Embodied Response Art: An Intervention for Drama Therapists

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ABSTRACT

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The following intervention research study examines how drama therapists may use embodiment and authentic movement processes as tools for countertransference (CT) management in post-session processing. The use of embodied techniques for post-session processing of CT by drama therapists is missing from the literature. This paper completes the first three stages of intervention research to fill this gap in the literature: identifying the problem, developing theory and theoretically building an intervention model. A review of how CT has been understood in the field is completed to provide the reader with an operational definition for the use of this term within this paper. CT management is emphasized as a requirement for therapists in the therapeutic process. Importance is placed upon the use of creative methods within the therapist's own modality to manage CT. Other creative arts therapies methods of CT management are paralleled with embodied ways of knowing and authentic movement to support the development of an embodied intervention for drama therapists to use in CT management. The term used for the intervention developed through this research is *embodied response art* (ERA), which is defined as an embodied drama therapeutic tool used by the drama therapist post-session for CT management. Recommendations for future research are provided to test the intervention and continue to fill the gap on CT post-session processing within the field of drama therapy.

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" We see in order to move; we move in order to see." William Gibson

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Overview

Countertransference (CT) refers to the cognitive, emotional and somatic reactions experienced by the therapist in session with a client. There is controversy in the literature regarding the definition and usefulness of CT. Some theorists believe that CT can offer the therapist greater insight into the client's experience and help the therapist in designing and facilitating an intervention with the client (Heimann, 1960; Metcalf, 2002). Other theorists believe that countertransference is actually an irrational response by the therapist that can mislead the analysis and interpretation of the client (Freud, 1910/1957; Lewis, 1992; Metcalf, 2002). Regardless of which position you choose to take, it is undeniable that therapists are affected by the interactions that occur in session with a client. Therapists need to acknowledge and accept this fact so they can learn to manage these reactions to protect themselves and their clients from harm.

CT management is a necessary part of the therapeutic process. CT management refers to the process of identifying, clarifying and utilizing CT. Research shows that unmanaged CT has a negative impact on the therapeutic relationship and outcome (Hayes, Gelso, & Hummel, 2011). The therapeutic relationship is one of the most important components of therapy, consistently proven to be the most curative factor within therapy (Coco, Gullo, Gelso & Prestano, 2011; Lambert & Barley, 2001). CT management supports therapists in strengthening the therapeutic relationship and producing more positive therapeutic outcomes (Hayes et al., 2011).

CT management methods should be grounded in a creative arts therapist's own modality to enrich the process and enhance its effectiveness. Other creative arts therapists use creative activities within their modality to manage CT. For example, art

therapists use response art post-session to identify and clarify CT reactions (Fish, 2005). The process of embodiment is also becoming an emerging method of CT management in the therapeutic field. Embodiment is a core process within drama therapy that refers to using the body to explore, process and communicate thoughts, feelings and ideas (Jones, 2007). In drama therapy, embodiment techniques offer clients containment, new perspectives (Jones, 2007), form to chaos (Harter, 2007), and a bridge between conscious and unconscious realities (Geller & Greenberg, 2012). In this same way, the body can also be utilized as a tool for the drama therapist in CT management. Therapists outside of the drama therapy community are already using embodiment practices to aid them with CT management. An analytical training program in Norway encourages the use of the body as the first method of post-session processing (Sletvold, 2012). It is suggested that the practice of post-session embodiment techniques (such as imitation of client postures) by the therapist can develop and strengthen therapists CT management skills (Sletvold, 2012).

An embodied technique used by drama therapists to manage CT is largely missing from the literature. Research on the use of embodiment techniques within the field of drama therapy to manage CT would fill an important gap in the literature. The purpose of this research is to design and develop an embodied intervention for drama therapists use post-session to identify, clarify and utilize CT (CT management). CT management functions to enhance the therapist's competency, therapeutic alliance and treatment outcome. This intervention will be referred to as *embodied response art* (ERA), which is an embodied drama therapeutic tool used post-session by the drama therapist for CT

management. The question guiding this theoretical intervention research is: What is the potential for using ERA in managing CT?

Methodology

According to Fraser and Galinsky (2010a), the intervention research model has six stages: "problem analysis and project planning; information gathering and synthesis; design of the intervention; early development and pilot testing; experimental evaluation and advanced development; and dissemination" (p. 460). This research paper completes the first three stages of this model to produce an intervention for drama therapists use post-session to support CT management. Using a theoretical frame of research, primary and secondary sources directly related to CT management and embodied ways of knowing were collected and synthesized to depict a fair representation of the theories and findings in the field. PsychInfo database was used for selecting journal articles and books of related key terms and phrases. Sources for this research paper were suggested to this author by experts in the field, and identified using reference lists of sources connected to the topic of this paper. A review of the definition of CT throughout history is completed to clarify the definition used within this paper. Empirical data on CT management is collected and synthesized to identify valid components necessary for effective CT management. Literature on CT management practices employed by practitioners in the creative arts therapies is reviewed and compared. Based on this information a large gap in the literature is identified and discussed. Guided by specific inclusion and exclusion criteria (for example, including articles with the keywords "countertransference" and "the body"), literature that is relevant in understanding the role that the body and embodiment can play in managing CT is synthesized. Using an

analytical induction approach (Hesse-Biber & Leavy, 2011), this author generates theory directly out of this data resulting in an intervention for drama therapists to manage CT called *embodied response art* (ERA).

Designing an intervention based on theoretical knowledge runs the risk of implementation failure (Fraser & Galinsky, 2010a). Fraser & Galinsky (2010a) claim that intervention research may have a higher chance of success in implementation if it utilizes methods already familiar to the intended users. ERA incorporates embodiment techniques familiar to drama therapists (the intended users of the intervention) therefore reducing the risk of implementation failure. As a drama therapist, this author is a potential user of this intervention as well as the researcher, which may also strengthen the design of this intervention. It is important to have this intervention tested to increase reliability and validity. Reliability and validity refer to the degree to which this intervention can produce consistent results and is reflective of the real needs of those it is intended for (Hesse-Biber & Leavy, 2011), in this case drama therapists.

Following Tracy's (2010) criteria of quality in qualitative research, efforts to accomplish quality research are employed, including: "having a worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, and ethics" (p. 839). CT management intervention is a worthy topic to pursue because it is an area of interest that is largely under researched. This author also has a personal interest in this topic, which makes it a more significant topic. With this personal interest in mind, the author is transparent about her bias and takes a critical position on the work of others that support her interest. Rich rigor was accomplished by putting the "appropriate time, effort, care and thoroughness" (Tracy, 2010, p. 841) into the research process. This author attained

sincerity by remaining objective, transparent and self-reflexive in the collection, analysis and interpretation of data. Credibility and validity are enhanced as the findings in this research are subject to opposing theories and analyses, with these multiple perspectives acknowledged and considered (Hesse-Biber & Leavy, 2011). A strong argument for the drama therapy intervention is presented with a wide range of reliable sources and evidence to support it. This author aims to increase resonance in the readers of this paper through offering findings that are transferable to the needs of other drama therapists. This research provides a significant contribution as it generates new knowledge, seeks to improve the practice of drama therapists and is theoretically significant (Tracy, 2010). Ethical guidelines are upheld throughout in an effort to "do no harm" (Tracy, 2010, p. 847). This intervention has not yet been implemented and tested out on human participants; therefore any possible risks associated with it are identified. Sufficient detail is provided for others who may decide to go further with this research and implement the design (Sheppard & Shulz, 2007).

The intervention research method is "evaluative and creative … which requires a blending of existing research and theory with other knowledge to create intervention principles" (Fraser & Galinsky, 2010b). Data collected on CT management is compared with theories of embodied ways of knowing and authentic movement, to generate evidence to support the creation of a drama therapist intervention for CT management. To support the use of ERA, literature is reviewed which details the way CT can influence the therapeutic relationship and treatment outcomes. This research is exploratory in nature in that this author seeks to understand embodied ways of managing CT, an area that is under researched. The purpose of this research is to develop an embodied

intervention for drama therapists to use for managing CT. This research fills a gap in available literature and the results are significant and valuable to drama therapists.

Literature Review

The Historical Development of "Countertransference"

The definition of CT has been extensively theorized and disputed over time. With its roots in psychoanalytic literature, the term has broadened in definition and theoretical perspective. In order to understand CT we must first define its counterpart: transference. Transference is the unconscious process of the client projecting feelings and attitudes from a relationship in their past into the therapist (Freud, 1905/1953). In 1910, Freud first used the term CT to describe the therapist's unconscious defensive reactions to client transference (Freud, 1910/1957). In this classical perspective, CT is viewed as being activated by the therapist's unresolved issues (Hayes et al., 2011) and an obstacle for the therapeutic process requiring self-analysis on the part of the therapist to recognize and eliminate it (Freud, 1910/1957). Classical CT has also been termed *interfering CT* (Holmes, 2013) as it is thought to interfere with the therapeutic process. Those who support the classical definition of CT believe that it is useless to the therapist (Hayes et al., 2011) and only functions to limit his/her understanding of the client (Falchi & Nawal, 2009). Freudian followers of CT believe therapists must remain neutral, and that any emotional or cognitive reactions to clients are immoral.

Freud's classical view of CT was widely accepted for nearly forty years until new theorists of the 1950's expanded the perception of it. New light was shed on the concept of CT after Winnicott's (1994) seminal article "Hate in the Countertransference". He argued that CT was more than just an obstacle to therapy but could be seen more broadly

as having the potential to provide insight into the client's inner world. He supported this theory using the terms *subjective and objective CT*. Subjective CT, also referred to as "syntonic CT" (Fordham, 1960, p. 5), is closely related to Freud's classical view in that it refers to the therapist's unconscious reactions to the client based on the therapist's unresolved personal issues. Subjective CT needs to be acknowledged and managed to avoid acting out defensively toward the patient and harming the therapeutic process. Objective CT refers to the therapist's emotional reactions to the client's transference behaviors. According to the theory of objective CT, the therapist reacts towards the client just as individuals in the client's life do, thus providing information about the client and their interpersonal dynamics outside of therapy (Cartwright, 2011). Objective CT is useful to the therapist as long as the process is acknowledged and then managed appropriately. Unconscious conflicts and defenses naturally arise within the therapist (CT). With active processing, these conflicts and defenses will eventually reach consciousness, at which point the therapist is able to examine this material and decide what to do with it (Winnicott, 1960). Awareness of CT is viewed as necessary in order to avoid potentially harmful CT acting out/enactments (Waska, 2008). Winnicott (1960) recognized the need for therapist self-analysis in order to maintain professionalism and objectivity when faced with CT.

