycles. The findings were presented in a dance performance at the Columbia College Chicago Student/Faculty Dance Performance on July 18th, 2018.

This process allowed me to understand the two cycles that occur when I am faced with a clinical decision. The cycles are as follows: Cycle A: 1. Exploration, 2. Fear and self-doubt, 3. Perceived or imagined disapproval, 4. Shedding, 5. Resentment, 6. Distancing and grounding and Cycle B: 1. Autopilot, 2. Anger and rebellion, 3. Shedding/dissociation/loss of identity/perceived approval. I was able to discover three additional themes of autonomy and inner-wisdom, hope, and self regulation. By recognizing these cycles and the additional themes, I have gained welcomed insight into ways in which I can become aware of the cycles as they happen and possibly intervene with the three additional themes to stop or slow the cycles. I’ve discovered

several ways in which I can stop or slow the cycles, which may allow me to become a more effective clinician as I encounter more opportunities for clinical decision making, potentially in high pressure environments in which I am being observed either directly by a supervisor or more organically by a client.

I performed my thesis choreography entitled *the watcher and the inextinguishable inner flame* at the Student/Faculty Concert “What Would Marian Say?” hosted by Columbia College Chicago. My choreography was partially choreographed and partially improvisational. Motifs were included in the performance to illustrate specific themes found in the movement and journaling data, which were repeated several times – such as being dragged to stage right, wiping my hand across my face, plucking at my heart, grabbing my throat, and spinning with my arms out and head looking up at the ceiling. Other parts, such as the times when I began in the center of the stage and was in the exploring stage of my cycle, I improvised. I moved with qualities that I associate with certain feeling states that I was imagining. For instance, I imagined being in an open field with the sun shining on me with energy flowing out of my limbs and my body relaxed and not tentative when trying to convey a feeling of freedom, joy, and inhibition.. These imagined feelings created movements that were characteristic of how I physically express those feelings- such as free, large and sweeping movements.

Performing this piece felt vulnerable as well as freeing. I felt like it was an authentic expression of a part of myself that I finally came to understand and was able to articulate through movement to an audience. It was like giving the audience a taste of what went on in my mind in a therapy session or during a stressful decision. I felt nervous to perform such an honest and personal piece of choreography in front of an audience for fear of being misunderstood. I worried that the piece would not be relatable to the audience, or they would read a different narrative into

it, other than the story I had intended it to show. However, even with all of this anxiety, I was excited to show it and fully embody this process with witnesses. It was a process of decision making done in front of an audience – a direct parallel to the topic being researched! This opportunity to perform was also an opportunity to practice autonomy, hope, and self-regulation in the face of witnesses who I give the opportunity to judge my artwork.

When I was on stage, I reminded myself to breathe deeply, and simply tune into my inner-wisdom. I was telling a story that I knew best, and the audience would interpret it how they did through their own lens and experience. At times, I felt the need to overperform or dramatize the piece so that the audience would see it more clearly, but I made a conscious decision to stay true to myself and create a performance that was authentic to my physical, mental, and emotional experience. To combat that need, I visualized my inner-flame and inner-child before going onstage. I grounded myself and re-entered the safe space that was created during data collection sessions by the research consultant. My heart was beating fast and I was fidgety, but I felt grounded in my feet, slowed my breathing, and visualized myself as the only one in the room when I was on stage. In order to give the most authentic performance, I had to tune out the audience and tune into myself using the tools I developed of self-regulation, hope, and autonomy and inner-wisdom.

I was not nervous to perform or to mess up, but I was mostly nervous about others' responses to my performance afterwards. I feared their interpretations would be far off from what I was experiencing on stage and that nobody would resonate with the true meaning of the piece unless I spelled it out with words. However, I knew that this practice in performing with the possibility of others misunderstanding, judging, or disapproving, was a practice in courage and would break me out of the decision-making cycle I found myself in during therapy sessions.

