

Dancing With Burnout, Compassion Fatigue, And/Or Physical Pain As A Dance Movement Therapist

An Investigation Into The Causes, Effects, And Possible Prevention Methods
For Therapists Who Are Combating Burnout, Compassion Fatigue And/Or
Physical Pain Through Their Embodied Work

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Dedication

To my Mother, who only ever wished for her daughters to be educated

And for the people of Palestine who are trying to survive tremendous ongoing pain, trauma, and suffering, and those who may treat them one day in the aftermath

Acknowledgments

I would like to acknowledge, in no particular order, those who played their role during this long journey of becoming a dance movement therapist.

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It is through movement that I have learned the infinite power of the mind and body in its sacred state of connection with the soul.

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Abstract

This thesis investigates the causes and effects of burnout, compassion fatigue, and physical pain during somatic countertransference in mental healthcare professionals, focusing on the niche population of dance movement therapists to understand which self-care practices and other factors may help mitigate the risks. It explores the prevalence of burnout, compassion fatigue, and physical pain in a study sample size of 13 female White or Caucasian and Hispanic or Latino dance movement therapists using the ProQOL 5 and Numerical Rating Scale, then further examines what self-care practices they participate in, as well as the presence of a support system or lack thereof to provide initial insight into possible treatment options. This is one of the first investigations of its kind to discuss an issue that is of particular relevance due to the increased global demand and interest in mental healthcare (Wainberg et al., 2017 & Kuehn, 2022). Dance movement therapists, due to the nature of their embodied work in a helping profession, are at greater risk of burnout and compassion fatigue. Therefore, it is necessary to understand and explore its impact so that viable solutions may be provided to mitigate or lower the overall risk.

Introduction

I felt it important to approach the topic of this master's thesis as a result of the two years I spent listening to the stories of my colleagues, their personal experiences while training to become dance movement therapists (Dmts), and my well-documented experiences during my journey to becoming a therapist. The time could be described easily as a time of self-reflection, self-understanding, and development of emotional intelligence, compassion, and body awareness. It could also be described as a roller coaster of learning, not only intellectually, but also emotionally and consciously through the mind, and physically through the body. Every part of my being was challenged to grow and evolve on this journey.

Before the internships began, I learned about a common phenomenon that often occurs between patients and therapists in which therapists who are using their bodies for their work would often experience physical pain with particular populations. We can refer to this physical pain as somatic countertransference (SCT) in the field of psychotherapy which is particularly relevant to practitioners of dance movement therapy (DMT) (Vulcan, 2009). I rarely experienced physical pain during my first year of clinical practice.

However, during my second year, I was indeed still recovering from a terrible accident that I suffered in October 2021. I fractured the radius and humerus and shattered my elbow joint in seven pieces in my left arm. I had also torn my left calf muscle just a week before during the first supervision of the new academic year. I spent a year in recovery before returning to the master's and was in decent physical health after months of physical rehabilitation and regaining about 90% of the movement in my left arm where I had sustained the majority of my injuries. Pain management has become a regular part of my life, though the pain generally comes and goes.

Yet during my clinical practice, I began experiencing new and specific types of pain in the hips, and the lower lumbar region, where I hadn't necessarily sustained any injuries. I worked closely with my physiotherapist during the entirety of my clinical practice to keep the pain under control. I often had a difficult time distinguishing between whether the pain was related to my injury, or if it was related to SCT because it was so constant, yet appearing in places in my body that seemed unrelated to the recent injuries I had sustained.

Through my supervision sessions, I learned quickly that I wasn't the only one who was experiencing physical pain. However, my colleagues hadn't necessarily sustained any major accidents or injuries as I had in the recent past. Aches and pains were almost always present, either in my own body, or the bodies of my colleagues during supervision, and were spoken about regularly. In addition to having so much pain circulating through my own body when arriving at the supervision sessions, the pain would often disappear after sharing what I was going through during the check-in and moving through the warm-up. While living through this experience, it was difficult to understand it all. Yet this had happened on more than one occasion, and would even happen during the sessions with my patients.