Heimann's (1950) seminal article "On Countertransference" expanded the definition of CT further to refer to all of the feelings that the therapist experienced towards the client. This definition has been referred to as *totalistic CT* (Cartwright, 2011) and *useful CT* (Holmes, 2013). In line with Winnicott's definition of objective CT, Heimann suggested that CT was not an obstacle at all but a significant tool for

understanding the client. She believed the therapist needed to remain emotionally open to the client so that the therapist could experience CT and use it as a guide to the client's unconscious (Heimann, 1960). Counter to Freud's classical definition, she saw CT as offering the therapist additional knowledge and understanding of the client (Heimann, 1950). Heimann (1960) challenged Freud's classical narrow view on CT, saying that his definition of CT caused therapists to fear any emotional reaction to their clients. This fear resulted in therapist CT repression and denial practices − also termed "CT illusions" (Fordham, 1960, p. 4) − that were more harmful to the therapeutic process than accepting CT to be a natural part of the process (Heimann, 1960). Rather than working towards eliminating CT, Heimann (1960) emphasized the use of self-analysis by the therapist for CT exploration, management and utilization. Similar to Winnicott, she noted the delay between unconscious and conscious understanding of CT and suggested that awareness and openness to CT will help bring it into consciousness. When CT reaches consciousness, the therapist is then able to determine its use and function in the therapeutic process. Heimann (1960) also highlights self-analysis and "self-training" (p. 14) as helpful to the therapist in becoming conscious of CT earlier to prevent harmful enactments and maximize utility.

Little (1960) critiques and differentiates between both Heimann and Winnicott theories of CT. She identifies the focus of Winnicott's theory of subjective and objective CT as being placed on the therapist and highlights the question the therapist asks: "What am I doing, and why am I doing it" (Little, 1960, p. 31)? Following Heimann's totalistic view of CT, the question the therapist asks is: "What is the patient doing, and why is he doing it" (Little, 1960, p. 31)? Little supports the necessity of both practices.

Both the classical and the totalistic definitions of CT have been disputed as having fundamental limitations. The classical definition has been viewed as excessively restrictive, ignoring the therapist's natural reactions outside of client transference (Hayes et al., 2011). Heimann's totalistic description of CT has been viewed as too broad, and may result in a loss of meaning and specificity (Hayes et al., 2011; Vulcan, 2009). The terms *integrative CT* (Hayes et al., 2011) or *intersubjective CT* (Holmes, 2013) have been used to recognize both the classical and totalistic definitions of CT. Integrative/intersubjective CT is viewed as an important tool for gaining insight into the client's problems and should be acknowledged, explored and utilized, as well as something to be cautious of and effectively managed (Hayes et al., 2011; Holmes, 2013). This theory is based on the idea that therapy involves a two-person interaction, in which both client and therapist co-create the dynamic of the relationship (Holmes, 2013). The therapist and client relationship is viewed just like any relationship in that both will be affected by conscious and unconscious experiences brought on by his or her own personal history and current state of mind (Holmes & Perrin, 2010). Integrative/intersubjective CT recognizes the inherent positive and negative aspects of CT.

There is little discussion in the literature of Jung's perspective on CT, however Fordham (1960) quotes him describing CT as a "transpersonal social phenomenon" (p. 1). According to Fordham, Jung's view of CT is in line with the two-person, integrative/intersubjective definitions of CT in that he saw therapy as a "product of mutual influence in which the whole being of the doctor as well as the patient plays a part" (p. 1). He disagreed with Freud's classical view and intention of eliminating CT as

he said, “by doing so he only denies himself the use of a very import organ of information” (p. 1).

Racker identified three types of CT: *concordant, complementary and neurotic* (as cited in Carveth, 2012). Concordant CT is considered therapeutically useful and unproblematic. It occurs when the therapist empathizes truthfully with the client, therefore responding to the client’s inner feelings and unconscious transference. Complementary CT is defined as problematic and occurs when the therapist identifies with the client’s projected unmanageable parts of the psyche, causing the therapist to act out CT defensively (Carveth, 2012; Panhofer, Payne, Meekums, & Parke, 2011). Neurotic CT occurs when the therapist’s own unresolved issues become projected onto the client, causing therapist to act out in response to it, which is harmful to the therapeutic process (Panhofer et al., 2011). Neurotic CT has also been referred to as *CT psychosis* (Little, 1981) and *narcissistic CT* (Bean, 1992).

There have been major developments in research and theory confirming that CT is a valuable aspect of therapy that can be utilized as a tool to understand client problems and patterns in relationships. Klein’s concept of projective identification has often been compared to CT and used to legitimize CT use in therapy. Projective identification describes the process of displacing parts of the self into the other which is similarly experienced in the process of CT. This notion of projective identification is used to justify how therapists are able to experience the unconscious experience of the client occurring in CT reactions (Holmes, & Perrin, 2010). Klein’s theory about the mother-infant relationship is also used to validate CT. Klein saw the role of the mother as container for the projected feelings of the infant that were intolerable for the infant to

hold on his/her own (as cited in Falchi & Nawal, 2009). The mother-infant relationship can be compared to the relationship between therapist and client (Falchi & Nawal, 2009). This statement is defended by Langs, who believed emotions experienced by the client in session were projected defensively into the therapist by the client because they were too unbearable for the client to experience consciously on their own (as cited in Holmes & Perrin, 2010). Through projective identification, the therapist unconsciously reacts to these client projections. As seen in the process of CT, the client unconsciously projects thoughts and feelings into the therapist, which the therapist must contain and manage appropriately in order to avoid harming the client and the therapeutic process. Langs advocated for therapists to embody the projections placed into them by their client to gain access to unconscious parts of the clients mind (as cited in Holmes & Perrin, 2010). This supports the use of an embodied intervention to help therapists identify CT (similar to projective identification) and manage it effectively.

There are several risks to denying the presence of CT reactions. Maintaining the classic Freudian "neutrality" within therapy is a nearly impossible goal which will only lead to therapist suppression and denial of their thoughts and feelings, eventually resulting in a negative effect on treatment (Cartwright, 2011; Holmes & Perrin, 2010). Therapists trying to avoid CT reactions may present symptoms of "withdrawal, acting out, excessive mothering, denial, avoidance of unpleasant issues, over permissiveness, or acceptance of the patient's distortions" (Jagarlamundi, Portillo, & Dubin, 2012, p. 108). CT denial may be fueled by the hope of minimizing conflict and finding common ground, however it can lead to "empathic failures, blind spots and analytic impasse" (Carveth, 2012, p. 72). Without identifying the CT reactions, the therapist risks misperception,

burnout and indifference to therapy (Jagarlamudi et al., 2012). Therapists have an ethical responsibility to identify and manage CT to protect the client and the therapeutic process as a whole. It appears that "the danger of such confidence in the unconscious CT is still less than the danger of repressing and denying them any objective value" (Holmes & Perrin, 2010, p. 273). Therapists need to learn how to utilize CT instead of being imprisoned by it (Carveth, 2012).

Therapists are warned against over identification with their CT reactions. Holmes (2013) believes that therapists who make interpretations based solely on their CT reactions can reinforce unequal power dynamics in the therapeutic relationship by discounting the client's perspective (Holmes, 2013). He notes that the client may end up feeling responsible for all of the therapist's feelings. To avoid this power imbalance in therapy, Holmes urges therapists to stay open to their own issues being provoked by the client and to experiencing unconscious projections from their client.

This paper applies the integrative/intersubjective definition of CT, which views CT as normal and useful to the therapeutic process. CT is defined as all of the therapist's unconscious reactions towards the client. These reactions originate from both client transference (objective CT) and therapist unresolved issues (subjective CT). CT resulting from client transference can be utilized as a tool to gain insight into client problems. CT resulting from the therapist's unresolved issues needs to be contained and managed appropriately. Regardless of which position you choose to take on CT, it is undeniable that therapists are affected by the interactions that occur in session with a client. Therapists need to acknowledge and accept this fact so they can protect themselves and

their clients from harm. Repressing or denying these reactions will only result in a negative effect on the treatment process.

Countertransference Manifestations

There has been a considerable growth in the literature on how CT manifests in practice. CT reactions begin to manifest as soon as the therapist and client come into contact (Straus, 1960). Both experienced and new therapists exhibit CT reactions (Gehlert, Pinke, & Segal, 2013). Therapist CT experience may manifest as subtle to intense and from simple to complex (Holmes, 2013; Parlow & Goodman, 2010). Anything the therapist "feels, daydreams about, visualizes, thinks and understands" (Parlow & Goodman, 2010, p. 117) is a CT reaction. CT manifests in therapist feelings, attitudes, thoughts, judgments and behaviors during interaction with a client (Gehlert et al., 2013). CT was originally thought of as affective and cognitive reactions (Freud, 1910/1957), but has since expanded to include dream states (Heenen-Wolff, 2005) and somatic experiences, termed *somatic countertransference* (SCT) (Ross, 2000).

SCT, *embodied CT* (Field, 1989), *embodied empathy* (Meekums, 2007), *bodily CT* (Panhofer et al., 2011), or *body-centered CT* (Athanasiadou & Halewood, 2011) refer to the physical and emotional unconscious reactions of the therapist to the client's body, personal material and transference (Forester, 2007; Ross, 2000). Examples of SCT include physical sensory experiences such as sleepiness, sexual arousal, trembling (Field, 1989), "breath, hear-rate, tension/relaxation, sleepiness, tingles, temperature, alertness and urge to kick with anger" (Forester, 2007, p. 127). These somatic experiences originate in the same manner as regular CT: unconsciously through client transference, projective identification, or unresolved issues of the therapist (Athanasiadou &

Halewood, 2011; Forester, 2007; Ross, 2000). Just like CT, SCT is fundamental to the therapeutic process and needs to be acknowledged, processed and managed in order to understand it correctly, enhance the therapeutic relationship (Athanasiadou & Halewood, 2011) and avoid harmful enactments (Forester, 2007). SCT acknowledges the body as a major source of information and a tool for understanding CT (Panhofer et al., 2011). SCT is fundamental to dance and movement therapy (DMT) and discussed minimally in psychoanalytic literature (Forester, 2007). Supporters of SCT believe that the body and the somatic experience of the therapist is an important source for communication and interaction between the therapist and client (Forester, 2007; Ross, 2000). SCT theorists encourage development and awareness of the therapist's own body − also called "self-sensing" (Ross, 2000, p. 462) − to enhance attunement and "kinesthetic empathy" (Forester, 2007, p. 124) with clients.