I used my visualization of a wall that emerged in my data collection to create a boundary between my projected expectations of the audience and my own authentic expression. This boundary allowed me to feel calmer and more able to effectively tune into the feeling states I intended for each section of the piece.

Viewer response and resonance panel. After the piece was over, I felt relief that I had finished as well as some fear about how it was received. I received feedback from classmates that the piece elicited an emotional response from the audience. One member of the audience mentioned that the movements reflecting the dissociation stage gave them goosebumps and made them feel a strong emotional response. Some audience members mentioned that they felt like I showed a part of myself onstage that they had not expected or seen from me before – a freer, more powerful and intentional version of myself. This made me feel like I had truly embraced my inner-feelings and articulated them effectively through movement and performance. Perhaps this emphasis on relationship and how others perceived the piece is relative to my theoretical orientation of RCT. I was focusing on connection and disconnection and hoping that my genuine expression of my internal process would be seen, felt, and honored by those watching, thus bringing us together in connection.

My resonance panel met two weeks after the performance, which each panel member attended live. We joined together in my residence and watched the performance video. In a semi-structured conversation guided by specific questions regarding the piece and themes, each resonance panel member shared their own interpretation of a movement or phrase of movement, then reflected upon my intended meaning. The panel discussed that they recognized the cycle within the piece because of the repetition of specific movements – such as wiping my face and returning to the right side of the stage. Since dance and choreography is highly subjective, each

panel member interpreted the piece from their own perspective and worldview. They all agreed that there seemed to be a cycle that repeated several times within the piece but disagreed about how it ended. Some saw a resolution where I let go of others' expectations and became weightless, and others saw what I had intended – dissociation. Each panel member utilized their own perspective to draw conclusions as to what the piece meant. Because of some panel and audience members' misinterpretations of my movements, my fear of being misunderstood was somewhat actualized. However, the response from the audience that they saw a different side of me - a stronger, fiercer, more authentic side, filled me with pride and confidence. I felt like I could utilize that strong and fierce self in session to make decisions and disregard the projected expectations that I was holding on to.

Limitations

One limitation of my research study is that it was a qualitative self-study in which I was the sole participant. Since only my own experiences were researched, the findings may or may not be generalizable to other clinicians' experiences. As generalizability was not a goal of this study, data regarding other therapists' experiences may differ from the data generated by examining my sole experience. Another limitation is that the data was collected in four sessions over five weeks, which was a relatively short period of time and small number of sessions. The analysis and creative synthesis also occurred in the span of two weeks, which is a relatively short period of time to synthesize the data collected. The subjective and non-verbal nature of the data is another limitation, as transforming body-felt sensations, feelings, and internal experiences into written form affords opportunities for misrepresentation. The final performance presented findings in the form of a dance piece. Audience members with little knowledge of dance or performance structures may have interpreted the piece differently, depending on their worldview

and own experiences. However, the intention of this performance was to express my findings, not to ensure the audience felt the same meaning I intended. One additional limitation in this study was that I took a week off between sessions one and two due to scheduling issues, which may have slightly altered the data as a result of unavoidable inconsistency in schedule.

Implications for Dance/Movement Therapy

With all of this knowledge about my clinical decision making process, I feel it will impact my professional performance in session. Also, because all dance/movement therapists make clinical decisions in their work as well as utilize body-based means of observation of self and others, I believe my results may be applicable to others in the field. I used a movement-based method of data collection and analysis, which would lend itself to those in the dance/movement therapy field who are interested in researching, whether formally or informally, their clinical decision making process to enhance their professional development. From speaking to other mental health professionals, I have noticed a consensus when it comes to feeling some anxiety when being observed by a supervisor. My results may assist clinicians in developing insight into their own physical, mental, and emotional response to being observed, as well as create potential coping skills to modulate and regulate the anxiety of being observed.