My patients were also regularly experiencing pain in their bodies during every single session, at least at the beginning of the sessions. Because I often also arrived at the sessions with severe pain, I often felt that we were moving through our pain together. I reviewed several journal entries where I noted the severe and excruciating pain that I was often experiencing before arriving at the sessions. Then during the regular check-ins that kicked off our therapy sessions, my patients would regularly describe the physical pain circulating through their bodies. During our sessions, we would move through this present pain together, and it often disappeared for me by the end of the session. I documented several instances when the patients had also shared that their pain had lessened or disappeared by the end of the session during the checkout. This, of course, left me with several questions that I needed to answer somehow.

Something that was not spoken about in preparation for this tedious, time-consuming, yet extraordinarily fulfilling period of clinical practice was the risk of reaching a state of burnout while trying to balance work, life, family, and studying for a master's degree, plus integrating all of the information on a cellular and psychological level. Not only did my choice to become a therapist affect my time and financial resources, but it also affected me emotionally, spiritually, and physically. I was challenged with learning boundaries and the fine line between giving too much or just enough of myself to the work I was trying to achieve. It challenged my tendencies towards perfectionism and was like holding a mirror up to myself to observe every movement I was making internally with thoughts and externally with my body, as well as every intuitive and intellectual decision I was making in the overall process.

With my background as a social media marketer and professional experience in short-form videography, I decided to not only document my second-year internship experience through the clinical practice journal but to also document myself through before and after videos every single day that I was leading the sessions with my psychiatric patients. This was another mirror, physical evidence that I provided to myself, as I could watch my overwhelming demise occur in real-time. I was overly saturated and burnt out by all that I was experiencing from both life and the internship experience of working as a therapist. It was evident from the video footage. To further confirm my suspicions of experiencing burnout, I took several different online quizzes. I was desperately trying to understand what I was experiencing. One of the quizzes suggested I was at high risk of being seriously burnt out.

I witnessed myself start on such a high note, filled with excitement and enthusiasm to begin this journey that I was so devastated to have been forced to stop in 2021. But then it became a rapid progression towards visible exhaustion, highs and lows of feeling so excited about the work I was doing yet so physically exhausted and in pain, despite doing everything possible to sleep enough, exercise enough, and eat well. The more I tried to control the situation through sleep, dance, yoga, and movement, the more I began to feel that I was losing control of my physical and emotional health. It felt like I was doing everything right, yet nothing I did could lessen the amount of stress and pressure I was feeling.

What also wasn't discussed before beginning the internships was the risk of experiencing compassion fatigue (CF), a term that has just recently begun circulating within circles of psychotherapists, mental healthcare advocates and professionals, and other medical and healthcare professionals who assume caregiver responsibilities (Kartsonakiet al., 2023). After my first year of training, I didn't have an explanation for the intense fatigue that I was experiencing through the observations of the special needs children I intended to work with. I also didn't have an awareness of what CF was until I was updating an acquaintance who is a psychotherapist about how overwhelmed, stressed, mentally exhausted, and physically fatigued I felt while arriving close to the end of my second year of clinical practice.

She was the first person to share the term "compassion fatigue" with me, and a lightbulb immediately went off. I wondered if CF was the explanation for the intense fatigue that I felt during my first year of clinical practice, and possibly for the emotional exhaustion that had crept up during the second year about midway through the internship. I had so many unanswered

questions remaining in my mind about the physical and emotional experiences I had gone through during both years. What's more, I noticed that the first-year interns also complained very often of having intense fatigue and having to take naps after their internships, which was exactly what I had done my first year. From that point on, I began researching CF to understand if that was part of what I had experienced.

As I reflected on my experiences after finishing the second-year internship and finalizing the practical part of becoming a dance movement therapist, I couldn't quite understand how, despite all of the steps we were required to take to achieve self-care during a delicate and critical period in our lives, I still personally reached a detrimental state of out burnout, possible compassion, fatigue, and intense physical pain. I had regular therapy sessions for three years, maintained a constant movement practice through dance and yoga, attended every single supervision session (except for the ones that happened when I was at the hospital in 2021), meditated, worked out, saw a physiotherapist regularly, wrote in my journal almost every single day... And yet I still reached a state that felt more overwhelming than anything else I had ever experienced, and I genuinely didn't think I would make it through at times despite feeling thrilled with the work I was doing.