Dreams therapists have about the patient has been termed the *CT dream* (CTD) (Heenen-Wolff, 2005). There is very little literature on the concept of CTD. This is probably due to the fact that they are difficult to interpret. Heenen-Wolff (2005) notes that the therapist's dream occurs outside of the therapy session, meaning that it is more likely affected by other interactions the therapist had, between the sessions and the dream. He also found that CTDs offer important information about the therapeutic interaction and insight into the unconscious processes of the client that was not consciously recognized in the waking state. Freud believed that dreams contain material that the individual is preoccupied with during the day (as cited in Heenen-Wolff, 2005). Those who support CTDs believe dreaming about a patient is a confirmation of CT

because it provides evidence that the therapist is excessively preoccupied and overinvolved with the patient (Heenen-Wolff, 2005).

The external expression of CT behavior is separate from internal emotional CT reactions. CT behaviors are referred to as *acting out*, *enactments*, (Friedman & Gelso, 2000) or *CT reactions* (Rasic, 2010). Acting out or enactments are the regressive defensive interactions between therapist and client (Dosamantes-Beaudry, 2007). CT emotional reactions need to be managed so that CT behaviors of acting out do not occur and hinder treatment (Friedman & Gelso, 2000; Jagarlamudi et al., 2012). If CT acting out/enactment occurs, they need to be acknowledged and then managed successfully in order to prevent any further occurrences (Hayes & Gelso, 2001). CT acting out may occur as the therapist becomes overly involved or under distanced, with too much preoccupation or not enough, or by having an intense need to be liked by the client (Fish, 1989; Hayes et al., 2011; Holmes & Perrin, 2010).

Friedman and Gelso (2000) developed a measure of assessment for CT behavior and analyzed 126 supervisor and supervisee counseling sessions. The study resulted in two main categories: *positive and negative CT behaviors* (Friedman & Gelso, 2000). Positive CT behaviors can be categorized by reactions that appear to be of the positive nature, such as being overly supportive or friendly (Friedman & Gelso, 2000). Positive CT may reflect the therapist's need to be liked or be seen as knowledgeable (Friedman & Gelso, 2000). Negative CT behaviors can be categorized by reactions that appear to be negative or inappropriate, such as dazing out in session or disliking a client. Both positive and negative CT will have a negative impact on therapy if it goes unacknowledged, unmanaged or is acted out (Markin, McCarthy, & Barber, 2013).

Most of the research on CT focuses on what occurs in session with only a few studies that look at the experiences of the therapist between sessions with clients. The CT reactions that the therapist experiences between sessions have been termed "intersession experiences" (Arnd-Caddigan, 2013, p. 146). These intersession experiences have been shown to have an effect on the outcome of therapy (Arnd-Caddigan, 2013).

Countertransference Management

CT management refers to strategies of CT awareness, exploration and utilization. CT management needs to be engaged in on a regular basis. Almost every theorist and researcher on the topic advocates for CT management (Hayes et al., 2011; Heenen-Wolff, 2005). Therapists need to be able to identify and contain CT reactions in order to explore and utilize it as a therapeutic tool. CT management is not used to eliminate CT reactions, but to effectively clarify its origins (subjective/objective) and to prevent harmful CT behavior (acting out/enactments). This distinction needs to be made for each therapeutic interaction (Gehlert et al., 2013). Therapists need to take note of any thoughts, feelings, and memories that the patient's words evoke in him/herself (Gubb, 2014). This may aid therapists in the process of differentiating between what Winnicott calls subjective and objective CT. According to Gubb (2014), Freud suggested a free-floating attention, which involves a soft focus of attention floating between what the client is presenting (verbally and non-verbally) and the therapist's reactions (thought, feelings, behaviors) as experienced in session. Maintaining this free-floating attention can help the therapist manage CT. The therapist needs to be able to remain open enough to join with the client

unconsciously to receive and contain a wide range of complex cognitive, emotional and somatic experiences without being ruled or mislead by it.

All therapists experience CT. A qualitative study by Hayes, McCracken and McClanahan (1998) observed eight therapists working with a patient for around 15 sessions each. Immediately following the observed sessions, semistructured interviews were conducted to study each therapist's personal reactions to the client. They found that CT was prominent in 80% of the sessions, supporting the theory that CT is universal to all therapists. Both quantitative and qualitative studies support the theory that CT negatively affects therapeutic outcomes (Hayes et al., 2011). With the potential for CT to have a harmful effect on the therapeutic process (Cartwright, 2011), the focus shifts from how to eliminate CT to how to manage it.

Both quantitative and qualitative studies support the theory that CT management is related to more positive therapeutic outcomes (Hayes et al., 2011). Studies show that both positive and negative CT has a negative effect on treatment, causing the therapist to become less competent if CT is not managed (Hayes et al., 2011). It is well documented that the therapeutic relationship has a major impact on the therapeutic outcome (Fuertes, Gelso, Owen, & Cheng, 2013; Hayes & Gelso, 2001). When CT goes unmanaged, the therapeutic relationship is weakened, therefore having a negative impact on therapeutic outcomes (Hayes et al., 2011). Managing CT supports the therapist and client in having authentic interaction, increasing the therapist's ability to develop empathy for the client (Norton, 2011).

There are limited empirical studies on CT management probably due to the fact that it is very difficult to gauge and measure. However there are some common themes

within the literature that emerge as being useful to the therapist for managing CT. This includes specific qualities of the therapist such as self and body awareness, mind-body integration, anxiety management (self-care), and empathy (Rosenberger & Hayes, 2002; Van Wagoner, Gelso, & Diemer, 1991). The therapist's goal should be to develop and strengthen these qualities and skills to effectively manage CT and utilize it as a tool in therapy.

Self-awareness is commonly named as the most important element in identifying and managing CT (Forester, 2007; Gehlert et al., 2013). High self-awareness is correlated with fewer CT enactments, whereas low self-awareness is related with more CT enactments (Hayes et al., 2011). Therapists need regular practice and development of self and body-awareness in order to understand and clarify the origin of the CT reactions (Forester, 2007; Gellar & Greenberg, 2012). With a strengthened self and body-awareness, the therapist's sensitivities and tools for identifying CT strengthen as well (Gehlert et al., 2013).

Fatter and Hayes (2013) found anxiety to be one of the most common affective CT manifestations, and therefore needs to be managed. They encourage self-care activities between sessions to assist therapists in managing anxiety, which lowers CT enactments in session. They found meditation to be a self-care activity effective for therapists' CT management. The process of focusing inwards found in meditation strengthens self-awareness, anxiety management and assists the therapist in clarifying the CT origin needed in CT management (Fatter & Hayes, 2013). Self-care activities such as meditation, done regularly over an extended period of time were proven to be more effective for therapists' CT management than participating in these activities irregularly

(Fatter & Hayes, 2013). Therefore therapists should routinely practice interventions to combat anxiety related CT reactions.

CT can only be useful to the therapeutic process as long as the reactions become conscious to the therapist (Carveth, 2012). If CT remains in the unconscious, the risk of CT acting out/enactment increases which can harm the therapeutic alliance and have a negative effect on treatment (Carveth, 2012). If CT is not acknowledged or identified due to a lack of awareness, the therapist cannot utilize it as a tool for positive gain or therapeutic insight (Carveth, 2012). Bringing CT into consciousness through self-reflection practice is the best method of protecting the therapeutic encounter (Jagarlamundi, et al., 2012). Therapists need to distinguish between their own unconscious drives and their clients' transference (Falchi & Nawal, 2009). In order to distinguish between what comes from the therapist's unresolved issues and what comes from client transference, the therapist must undergo careful self-examination (Heenen-Wolff, 2005). Creative methods of engagement other than traditional verbal exploration (Ex. embodiment) offer the therapist (just as it does the client) safe passage into the unconscious psyche, and should be considered as an intervention for therapists in managing CT. A nonverbal method of engagement can become the means to "externalize the image and explore its meaning" (Robbins & Erismann, 1992, p. 368). In this way processes of embodiment can be used as a creative non-verbal method of engagement that can function to externalize internally held (unconscious) CT.

Self-examination has been encouraged since the first use of the word CT in 1910. This need recognizes the stress that therapists endure and the necessity of therapist self-examination (Winnicott, 1960). In order to utilize CT as a tool in therapy, therapists are

encouraged to engage in regular self-examination through supervision (Forester, 2007; Gehlert et al., 2013; Van Wagoner et al., 1991), personal therapy (Von Wagoner et al., 1991) and self-supervision (Cartwright, 2011). Personal therapy functions to build self-awareness, uncover personal unresolved issues, and help the therapist manage subjective CT reactions to his/her clients. Therapists must undergo serious self-examination to understand their past so that they are not restricted by it in session with clients (Siegel, 2010). "Developing the capacities to monitor and then modify such shut-off states is essential for remaining open to clients" (Siegel, 2010, Chapter 3, Section 2, para. 5).

Supervision functions to protect the therapeutic process and dynamics as a whole. Therapists are able to gain a second opinion in supervision and assisted in "recognizing, expanding, and questioning" (Jagarlamudi et al., 2012, p. 111) CT reactions that affect the therapeutic encounter. Therapists are encouraged to use supervision to help them become more aware of their responses to clients and the material explored in session (Gehlert et al., 2013). This way the therapist is better able to distinguish between the subjective and objective CT reactions and build greater empathy for the client (Gehlert et al., 2013). With experience, the need for supervision may lower as the therapist becomes more self-aware and integrated (Cartwright, 2011). However some still caution against self-supervision and advocate for additional sources of validation (Holmes & Perrin, 2010).

Supervision does not often integrate the creative processes specific to the modality of the therapist (Robbins & Erismann, 1992). Supervision is generally directed at therapist self-awareness, mainly through verbal processing. Typical verbal supervision has many limitations and may not fit the needs of creative arts therapists. The whole self

of the therapist is needed to describe and express the cognitive, affective and somatic dimensions of the therapeutic interaction (Panhofer et al., 2011). An emphasis on verbalization (often seen in typical supervision and post-session processing techniques) excludes the body, which risks excluding large amounts of information, stored in the body or other sensory modalities (Panhofer et al., 2011).