This section will detail different implications of my research study including how I plan to prepare for future observation by supervisors, how I anticipate knowledge of my process will affect my freeze response, and how I will use the three additional themes of autonomy and inner-wisdom, hope, and self-regulation to slow the cycles. My research question of “how do I, as an emerging dance/movement therapist, approach the clinical decision making process?” is answered further by this section, as well as the implications of these findings. I also include how I see this question being answered in the future, now that I have the knowledge of my process.

Using autonomy and inner-wisdom, hope, and self-regulation. The three embedded themes that emerged when analyzing the data were autonomy and inner-wisdom, hope, and self-regulation. I found that in my journaling, the times when I felt less anxious were moments in which one of these themes was being experienced. In my future clinical work, it would be beneficial for me to first notice when the cycle happens and intervene with one of these themes in order to stop or slow the cycle.

First, to notice when the cycle is happening, I can take note after a session of times when I feel I froze and write down the precipitating events or details of the interaction that triggered the response in me. This can help me recognize trends in when I freeze – if there are times when my freeze response happens other than when being observed, or patterns of countertransference. For instance, if I realize that in sessions with older clients I am more likely to freeze than in sessions with younger clients, it would allow me to find ways to anticipate this reaction and intervene earlier before I enter the cycle. This idea will be described in the next section about preparation for observation.

Second, knowing that autonomy and inner-wisdom, hope, and self-regulation are ways in which to intervene, I will find strategies to slow or stop the cycles. In order to tap into my autonomy and inner wisdom, I could picture the image that emerged in the data - my inner-flame, a red orange fire in my chest. I could even use my body in this intervention by placing my hand on my chest. This could help me become more centered and tap into the inner-wisdom within my mind, body, and spirit. To intervene with hope, I could remind myself that I am a new clinician and that I will likely make mistakes in each session but that is the way I will deepen my understanding of how to make clinical decisions. I could also imagine the image of myself under the sunshine in a field, to elicit feelings of freedom and bring me back to hope. I will also remind

myself of the hope I have for my future professional development and learning from mistakes is just a stepping stone to become a more effective clinician. Finally, I can remind myself that I have the potential to improve upon my decision making as well as instill hope within myself that I will find ways to calm myself when I freeze. To intervene with self-regulation, I will visualize the image of calming my waters – an image that came about in the data. I could also utilize the movements that emerged with this theme which were slow and sustained movements with no abrupt transitions. When I freeze, it often feels like I am in the middle of a storm that will not calm enough for me to react to it. The image of that storm calming may facilitate the calming of my mind and body. In these moments of dysregulation, I can also utilize coping skills that I would offer to clients, such as deep breathing, pausing for a moment, checking in on my muscle tension, and reminding myself that I am safe in the moment. These strategies will offer moments of self-regulation, which will likely enable me to see a client interaction more clearly – without the shame, doubt, and hyperarousal that come with my freeze response to being observed.

Finally, I plan to utilize mental boundary setting between myself and the supervisor by utilizing the image of a wall that emerged in data collection. I will imagine myself on one side of the wall leading the session, and my supervisor on another side of the wall. This will enhance my sense of safety and regulate my concern of their opinion of me. This wall image may also be helpful when in a session with a client who discloses disturbing material, as I can create a wall between their feelings and my own. Additionally, through reading a dance/movement therapist's thesis, I recognized similarities in anxiety responses within session as well as examples of ways to regulate that anxiety. One strategy I will use to attempt to remain grounded has already been articulated by Batko (2015) and involves breathing deeply, stretching, and firmly pressing my feet into the floor.