The importance of self-care had been made very clear by the master's program requirement to be in therapy while treating patients, through our supervision discussions, and simply through everything I know as a dancer, yoga practitioner, and dance movement therapist. I know and understand on a deep level the importance of taking care of your mental health in combination with your physical body. I learned this at a very young age as a result of watching my mother struggle with mental health issues due to her diagnosis of bipolar disorder, anxiety, and depression. She is also a trauma survivor and mental disorders are rampant on both sides of my family. It has been no secret to me my entire life how important it is to take care of your mental health. This is where my passion for psychology and mental health advocacy was birthed.

So how could it be that, despite taking all the steps towards maintaining my mental and physical health, being knowledgeable in the subjects, and having witnessed firsthand what a breakdown in mental health can do to someone's life when not properly addressed, could I still have reached what felt like the point of no return? My embodied experiences lead me to believe that burnout, CF, and physical pain during SCT are somehow deeply intertwined.

Although I was experiencing a deterioration in my mental health while working as a dance movement therapist, as well as severe physical pain while completing the second-year internship, I was concurrently witnessing massive progress in my various patients. I received a great deal of praise from the head of the psychiatric day center overall, but especially regarding one patient who had made significant lifestyle changes while undergoing psychotherapeutic treatment with me in addition to receiving medication, psychiatric treatment, occupational therapy, and various other forms of regular treatment. I shall refer to him as Guillem.

Guillem is a former chemical engineer and artist in his 60s, with a diagnosis of schizoaffective and bipolar disorder, a tendency towards hypomania and euphoria, panic disorder, Parkinson's disease, diabetes, overall trouble walking due to arthritis and progression of Parkinson's, and overweight. He was also a heavy smoker when he began receiving treatment in the form of DMT.

During his therapeutic process, Guillem managed to quit smoking and went from being a stagnant person who sat on his couch drinking liters of Coca-Cola and watching TV for the majority of his days to participating in movement at home regularly in between sessions. He often arrived at the sessions experiencing pain in his knees, moving through time and space slowly and cautiously, but the pain would often transform, sometimes disappearing by the end of the session. He made an extra effort to attend the sessions, even surprising the team of occupational therapists because he had a history of not attending sessions at the day hospital if it was raining outside. He still showed up to our DMT sessions on rainy days.

Once Guillem had communicated to me verbally that he realized he had “abandoned” his body. He developed a newfound awareness of his self-abandonment and while vacillating between hypomania, euphoria, and depression, he found a renewed sense of meaning in his life through his art, as well as the movement and music we shared in the sessions.

Guillem expressed his gratitude to me on various occasions and he was vocal about how much he felt the sessions were a gift in his life. I witnessed his progression from not being able to look me in the eyes when I first observed him, to being able to make eye contact on most days. There were physical changes too. He lost weight, went from smelling like a cloud of cigarette smoke to smelling like fresh cologne, and changed from having greasy hair and unkempt facial hair to cutting and styling his hair and presenting with a clean-shaven look. It was like seeing a different person emerge, a new dimension of self that surfaced after reconnecting with his body.

On my very last day at the hospital, which was at the end of August 2023 because I had been asked by the hospital to continue offering a weekly group DMT session after finishing my internship, it was time to officially say goodbye to my patients. I *rarely* had any physical contact with any of them, but after we closed the session one patient asked to hug me goodbye. After that, my patients lined up one by one to hug me, including Guillem. It was the only time we ever made physical contact, but in that moment I felt the trust he and the others had entrusted in me. It was an extraordinarily beautiful feeling that left me feeling a sense of accomplishment in knowing that I had made a difference in some of their lives.

I felt a huge sadness in closing this process. Completing this internship had cost me so much physically, mentally, and emotionally. Yet there is no doubt that it's the most fulfilling work I have ever experienced despite whatever detrimental experiences I had during the process.