One of the obstacles in CT management is the stigma therapists face of not having it all together. Therapists experience shame because of their need for help and often minimize it as a result (Cooney, 2007). Having strong reactions (emotional, cognitive and somatic) about clients conflicts with the neutral role that therapists are supposed to play (Rasic, 2010). CT management requires serious and honest self-examination and the process can be intimidating to many therapists. More discussion about CT is necessary in order to normalize its existence. Rasic (2010) emphasizes the discussion and exploration of CT in training, supervision and team meetings in order to support the awareness and exploration of the phenomenon. Most therapists will not have the time or motivation to explore CT after every client session. Exploring CT requires a drive towards professional and personal growth and the ability to manage one's time effectively as there is often very little time between clients to process a session (Rubin & Gil, 2005). "If there was a larger tool box which best suits the therapists personal style, comfort level and orientation" (Morningstar, 2014, p.12) it may lessen therapists' shame towards CT and increase their ability to manage it, resulting in more favorable treatment outcomes. Morningstar (2014) identifies the need for research that examines drama therapy techniques, such as embodiment, projection and role, for use as an intervention in CT management.

Creative Art Therapy and Countertransference Management

Art therapy. Art therapy has been utilizing response art since the beginning of the profession (Fish, 2005). *Response art* or *responsive art making* (Fish, 2005) and *CT art* (Gil & Rubin, 2005), is defined as the intentional use of making art by the therapist to "explore, contain and express clinical work" (Fish, 2005, p. 6). Response art can be done before, during or after session and can be engaged in for short or extended periods of time (Fish, 2005). Response art can be spontaneously created or made with a specific intention in mind. An example of response art done spontaneously is to make art and then reflect on the process, content and associations to session material afterwards (Gil & Rubin, 2005). However, Fish (2005) warns therapists of the risks of using response art, and emphasizes the need for a clear intention when engaging in it. Fish (2005) defines intention by that which expresses "what one hopes to explore, accomplish, or learn from the image making experience" (p. 12). If response art is made without a clear intention, the risk of focusing on the therapist's personal unresolved issues may begin to pull focus rather than the client material, which may hinder the therapeutic process. Although Fish sees this as a risk, it is necessary to process the unresolved issues of the therapist and may actually be a desired outcome rather than a risk in response art.

Response art has been documented as useful to the therapist in CT management. Response art can help the therapist generate new knowledge and gain new perspectives and insight (Fish, 2005). Response art is used as a method of self-care and allows the therapist to "explore unclear relationships, understand intense responses to difficult clients and defuse unrelated personal issues that are stirred in session" (Fish, 2005, p. 42). Response art done post-session has been found to help the therapist "develop empathy

with the client, clarify the therapist's feelings, explore the preconscious and unconscious, differentiate the therapist's feelings from the client's and explore the therapeutic relationship" (Deaver & Shiflett, 2011, p. 263). One small study of nearly twenty art therapy students found that drawing as a method of response art offered them greater insight and understanding about clients while also offering a more personally rewarding experience than the typical methods of post-session processing (Deaver & Shiflett, 2011). This finding suggests that use of a therapist's own modality will provide him/her with more satisfactory methods to explore and manage CT. Replicating clients' images in post-session response art was found to develop and strengthen therapist understanding and empathy towards the client (Deaver & Shiflett, 2009). Response art involving the spontaneous creation of an image to represent a client has been used to explore and manage CT (Deaver & Shiflett, 2011; Fish, 1989; Gil & Rubin, 2005). Another exploratory study found that therapist art making post-session fostered the exploration of the therapeutic alliance, development of empathy for their clients, and aided the therapist in acknowledging and evaluating CT reactions towards clients (Kielo, 1991).

The creative arts offer several method of engaging in CT management. Fish (2005) suggests that "movement, psychodrama and music" (p. 26) could be used in the same way as response art, but does not discuss the details of such a process further. Engaging in creative acts generates a heightened state of attention and sensory awareness that may broaden our perspective (Fish, 2005). The creative arts can be used to bypass our defenses, as they create a safe path inwards, lowering our self-consciousness and building a bridge between the conscious and unconscious worlds (Gil & Rubin, 2005; Klein, 1973). Visual journaling is a method of response art that combines artmaking with

reflective writing, which provides the therapist with an organized visual record of clinical work (Deaver & Shiflett, 2011). This type of journaling can be done outside of supervision and brought in for discussion. Visual journaling was shown to enhance self-awareness and reflection capabilities as well as decrease stress (Deaver & Shiflett, 2011). A qualitative case study looking at therapists' experience with 15 weeks of visual journaling during an internship revealed the therapist interns in general gained clarification and insight into an emotion, thought or behavior that occurred in session (Deaver & McAuliffe, 2009). Through journaling, the interns were able to identify and differentiate between CT and transference (Deaver & McAuliffe, 2009).

Sand play therapy. CT utilized in sand play is referred to as *CT sand world* and uses CT trays in the same way they are used with clients (Gil & Rubin, 2005). The sand play therapist checks in with his/her thoughts, feelings and responses towards a particular client and then intuitively and spontaneously places objects in the sand tray (Gil & Rubin, 2005). The therapist may create an image in the CT tray that represents an intense therapeutic relationship (Gil & Rubin, 2005). These playful techniques are recommended for use before or after a session. Gil and Rubin (2005) suggest the use of "collage work, role-playing and story telling" (p. 98) while cautioning that such creative and playful approaches to CT management are not effectively done by just anyone. Due to the complex nature of CT, therapists are encouraged to have a strong knowledge of the theories and practice of CT and the desired method of exploration (Gil & Rubin, 2005).

Music therapy. The term *musical CT* (MCT) was created in 1975 by Mary Priestly who defined it as "sound patterns that reflect or evoke feelings, thoughts, images, attitudes, opinions and physical sensations originating in and generated by the music

therapist, as an unconscious or preconscious reaction to the client and his/her transference" (Priestly, 1975, p. 185). The exploration process of MCT involves the therapist creating music in response to CT reactions stimulated by the client (Dillard, 2006). There is limited literature on MCT and most are comprised of the theoretical viewpoints of the author. In one phenomenological study focusing on music therapists' issues and patterns of MCT it was found that all of the music therapists found MCT significant as a tool for increased understanding of their clients (Dillard, 2006). MCT supported the therapists in client assessment and treatment planning as well as for clarifying and containing CT (Dillard, 2006). MCT supports the use of a therapist's own modality for post-session processing and CT management.

Poetry therapy. Poetry is also a method used to contain and organize CT. The poems created by the therapist are said to originate from unconscious CT between client and therapist (Bean, 1992). Poetry is said to be the most efficient method of expressing the conscious and unconscious worlds of an individual (Bean, 1992). It offers a knowing that did not exist before the poem was written (Bean, 1992). Poetry writing followed by exploration and analysis of the poem offers a method of CT management. In a phenomenological study of one therapist's experience with CT, poetry functioned as a useful therapeutic tool as it helped her document, contain, organize, and understand her CT reactions (Bean, 1992, p. 349). Bean (1992) also found that the poems acted as a transitional object for her between sessions. Through documentation, she was able to find order amongst the chaotic CT feelings she was experiencing post-session. Poetry writing post-session is shown to effectively translate unconscious feeling and thought (Bean, 1992). The CT poetry acts as the container for the therapist to actively and safely

reflect upon the session and process associated feeling and thoughts (Bean, 1992). Similar to Winnicott's favorable holding environment between the mother and child, the poem provides holding for therapist CT (Bean, 1992). The poem brings order to the chaotic CT reactions experienced by the therapist.

Dance and movement therapy. CT is most often addressed as SCT in dance and movement therapy (DMT) literature. Most DMT theorists believe SCT to be a significant tool to aid the therapist in understanding and managing the therapeutic relationship and process (Vulcan, 2009). DMTs suggest the development of somatic awareness (body-awareness) in order to achieve relevant insight into SCT processes. This is encouraged through individual exploration or supervision (Athanasiadou & Halewood, 2011; Forester, 2007; Vulcan, 2009). There are several techniques suggested to increase somatic awareness including body scans for somatic sensations (Forester, 2007). Knowledge of one's own movement repertoire is suggested to help the therapist differentiate the origins of CT (Vulcan, 2009).

Embodied techniques familiar to drama therapists are also utilized by DMTs for SCT/CT management. Forester (2007) suggests intentionally mimicking the patient's body postures, which can deepen the therapist's understanding of the patient (kinesthetic empathy), therefore aiding CT management. Another author suggests tracking the client's somatic experiences and then mirroring the observed movement patterns (Dosamantes-Beaudry, 2007). Panhofer is the most recent and noteworthy DMT who developed and tested an embodied method of post-session processing for DMTs (Panhofer et al., 2011). His aim was to use the body and movement to gain access to the therapist's unconscious body knowledge gained in session. Body knowledge refers to the

bodily reactions of the therapist experienced in session, which is also referred to as SCT. Six DMTs were asked to reflect upon a significant moment from a client session. A significant moment is defined by Panhofer et al. (2011) as "an event that developed the therapeutic relationship or pushed the therapy forward in some way" or when "insight was reached" (p. 10). These significant moments were used as the basis of further investigation, which included writing exploration, movement (improvisation and free play), and expressive response/free association writing. Results from this study showed that this writing-moving-writing process strengthened the therapists understanding of the CT interaction, fostered whole-body engagement of the therapist, facilitated dialogue with the therapist's inner/unconscious self, as well as strengthened the therapist's engagement in the therapeutic process as a whole. Participants reflected on their improvement in self-awareness and personal insight. Thinking and writing without movement appeared to have a much smaller impact on therapist self-knowledge of the therapy session. Panhofer et al. (2011) emphasizes embodiment practices in self-supervision to engage the therapist's inner supervisor, to strengthen self-awareness and in understanding and managing CT.