Preparation for observation. Knowing that my automatic reaction occurs when in a stressful clinical situation, such as being observed by a supervisor, I believe I would benefit from developing strategies to prepare for observation. In conversation with the research consultant, she mentioned that it could have been helpful for me to hear phrases such as “there is no right way to lead the session,” “I am excited to see the way you choose to lead,” or “lead the way you feel is true to you, and that will be enough.” These phrases calm my anxiety about being observed and offer encouragement when I reach the perceived disapproval stage in the cycle. Depending on my relationship with the observing supervisor, I could ask them to relay a similar sentiment to me before the observation to help me enter a calm mindset and reduce the likelihood of entering the cycle without realizing it. If the relationship with the observing supervisor is not as developed, I could create affirmations to repeat back to myself to remind me that the way I choose to make a clinical decision is valid and I only need to be true to myself. Some examples of these affirmations are: “I trust my judgement,” “when I am true to myself, the clients benefit,” “I do not need to lead the way [my supervisor] would; I only need to lead like me,” and “there is no right way to lead this session.”

Future response to observation. With this plan for preparation and utilizing autonomy and inner-wisdom, hope, and self-regulation, I hope to reduce the intensity of the freeze response and eventually create a new habit. The more often I practice preparing for a session with affirmations and slowing the cycle by noticing what environments the response is more likely in as well as intervening with autonomy and inner-wisdom, hope, or self-regulation, I will rewrite what has been my automatic reaction to being observed. I hope that I will continue to gain awareness into the environmental factors, people, and situations that are most likely to elicit the cycles that have emerged in this study. Eventually, I would like to see that repatterned behavior

of preparing and using strategies to slow the cycle become automatic and reflect more confidence in my judgement as a clinician. Also, since this reaction is physically, mentally, and emotionally taxing, reducing the frequency of this reaction will reduce my susceptibility for burnout – which is very common in the mental health field.

Future Questions for Exploration

This study elicited many pathways of curiosity within me for future research. Because of the apparent pattern of exploration and validation seeking from supervisors in my data, I believe that the following question could yield interesting results regarding the supervisory relationship: How can attachment relationships affect the supervisory relationship? Additional questions for future research might include: How do I self-regulate when presented with intense content in session? How does the pathway of development of a novice clinician parallel Erikson's stages of development? How can novice clinicians balance autonomy and connecting with inner-wisdom (intuition) with analytical approaches to decision making? Do dance/movement therapists approach clinical decision making differently than other clinicians, due to their increased body awareness? Is the cycle I discovered in my research a common reaction to clinical decision making in novice clinicians? Is my process of self-exploration through movement and journaling an effective way for other dance/movement therapists to learn more about their own clinical decision-making patterns?

Summary

When I first began this study, I looked at the freeze response I experienced in session. Throughout this study, I found a structure that described what happened to me in the moment of the freeze response, what factors influenced the response, and ways in which I could slow or break the cycles I found myself stuck in. The purpose of this study was to engage in an in-depth

exploration into my own process of clinical decision making. This process has allowed me to answer the following research question: How do I, as an emerging dance/movement therapist, approach the clinical decision-making process? My results indicated that my process of clinical decision making is represented in two cycles: Cycle A: 1. Exploration, 2. Fear and self-doubt, 3. Perceived or imagined disapproval, 4. Shedding, 5. Resentment, 6. Distancing and grounding and Cycle B: 1. Autopilot, 2. Anger and rebellion, 3. Shedding/dissociation/loss of identity/perceived approval. Additionally, there were three embedded themes that broke or slowed the cycle: autonomy and inner-wisdom, hope, and self-regulation. This information allowed me to determine the cause of this response as well as ways to combat it and intervene in sessions from an integrated and grounded place of self-efficacy and self-confidence, with less fear and anxiety.

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Appendix A

Link to Dance Performance:

<https://www.youtube.com/watch?v=wyyF2sQ3Ock>

Title: the watcher and the inextinguishable inner flame

Choreographer and Dancer: Sarah Wiltgen

Music: Accumulation of Time by Park Jiha

Show: Student/Faculty Dance Performance entitled “What Would Marian Say?”

Venue: Columbia College Chicago’s Dance Center

Date: July 18th, 2018