Ultimately, Panhofer et al. (2011) created a five-stage model to self-supervision for the DMT: identifying the presenting problem, warming up, allowing the movement to emerge, composing a final narrative, evaluation and contemplation. Identifying the problem involves exploration of a problem on paper through words or images (Panhofer et al., 2011). Then the therapist creates a title for it and may also underline certain words within it. Warming up is to be a non-verbal process and is intended to help the therapist turn their focus inwards. The therapist then turns focus to the presenting problem just

explored on paper. With eyes closed and an intention in mind, the therapist is asked to allow movement to emerge intuitively. A movement sequence is suggested to emerge from the intuitive movement exploration. Panhofer et al. (2011) suggests a timer and video recording to enrich the exploration process. After the movement, the therapist is to write a reflection of the process in any narrative form. To gain perspective, the final evaluation and contemplation stage is suggested to be done after some time has passed to gain perspective and insight from the process (see Panhofer et al., 2011 for more details).

Drama therapy. In comparison to the creative art therapies, there is a large gap in drama therapy literature that investigates CT management. Only one research paper published advocates for the need of a post-session processing tool specific to drama therapists for CT management (Morningstar, 2013). One other research paper explores CT with drama therapists, however the focus was on in-session utilization of CT rather than post-session processing (Philipose, 2003). Most post-session interventions found within drama therapy literature are developed for the purpose of self-care to minimize burnout and include processes outside of the drama therapy modality.

Each modality except drama therapy actively approaches CT with methods originating in their modality. As mentioned above, art therapists use several different techniques used within their modality in a process called *response art* to effectively manage CT (Fish, 2005; Fish 2012). These mediums include and are not limited to image making (Fish, 2005; Fish, 2012), sculpture making (Robbins & Erismann, 1992), journaling (Deaver & McAuliffe; Deaver & Shiflett, 2011), and poetry (Bean, 1992). Music therapy has its own term for CT called musical CT that was created decades ago (Priestly, 1975). DMT mainly utilizes SCT for CT/SCT management, with a significant

amount of research around it. DMTs use techniques specific to their modality as interventions to explore and manage CT (Panhofer et al., 2011). Drama therapy appears to be the only modality within the creative arts therapies with no literature or research establishing a CT intervention for therapists utilizing techniques within their own modality. The ways in which the creative arts therapies have utilized techniques from the various modalities as effective CT management supports the creation of using drama therapy processes in this same way.

Morningstar (2013) suggests the use of three core processes of drama therapy to manage CT, including: projection, witnessing, and role-playing. Each of these processes interrelates closely with one another. Projection is a creative process that functions to externalize internal conflicts or emotions (Jones, 2007). Projection allows for exploration and insight as it offers a safe distance to work on a problem (Jones, 2007). Projection processes can offer the drama therapist the safe distance needed to explore CT, allowing internal and unconscious thoughts, feelings and behaviors (CT reactions) to come into awareness. Each of the processes utilized in the other creative arts therapies for CT management (ex. image making, journaling, poetry, sculpture work, sand play etc.) can be categorized as projection processes and offer validation for additional uses of it.

Drama therapists can also use role-playing techniques in CT management. Role-playing is an embodiment process that utilizes projection as the individual takes on a new role. Role-playing in therapy offers the client a safe method of exploration of denied thoughts, feeling or behaviors (Jones, 2007). Clients can gain new perspectives by stepping into another's shoes and viewing things from another's point of view. For the drama therapist, role-playing as the client can offer the drama therapist safety in

exploring and expressing denied CT reactions. Unconscious CT experiences may be more easily accessed given the safety the drama therapist feels through this method of engagement. Role-playing also offers the therapist new perspectives, as an individual can step into another's role and experience what it is like to be someone else. In one study of therapists' intersession CT experiences by Arnd-Caddigan (2013), most were found to engage in *imaginary conversations*. This imaginary conversation process utilizes dramatic projection and role-playing processes, as the therapist has an imaginary conversation with a client. Arnd-Caddigan found that after a therapist's participation in these imaginary conversations, unconscious CT emotions were made conscious and therefore were easier to manage. Additionally, less CT enactments occurred in session with clients, which lead to more positive therapeutic outcomes.

Embodiment is a core process within drama therapy and can be used to explore and manage CT. In embodiment processes emphasis is placed on the body as the main means of communication between oneself and others (Jones, 2007). It is used with clients as a safe method of exploring and releasing emotions and bodily tension (Jones, 2007). It facilitates conscious as well as unconscious means of communication and can develop and strengthen empathy. It offers a physicalized way of knowing which is much deeper than cognitive or verbal knowing (Jones, 2007). Embodiment may be utilized through gesture, expression or voice (Jones, 2007).

Theories to Support an Embodied Drama Therapy Intervention

The Body as a Way of Knowing

There is an increasing interest in the role of the body in the therapeutic encounter (Sletvold, 2011; Vulcan, 2009). Emphasis on the body as a therapeutic tool to receive

unconscious information from the client, develop empathy and generate intersubjectivity originated with Freud not long after the term CT was created (Sletvold, 2011). However, the body as a tool in CT management has gone largely overlooked until recently, becoming a more widely accepted concept. This movement has been largely guided by DMTs and their interest in SCT (Vulcan, 2009).

Embodied ways of knowing can be used as an intervention for drama therapists in CT management. According to the literature on CT management, self and body awareness, mind-body integration, anxiety management, and empathy are the most important qualities needed in the therapist in order to effectively manage CT (Rosenberger & Hayes, 2002; Van Wagoner et al., 1991). Higher self and body awareness leads to an increased ability to identify and clarify CT reactions (Gehlert et al., 2013), which leads to lower harmful CT enactments (Hayes et al., 2011). CT must be brought into the therapist's conscious awareness in order to manage it effectively (Carveth, 2012). The literature on embodiment and the body as a way of knowing highlights the body's ability to develop and strengthen the qualities needed in CT management. Embodiment processes foster self and body awareness, mind-body integration (Koch, & Fuchs, 2011), empathy and the expression of conscious and unconscious parts of the psyche (Federici-Nebbiosi & Nebbiosi, 2012; Sletvold, 2011). Embodiment processes within drama therapy are used with clients for exploration, expression and containment of thoughts, feelings and behaviors (Jones, 2007). In this same way, therapists can use embodiment processes to manage anxiety by offering them emotional expression and containment of CT reactions brought up in session.

Researchers such as Dosmantes-Beaudry, 2007), Forester (2007), Panhofer et al. (2011), and Sletvold (2012) have provided theories and evidence to support the use of the body and embodiment as CT management. As stated above, Panhofer's et al. (2011) study with DMTs experimented with embodied ways of knowing through a writing-movement-writing process. The embodied movement processes included free play and improvisation. The results proved to strengthen therapist CT management skills such as bridging unconscious and conscious material, mind-body integration and a strengthened understanding of CT interactions (Panhofer et al., 2011). Forester (2007) suggests body scans for increasing the therapist's self and body awareness. Dosmantes-Beaudry (2007) suggests mirroring client's movement patterns to help the therapist build empathy for the client.

Sletvold (2011) has more recently contributed to this body of knowledge in the therapeutic field, advocating for embodiment practices found in theatre performance art for use in CT management. Sletvold (2011) shares knowledge of a therapist training centre in Norway called the Norwegian Character Analyst Institute (NCAI) that uses the body as the first method of therapeutic processing post-session. At NCAI therapists engage in embodiment processes of the *embodied self*, the *embodied imitation* and the *embodied reflexivity*. Each of these processes can be termed "embodiment processes" and are familiar to drama therapists. Embodied self practices involve the therapist embodying his or herself as they are in relation to the client. These exercises offer therapists the opportunity to check-in with themselves and identify their unconscious CT reactions to their client. Next is the *imitation*, *replication*, or *miming* of the client's facial expressions and body language (Federici-Nebbiosi & Nebbiosi, 2012; Sletvold, 2011).

Imitation is defined as "the process whereby we discover and rediscover, we find again the remains of the effects of another body on our body" (Federici-Nebbiosi & Nebbiosi, 2012, p. 5), in other words the transference/CT effects. Sletvold (2012) suggests that through imitation the therapist is able to connect with the client on a deeper level. In this way therapists can intentionally focus on the client's nonverbal signals in an effort to clarify the origins of CT and build empathy. Imitation can be equated with the embodied drama therapy process of mirroring. Imitation or mirroring has been known to "stimulate empathy through muscle feedback to the brain" (McGarry & Russo, 2011, p. 178). During imitation or mirroring, the therapist is given information from his/her own mind and body that allows for access into the client's internal experience. The therapist is given a new perspective of the client through the embodiment or imitation of them. According to Wyman-McGinty (1998), Jung was better able to understand a client by imitating and reflecting client gestures. Through this embodied imitation the therapist's senses are heightened as he/she focuses on the non-verbal aspects of the client (Sletvold, 2011). Through this embodied imitation, the therapist is able to develop and strengthen empathy with the client, by gaining a "sense of the expression in ourselves" (Sletvold, 2011, p. 458). The therapist is thus able to feel what the client was feeling (Federici-Nebbiosi & Nebbiosi, 2012). The process of imitation employs the drama therapy core processes of dramatic projection, embodiment and role-play and supports the use of these processes in CT management. The third and final process of embodied reflexivity occurs as the therapist steps out of role (imitating the client), and reflects upon the difference of experience between being oneself and role-playing (imitating) another (Sletvold, 2012). Embodied reflexivity processing can be seen as fostering self and body awareness as well

as aiding the therapist in clarifying between objective and subjective CT. There are more specific techniques that are utilized at NCAI that may be of interest to the reader (see Sletvold, 2012). Each of the processes found within NCAI described here provides evidence to support an embodied intervention for drama therapists to use post-session for CT management.

The presence of a supervisor is not always encouraged during the embodiment processes outlined by Sletvold (2011), as it may inhibit the therapist's ability to engage authentically, therefore interfering with the process. Seltvold suggest self-exploration or self-supervision during embodied imitation. The therapist needs to be comfortable, confident and familiar with the processes in order to explore it in the presence of others (Federici-Nebbiosi & Nebbiosi, 2012). This theory supports the use of embodied CT management interventions familiar to drama therapists in a supervision setting in which they feel safe to explore and express themselves freely. Since drama therapists are highly experienced with embodiment techniques, they should be able to engage in them in any supervision setting they prefer. However, when utilizing them for CT management specifically, all therapists are encouraged to gain a second opinion of the surfaced CT material to avoid misinterpretation and uphold ethical responsibilities to the client. Sletvold (2012) supports the embodied processes used at NCAI as an intervention complementary to regular verbal discussion found in supervision.

Authentic Movement

Authentic movement (AM) is a DMT process that is familiar to most drama therapists. There are two roles necessary for AM: the mover and witness. The mover and witness decide together the length of time the AM will last or else the mover will

naturally allow it to come to an end (Musicant, 2001; Wyman-McGinty, 1998). The process of AM transitions from a bodily experience to reflection, integration, and conscious working through. The mover begins seated, lying down or standing with eyes closed in stillness and silence as they turn their focus inwards (Musicant, 2001; Wyman-McGinty, 1998). The witness actively observes the mover throughout the entire process. The mover learns to wait for the unconscious impulse of being moved and tries not to produce any movement intentionally (Wyman-McGinty, 1998). The mover should notice any "breath, bodily sensations, images or feelings that arise" (Wyman-McGinty, 1998, p. 241). Focusing internally in the body evokes unconscious material, and stimulates affective and somatic memory (Wyman-McGinty, 1998). With this internal focus, the mover is able to engage with a heightened awareness as a bridge is built between their conscious and unconscious worlds (Brangante, 2006; Musicant, 2001; Stromsted, 2009; Wyman-McGinty, 1998). The action takes place in external reality while the focus is on their internal reality (Bragante, 2006). A sound should signal the movement to come to an end, "signifying the transition from bodily expression to self-awareness" (Brangante, 2006, p. 59).

The next phase is the mover and witness sharing reflections of the experience. It can be done verbally or through creative mediums like movement, art, and sound (Brangante, 2006; Musicant, 2001). The mover shares their experience first. They may choose to say nothing, say what they remember or what was significant to their movement experience (Brangante, 2006). Then afterwards, and only by request of the mover, the witness is asked to respond by saying what they saw physically during the AM and they may reflect upon their bodily "sensations, emotions, images and thoughts

experienced during the movement" (Brangante, 2006, p. 59). During this time, the mover and witness can connect to all of the sensations, emotions and images that came up during the movement phase. This reflective process fosters integration of the mover's mind-body experience (an important quality in CT management).

AM can be used by drama therapists for CT management in post-session processing. As stated earlier, research proves that certain therapist qualities are needed for effective CT management. The therapist qualities needed in effective CT management include self and body awareness, mind-body integration, anxiety management, and empathy (Rosenberger & Hayes, 2002; Van Wagoner et al., 1991). The therapist needs to be consciously aware of CT in order to manage it (Carveth, 2012). AM used in therapy involves the client as mover and therapist as witness. AM facilitates the mover towards exploring the somatic unconscious, "the unconscious that is experienced and expressed on a bodily level" (Wyman-McGinty, 1998, p. 241). Having a witness present in the process fosters emotional expression and anxiety management in the mover while being safely contained in this embodied form of movement. In this same way, AM can be used as a tool for post-session processing and CT management. The therapist can act as a mover while a supervisor can act as a witness. Training and practice in AM has also been shown to increase therapists' abilities to contain projections, thus supporting AM as a useful CT management tool (Musicant, 2001). AM also functions to strengthen the mover's ability to be open and accepting (Musicant, 2001). AM could then support the therapist as mover to develop these same qualities which would support the treatment process and engagement with CT, therefore enabling deeper more meaningful work.

AM can be viewed as a spontaneous process. Movement beginning by impulse instead of consciously planning it is a defining characteristic of AM (Wyman-McGinty, 1998). This can be understood as spontaneous movement with no intention. Mary Whitehouse created a body-centered method of connecting to and exploring the unconscious called *movement-in-depth* (Wyman-McGinty, 1998), which can also be viewed as AM. Her concept is described as "the intention to allow oneself to be directed from within and to give form, through movement, to the images and feelings which arise from attending to one's somatic experience" (Wyman-McGinty, 1998). AM can be viewed as non-directive, with the intention only to surrender to the body's natural impulse to move, and stay physically safe (Brangante, 2006; Musicant, 2001). This openness to experience and spontaneity in movement produces a heightened sense of awareness, which facilitates CT management.

There are a few requirements for this method of exploration and self-examination. The mover needs to be psychologically stable enough to enter and then exit this altered state of consciousness safely (Brangante, 2006). The mover should also have a general awareness of her body, to aid in the separation of her own past experiences and that of her clients (Bragante, 2006). The therapist would need to have a witness/supervisor that they trust and who has experience with this method of spontaneous movement (Bragante, 2006). Drama therapists using AM as an embodied intervention for CT management would need to meet each of these requirements to ensure safety and ethical therapeutic responsibility.

Having a witness present during AM provides some advantages and disadvantages to the therapist if used in CT management. Witnessing plays a crucial role

in AM. The witness helps contain the mover, creating a "welcoming, holding, warm and accepting atmosphere" (Brangante, 2006, p. 62). The witness also provides the mover with physical safety, as the mover is ensured safety from physical harm as they move freely with their eyes closed. A safe atmosphere is created allowing for deeper exploration as unconscious material surfaces, mind-body integration occurs and awareness is strengthened. AM can provide the drama therapist (as mover) opportunities for insight and new perspectives, which can aid the therapist in CT management. However, AM used by drama therapists for CT management would need to be done in individual supervision to maintain confidentiality of client material. This means that there would be a larger space between the ending of a session and the management of CT. The more space there is between processing and the ending of the session leads to a greater risk of CT contamination and confusion in the therapist from experiences had in between session and supervision. There are always risks to the therapist and client with CT, however the risk of CT contamination will always be lower than denying them any value at all. The use of a supervisor as witness whom the therapist feels safe with will support him/her in effective identification, clarification and containment of CT.

Embodied Response Art: An Intervention Model

Introduction

This section of the paper outlines the procedures of *embodied response art* (ERA). ERA is an embodied drama therapeutic tool created for drama therapist use post-session for identifying, clarifying and utilizing CT. ERA is intended for drama therapists' use however, other therapists who are knowledgeable and experienced in embodiment techniques can utilize it as well. The drama therapist should read this whole

document before applying the guidelines in his/her daily work in order to gain a better understanding of the process. The procedures of ERA outlined in this document are based on drama therapy theories of embodiment, projection and role-play as well as theories of authentic movement. Embodiment is a process that uses the body for exploring and expressing conscious and unconscious thoughts, feelings and ideas (Jones, 2007). Embodiment naturally involves drama therapeutic projection, which entails using the body for externalizing personal material held internally (Jones, 2007). Role-play also involves embodiment processes through use of the body when taking on a new role. Similar to embodiment, role-play allows for exploration and expression of conscious and unconscious thoughts, feelings and ideas. Embodiment provides the drama therapist with a bridge, connecting the unconscious and conscious psyche, which is needed in CT management. Response art done by art therapists, Panhofer's et al. (2011) embodied post-session processing techniques, and embodiment practices used by the Norwegian Character Analyst Institute, each offer validation for the creation of this embodied intervention for drama therapist CT management.

ERA involves both intentional and spontaneous embodied procedures. Theories for and against both intentional and spontaneous procedures for CT management have been lightly disputed in the literature. Some therapists believe a clear intention is needed while engaging in CT management processes in order to maintain a focus on the client (Fish, 2005). Others advocate for spontaneity in the process in order to gain access to unconscious material (Deaver & Shiflett, 2011). Intentional drama therapy embodiment techniques, such as mirroring and role-play, are being utilized by therapists (not within drama therapy) in post-session processing (Sletvold, 2012). This provides evidence to

support intentional embodiment processes as useful for therapist CT management. Spontaneous and intentional authentic movement techniques have been utilized by DMTs with evidence that they are also useful for CT management (Panhofer et al., 2011).

ERA fills a gap in the literature, providing drama therapists with their own method of CT management utilizing one of the core drama therapy processes of embodiment. Many of the creative arts therapies rely on their own method of CT management utilizing techniques within their own modality, including but not limited too: response art for art therapists (Fish, 2005), poetry for poetry therapists (Bean, 1992), CT sand world for sand play therapists, and musical CT (Priestly, 1975) for music therapists. Response art done by art therapists is the most well documented form of CT management within the creative arts therapies. It has been proven to support the therapist in effective CT management (Deaver & Shiflett, 2011; Fish, 2005). Engaging in a creative embodied process (such as embodiment and authentic movement in ERA) is supported by theory and research to assist the therapist in the same way as response art, offering an effective method of CT management (Federici-Nebbiosi&Nebbiosi, 2012; Musicant, 2001; Panhofer et al., 2011; Sletvold, 2011; Wyman-McGinty, 1998).

Purpose

ERA is an embodied drama therapeutic tool used by the drama therapist post-session for CT management. CT management involves identification, clarification, and containment of CT, which functions to protect and strengthen the therapeutic alliance and produce more positive therapeutic outcomes. CT management is necessary in order to utilize CT as a therapeutic tool and to prevent harmful CT acting out/enactments by the drama therapist. ERA is designed to develop and strengthen certain therapist qualities

proven in research to be necessary in effective CT management. These qualities include: self and body awareness, mind-body integration, anxiety management (self-care), and empathy (Hayes & Rosenberger, 2002; Van Wagoner et al., 1991).

Populations

This intervention is intended for use by drama therapists. Certain drama therapists may require ERA more including: trainees, drama therapists working with child and adolescent populations and trauma, drama therapists with large caseloads and during termination. Trainees may have a greater need for ERA as research shows they generally have more difficulty managing their reactions to clients (Hill, Sullivan, Knox, & Schlosser, 2007). Intense CT reactions occur more often in therapists when working with sensitive topics such as trauma (Holmes, 2013). Therefore, drama therapists who work with clients/populations with trauma will have a greater need for CT management. Drama therapists working with children and adolescents may be at greater risk for intense CT reactions because there are more people involved, including other family members and other healthcare workers (Rasic, 2010). With more people involved the CT dynamics become more complex, which make CT more difficult to manage. Therapists who have large caseloads have an increased need an intervention for CT management. Drama therapists who have large caseloads run the risk of more frequent and intense CT reactions (Rasic, 2010). The more frequent and intense CT reactions are, the more likely harmful CT enactments are to occur. Termination is also a time that requires a greater need for CT management. Research shows a higher frequency, intensity and complexity of CT reactions in therapists during termination (Rasic, 2010).

Requirements

Body awareness. The drama therapist should have a general awareness of his/her body to engage in ERA. With experience in this method of intervention, the drama therapist's body-awareness will develop and strengthen. Body awareness will support the drama therapist in CT management by increasing his/her ability to clarify and differentiate his/her own bodily sensations and other somatic experiences from that of his/her clients (Bragante, 2006).

Time. The drama therapist should engage in ERA after the post-session body scan and initial process writing. This supports effective exploration and management of CT brought up in session and functions to avoid any CT contamination or confusion with other stimuli experienced throughout the day. There is no specific time limit requirement to engage in ERA. ERA is designed to accommodate a drama therapist's schedule, which normally has minimal time between clients, and should not exceed 15 minutes per client.

Space. A private space with enough room to freely move the body within the drama therapist's personal kinesphere is required to safely engage in ERA. A general guideline for discovering the ideal space is to extend and reach both arms in all directions at varying levels. If this can be done freely without the risk of bodily harm, then it is an ideal space. However, some of the ERA processes involve less physical movement, so it is suggested that the drama therapist use his/her own discression in finding a suitable space to engage in ERA.

Supervision. ERA is done as part of supervision and may include group, peer, individual or self-supervision. Individual, group or peer supervision may or may not be required for the drama therapist engaging in ERA. ERA involving AM requires a

witness, and therefore needs a supervisor present during the process. The supervisor must be someone that the drama therapist trusts and who has some knowledge of and experience in AM (Bragante, 2006). Those with adequate training and practice utilizing the interventions can do all other ERA tasks in self-supervision. These tasks include: embodiment of client posture, gesture, facial expression and therapist feelings/therapeutic alliance. Self-supervision is not suggested to drama therapists who are less experienced with the processes of embodiment utilized within ERA. The therapist should seek a second perspective through group, peer or individual supervision for clarification of CT insights gained in self-supervision. With more experience in ERA this requirement lessens, as the drama therapist should be better able to identify, clarify and contain CT effectively individually.

Documentation. All documentation collected during the ERA process will be subject to the same ethical guidelines found in the North American Drama Therapy Association (NADTA) Code of Ethical Principles including: Professional responsibility and respect, competence, confidentiality and informed consent (NADTA, 2014). ERA documentation must remain confidential and be kept on file as the therapist's own personal record of the client (process notes not progress notes). Only documentation of client material/insights surfaced during ERA should be documented on file. This will help the therapist maintain focus on the client rather than him/herself in the process. ERA documentation may include any creative artwork, sound/video recording, photography, creative writing, and process notes. Due to the time constraints between client sessions for most drama therapists, some of these documentation methods may not be practical. Therefore process notes (described below) may be the most effective way to

document ERA. The drama therapist should have writing tools available for proper ERA documentation. No props are needed in ERA.

ERA process notes. ERA follows a writing-moving-writing process. As demonstrated by Panhofer et al. (2011) this writing-moving-writing process is an effective model for CT management. After each client session the drama therapist is to begin with a body-scan, which is described in detail below. Following the body-scan, the drama therapist will write process notes as usual, summarizing and highlighting information gathered and sensations experienced in session. Next the ERA task(s) will be engaged in. Immediately following each ERA the drama therapist must write process notes summarizing the main thoughts, feelings and images that surfaced through the exploration.

Process notes can be done in any creative form, for example, poetry and image creation through drawing (Panhofer, 2011). It is suggested that the drama therapist create a title to represent each ERA engaged in. Title creation was used by Panhofer et al. (2011) in his post-session processing study with DMTs and found it to deepen the processing of the session. If the drama therapist chooses to engage in both the intentional and spontaneous methods of each ERA task provided below, he/she is encouraged to contrast and compare what information is gathered by both methods.

Body scans. Body scans done pre and post-session foster self-awareness, focus and presence in the drama therapist, which supports CT management. Body-scans consist of mentally scanning the body from head to toe bringing any bodily sensations into awareness. The body scan begins with the drama therapist in a comfortable seated position with eyes closed. The drama therapist brings his/her focus inwards, bringing

awareness to all parts of the body beginning at the top of the head, going through the neck, shoulders, arms, chest, abdomen, back, pelvis, legs and feet. Once a sensation is found in the body, the goal is not to fight or release it, but to take note of it, and accept where he/she is in that moment. Body scans train the therapist's mind to stay calm and focused while also helping him/her becoming aware of what sensations they bring in and out of session. Therefore pre and post-session body scans support ERA by helping the drama therapist increase self-awareness and differentiate their own bodily experience from that of their client.

Optional Process

Meditation. Meditation should be done at the start of every workday for 15 minutes. Similar to the body-scan, daily meditation is proven to strengthen therapists' self-awareness and focus while supporting differentiation between subjective and objective CT (Fatter & Hayes, 2013). The drama therapist requires these qualities for effective CT management. Meditation practiced by therapists regularly over time is connected to effective CT management (Fatter & Hayes, 2013). This data suggests that meditation done every workday will increase a therapist's ability to manage CT effectively. One form of meditation may include the following: beginning in a comfortable seated position with eyes closed. The drama therapist brings his/her focus inwards, bringing awareness to the abdomen rising and falling with each breath. The challenge is to maintain focus on the breath while keeping the mind free from thought. As thoughts enter the mind and begin to take focus, simply acknowledge it by naming it a "thought" and releasing it, continuously bringing your focus back to your breath. This

author suggests naming the abdomen "rising" and "falling" as it does so, to support one's focus on the breath.

Embodied Response Art: Tasks

The following section describes in detail the appropriate steps to each ERA intervention task. ERA tasks involve both intentional and spontaneous embodiment techniques and spontaneous authentic movement techniques. The previous section requirements are to be upheld during the application of each ERA. ERA follows the body scan and writing done immediately post session. At least one ERA task should be done in response to each client engaged with in session. The following ERA tasks can be done separately or consecutively.

Embodiment of client postures. Begin by shaking your body out and resting in a neutral standing position. With eyes closed or open and having the intention of embodying a client's posture as seen in session, move into the client's posture. Additionally, the therapist can add a sound or word that intuitively comes to the therapist while in this client posture. Hold the posture for several seconds. The drama therapist may have several different postures of the client in mind from session and can create one ERA for each. If there are multiple client postures created during his/her ERA, the drama therapist can use them to create a movement sequence and explore moving from one to another. Panhofer et al. (2011) found this movement sequence to deepen the exploration in his research with DMTs. Alternatively, with eyes closed or open, the drama therapist may spontaneously create a posture that he/she intuitively believes represents the client.

Embodiment of client gestures. Begin by shaking your body out and resting in a neutral standing position. With eyes closed or open and with the intention of embodying

a client's gesture in mind, create a gesture that the client was producing in session. Alternatively, with eyes closed or open, the drama therapist may spontaneously create a gesture that he/she intuitively believes represents the client.

Embodiment of client facial expressions. Begin by shaking your body out and then tensing and widening your facial muscles, resting in a neutral standing or seated position. With eyes closed or open and with the intention of embodying a client's facial expression in mind, create a facial expression that the client was producing in session. Alternatively, with eyes closed or open, the drama therapist may spontaneously create a facial expression that he/she intuitively believes represents the client.

Embodiment of therapist feelings/therapeutic alliance. Begin by shaking the body out and resting in a neutral standing position. With eyes closed or open and with the intention in mind, move into a frozen posture or moving gesture that represents: a) how the drama therapist feels towards the client, or b) the therapeutic alliance. Additionally the therapist can add a sound or word that intuitively comes to the therapist while engaging in this posture or gesture.

Embodied response art: Authentic movement. As specified above in the requirements section, this ERA task is more suitable for use in individual supervision and requires two participants: mover/drama therapist and witness/supervisor. The following steps involved in ERA authentic movement utilize general authentic movement processes as outlined by Bragante (2006). ERA authentic movement steps are outlined as followed:

1. Mover and witness decide on the amount of time for exploration. No more than 10 minutes of AM is suggested.

2. Mover begins seated, lying down or standing with eyes closed in silence and stillness. Focus is turned inwards. Mover waits for an unconscious impulse to move, trying not to produce any movement intentionally. Witness actively observes acting as a container of the exploration and seeks to keep the mover physically safe during the movement. The exploration ends by a sound or the witness's voice.
3. Mover shares reflections of the experience first, followed by the witness. This step can be done verbally or through creative mediums like movement, art, and sound (Bragante, 2006). The witness is asked to respond by saying only what they actually saw in the movement, recalling specific qualities and movements. The witness may also reflect upon his or her own somatic experiences stimulated by the authentic movement exploration.
4. Mover then takes time to write process notes reflecting upon the thoughts, feeling and images that surfaced during the ERA authentic movement exploration. They can also reflect upon and make connections to what the witness observed and what was actually experienced. A title or word can be used to describe the exploration to help with record keeping and tracking progress.
5. Deeper discussion is suggested after some time has passed to gain new perspectives and distance from the experience. Working towards clarification, identification and utilization of CT.

Summary

ERA is designed to support drama therapists in identifying, clarifying and containing CT in order to protect the therapeutic alliance and achieve more positive

therapeutic outcomes. ERA follows a writing-moving-writing process which has been shown to strengthen therapist CT understanding, facilitate conscious/unconscious communication and increase engagement in the therapeutic process as a whole (Panhofer et al., 2011). ERA offers both intentional and spontaneous processes familiar to drama therapy. The ERA process follows these four steps: 1) Pre and post-session body scans, 2) writing process notes, 3) ERA engagement, and 4) writing process notes. Meditation is offered as an optional process for drama therapists seeking additional strengthening of CT management skills. The ERA intervention process is outlined clearly at the end of this document (see Appendix).

Discussion

Limitations and Recommendations for Future Research

There is a very limited amount of data from empirical research to verify embodiment as a method of CT management. Most of the literature is theoretical and lacks statistical evidence to support it. Of the empirical research available, the focus remains on CT management within session rather than post-session. This demonstrates the need for future research to be done that tests embodied methods of CT management done post-session. Drama therapists should be involved in the evaluative research on ERA.

Clarifying the origins of CT remains to be one of the most challenging aspects of CT management. This paper suggests that certain therapist qualities and gaining a second opinion will help with clarification, however within the literature, there is no way to be certain of the origins of CT. How can a therapist truly know whether the CT is coming from client transference or their own unresolved issues? This highlights the importance

of continuous self-reflection (which is part of CT management and ERA) and staying open to possibility without holding onto interpretations as fact. ERA is a process of self-reflection that is done post-session. It is important to consider other applications of the skills developed through this self-reflective process conducted post-session. Could interpretations or clarifications found through ERA be brought into session afterwards and addressed with the client? With a developed skill in ERA, could these techniques be utilized to gain insight immediately within session?

There is a debate within the literature about whether CT management practices should be engaged in with an intention in mind or spontaneously with no intention. Fish (2005) suggests maintaining an intention to avoid turning the focus towards the therapist and engaging in a practice that is only supporting the therapist's ego. Sletvold (2012) points out that embodied practices done post-session is best done alone to avoid inhibition of authentic impulses due to the self-consciousness that transpires with a witness or audience present. He suggests only engaging in embodied methods when the therapist is confident enough in the process to freely express themselves with others present. However, this conflicts with the conclusion stated earlier, that it is important to engage in these practices in the presence of a supervisor until certain competency in ERA is achieved. The strengths and weaknesses of engaging in supervision and self-supervision for post-session processing were not thoroughly discussed in this paper. Further research needs to be done to examine the differences between these approaches and what effect they have on CT management.

This intervention may not be suited for all drama therapists. This author has a personal affinity towards embodied methods of engagement and exploration, and

therefore is gravitated by personal bias. Not all drama therapists have this same desire. There is still a need for additional methods of CT management for drama a therapist that "best suits the therapist's personal style, comfort level, and theoretical orientation" (Morningstar, 2013, p. 12). Future research needs to be done that incorporates other core processes of drama therapy, for those not interested in embodiment techniques.

Due to the scope of this paper, the author was unable to review how CT affects different therapists according to one's gender, culture or ethnicity. While more females advocate for, publish about, and voice the need for CT management, it is not clear if this is reflective of one gender actually requiring it more than the other. However this imbalance in authorship of men to woman may also be due to the stigma attached to men who are emotional, causing more men than women to deny their CT reactions. It would be interesting to conduct research assessing the different needs of CT management of the drama therapist based on their gender, culture and ethnicity.

Summary and Conclusion

Drama therapists need an intervention to help them manage CT effectively to avoid harming the therapeutic relationship and increase positive therapeutic outcome. This paper recognizes CT from an integrative/intersubjective perspective. CT is defined as all the unconscious reactions from the therapist towards the client. This perspective views CT in two distinct ways: 1) as an important tool which can be utilized to gain information about client problems and support the treatment process and therapeutic alliance, 2) as originating from the therapist's own unresolved issues which must be acknowledged and managed to avoid harming the therapeutic alliance and hindering treatment. These reactions manifest in thought, feeling, behavior, somatically and even

dream states. CT behaviors need to be managed effectively in order to prevent harmful CT acting out or enactments by the therapist. Both positive and negative CT reactions have been found to correlate with a negative impact on treatment (Markin et al., 2013). CT management is imperative to the treatment process in order to identify, clarify, contain and utilize CT and lower the risk of harm to the client and therapist.

Effective CT management interventions involve the strengthening of certain qualities in the therapist, gaining access to the unconscious psyche and a commitment to self-examination. CT originates in the unconscious psyche. In order to access it, the therapist must first identify it through processes that bridge the unconscious and conscious psyche. Self and body awareness, mind-body integration, empathy, and self-care practices to lower anxiety have been found through empirical research to support the therapist in effectively managing CT and utilizing CT as a tool in treatment (Hayes & Gelso, 2001; Rosenberger & Hayes, 2002; Rubin & Gil, 2005; Van Wagoner et al., 1991). Self and body awareness helps the therapist clarify the origin of the CT reaction (the therapist's unresolved issues or the client's transference) and prevents harmful acting out/enactments (Forester, 2007; Geller & Greenberg, 2012). Anxiety is the most common manifestation of CT, and it must be managed (Fatter & Hayes, 2013). CT management involves careful self-examination, which can be done through personal therapy, group or individual supervision and self-supervision. While self-supervision may be sufficient for experienced therapists, it will always be challenging to manage CT alone. Having a secondary source for verification of CT is encouraged, especially to training therapists, therapists with a large caseload, working with trauma and those less experienced with the intervention process.

Drama therapists need an intervention that utilizes processes familiar to the therapist within their own medium. Art therapists utilize art through response art to manage CT. DMTs have begun exploring the use of movement for managing CT. Poetry therapists utilize poetry, while sand play therapists utilize the sand tray for CT management. There is a gap in the literature that explores CT management in the drama therapist. Other authors advocate for an intervention specific to the therapist's medium for CT management (Morningstar, 2013; Rubin & Gil, 2005). Embodiment is a core process used within drama therapy and can be used as an effective intervention to manage CT. Embodiment processes have been utilized successfully by DMTs and by psychoanalysts in Norway, which provided evidence for use as an intervention for CT management (Panhofer et al., 2011; Sletvold, 2012). AM is an embodiment process used within DMT and sometimes applied within the context of drama therapy and other creative arts therapies. AM can be used as a tool to help the drama therapist manage CT.

ERA is an intervention specific to drama therapists, which uses embodiment techniques to manage CT successfully. Engaging in AM practices within supervision has been identified as a useful technique to manage CT (Sletvold, 2012). Engaging in the embodiment of client postures, gestures and facial expressions has been utilized by therapists outside of the creative art therapies, and have found it to be useful in identifying and clarifying the origin of CT in the therapist while building empathy for the client (Sletvold, 2012). Exploring the therapist's feelings towards the client and/or the current therapeutic relationship has been done by sand play therapists and has been shown to help the therapist manage CT. Each ERA intervention process utilizes the drama therapy core process of embodiment, and therefore should be utilized by drama

therapists specifically to identify, clarify, and contain CT. This way CT can be used as a tool to better understand the client, strengthen the therapeutic relationship and increase positive therapeutic outcome.

There is a scarce amount of research on the topic of CT and its management within the creative art therapies. Most of the research on CT is found within psychoanalytic literature, with the focus on what occurs in session rather than post-session. There is a need for more research that focuses specifically on post-session processing of CT. Our field would benefit from a heuristic based research enquiry of CT within drama therapy to demonstrate and understand the lived experience of engaging in this method. Using ERA as part of a heuristic research inquiry could help validate this intervention as a tool for helping drama therapists manage and utilize CT.

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Appendix

Embodied Response Art: The Intervention

The embodied response art process follows four steps: 1) Pre and post-session body scans, 2) writing process notes, 3) embodied response art task engagement, and 4) writing process notes. Meditation is offered as an optional activity for additional advancement of CT management skills.

Embodied Response Art: Before and After

Check-In

Quick body scan is done before and after each session to check-in with your body and yourself to help differentiate what you are bringing with you into session and what is being triggered by CT reactions.

Process Notes

After the post-session body scan, write process notes for the session, highlighting information gathered and sensations experienced during session. After each *embodied response art,* write down any thoughts, feelings and images that surfaced during the exploration. Write down any additional words or sounds engaged in during the process. Create a title for each *embodied response art* engaged in to help with record keeping and monitoring progress.

Embodied Response Art: Tasks

Embodied response art tasks are the embodiment techniques engaged in post-session by the drama therapist for countertransference management. A space that is conducive to a wide range of movements is preferred for this exploration.

The following embodied response art tasks can be done separately or consecutively:

Embodiment of Client Posture

1) Begin by shaking your body out and resting in a neutral standing position. With eyes closed or open and with the intention in mind, move into the client's posture seen in session. Additionally the therapist can add a sound or word that intuitively comes to the therapist while in this client posture. Hold the posture for several moments.

2) Begin by shaking your body out and resting in a neutral standing position. With eyes closed or open, spontaneously create a posture that the drama therapist intuitively believes to represent the client.

3) The therapist can move into an exploration and creation of a client gesture from this posture in role as the client. Additionally the therapist can add a sound or word that intuitively comes to the therapist while engaging in this client gesture.

4) The therapist can move into an exploration and creation of a client facial expression from this posture or gesture in role as the client. Additionally the therapist can add a sound or word that intuitively comes to the therapist while engaging in this client gesture.

Embodiment of Client Gesture

Begin by shaking your body out and resting in a neutral standing position. With eyes closed or open and with the intention in mind, create a gesture that the client was making, or that you intuitively believe represents the client.

Embodiment of Client Facial Expression

Begin by shaking your body out and resting in a neutral standing position. With eyes closed or open and with the intention in mind, spontaneously create a facial expression that the client was engaging in, or that you intuitively believe represents the client. Add a sound or word to this facial expression in role as the client.

Embodiment of Therapist Feelings/Therapeutic Alliance

Begin by shaking your body out and resting in a neutral standing position. With eyes closed or open and with the intention in mind, spontaneously move into a frozen posture or moving gesture that represents: a) how you feel towards the client, or b) the therapeutic alliance. Additionally the therapist can add a sound or word that intuitively comes to the therapist while engaging in this posture or gesture.

Embodied Response Art: Authentic Movement

This method requires two participants: mover and witness. This embodied response art task is more suitable for use in supervision. The steps are as follows:

Step 1: Mover and witness decide on the amount of time for exploration (no more than 10 minutes is suggested).

Step 2: Mover begins seated, lying down or standing with eyes closed in silence and stillness. Focus is turned inwards. Mover waits for an unconscious impulse to move, trying not to produce any movement intentionally. Witness actively observes acting as a container of the exploration and seeks to keep the mover physically safe during the movement. The exploration ends by a sound or someone's voice.

Step 3: Mover share reflections of the experience first, followed by the witness. This step can be done verbally or through creative mediums like movement, art, and sound (Bragante, 2006). The witness is asked to respond by saying only what they actually saw in the movement, recalling specific qualities and movements. The witness may also reflect upon his or her own somatic experiences stimulated by the authentic movement exploration.

Step 4: Mover then takes time to write process notes reflecting upon the thoughts, feeling and images that surfaced during the *embodied response art* authentic movement exploration. They can also reflect upon and make connections to what the witness observed and what was actually experienced. A title or word can be used to describe the exploration to help with record keeping and tracking progress.

Step 5: Deeper discussion is suggested after some time has passed to gain distance from the experience and new perspectives. Working towards clarification, identification and utilization of CT.

Meditation (Optional)

To be done at the start of every workday for only 15 minutes. Begin seated in a comfortable position with eyes closed. Turn the focus inwards by noticing the breath or doing a body scan. Body scans consist of mentally scanning the body from head to toe looking for any tension in the body. The goal is not to fight the tension or release it, but to take note of it, accepting that is where you are at in that moment. The therapist is training the mind to stay calm and focused. As thoughts distract your focus, simply acknowledge them as "thoughts" and bring your focus back to the breath and your body.