What I have learned through these experiences is that not only is self-care crucial throughout working as a dance movement therapist intern, but it is of the utmost importance throughout your continued career as a therapist or other mental healthcare professional. I would even go as far as to say that self-care is understatedly important in life in general, especially when it comes to taking care of your mental health. I have made the personal revelation that caring for my mental health will be a lifelong journey, just as I will always be required to take care of my physical health.

Fortunately for us mental healthcare professionals (MHPs), there has been an upward trend in the demand for mental healthcare services since the COVID-19 pandemic began (Mannion, Konteh, and Jacobs, 2023), as well as overall interest in embodied practices that continues growing. The concept of embodied research and embodied practices is becoming increasingly recognized and integrated into various fields, including performing arts, sustainability transformations, science, and higher education (Bentz, do Carmo, Schafenacker, Schirok, & Dal Corso, 2022). Of course, the upward trend in the *need* for mental health services comes at a cost, indicating that people are collectively experiencing declines in their mental health and suffering from higher instances of anxiety and depression, among other mental illnesses (Mannion et al., 2023).

However, higher demand in assuming caretaker roles as therapists, psychiatrists, nurses, and doctors, to name a few, suggests that the need for self-care increases directly in correlation

with this demand. The risk also likely increases for any professionals working in such roles to become burnt out, and experience CF or physical pain due to the very nature of the work we are doing, especially if the infrastructure of the healthcare systems themselves is strained and places a higher demand of output on the professionals. For this reason, I believe there exists profound importance in assuring that us MHPs receive the support we need not only through our self-care practices but also through the support of other professionals, and the communities and systems within which we operate and offer embodied practices to diverse populations.

This thesis investigates the causes, effects, and possible prevention methods for therapists combating burnout, CF, and/or physical pain through their embodied work. It aims to answer the questions: what self-care steps do therapists need to take in conjunction with therapy and supervision group support to maintain stable emotional and good physical health through their work? How can they receive the support they need through their communities and society to remain mentally stable and physically healthy while practicing?

Topic

Burnout, CF, and/or physical pain appear to be common issues that Dmts may encounter as MHPs. While the risk of experiencing such issues is certainly not limited to the population of Dmts, there currently exists a minimal body of research targeting such an audience. If we are to take steps toward understanding how Dmts can be supported in their work, it is necessary to collectively take a proactive approach toward understanding their current needs and where gaps exist. We must examine what self-care steps they may be taking to effectively care for their mental and physical health, in addition to what community support they may be eligible to receive from existing structures and systems to gain a clearer understanding, as was asserted by Francesc Tosquelles during WWII.

Francesc Toquelles, a Catalan psychiatrist who was active in the resistance against Nazi Germany and their attempts to exterminate mentally disabled individuals, believed that the healing of our societies first begins with the healing of our institutions (Robcis 2002). The healing necessary to treat patients enduring psychosis as a result of living in concentration camps was not limited to the healing of only the patients but instead required the establishment of the collective as an unending body of work where healing continues within each of the individual participants (Robcis 2002). Tosquelles and his contemporaries believed in the intersection between psychiatry, psychotherapy, neurology, art, and politics.

As a result, with the current political climates and global wars persisting in Ukraine, Gaza, the Congo, and Sudan, among others, some mirroring the landscape of Nazi Germany against the Jewish population and their commital of genocide and ethnic cleansing, Dmts must be armed with the tools they need to support their mental and physical health adequately. Dmts and other caretaker professionals will be the ones to support political refugees and asylum seekers, amongst other populations, in their healing journeys so they must be cognizant of how to successfully attend to their own mental and physical health. The importance of understanding how to do that cannot be overstated as the world continues facing destabilization and chaos that impacts global communities.

General Picture

Mental Healthcare Is In Demand

The field of DMT is proliferating as a result of the current need that exists in mental healthcare, and with it comes the need to address the challenges that therapists face in their work. According to a 2022 report that was published by Mental Health America (Reinert, M, Fritze, D. & Nguyen, 2021), approximately 20.78% of US adults, or the equivalent of 50 million Americans, reported experiencing a mental illness at some point in 2019-2020. In 2022, the National Center for Health Statistics reported that 12.5% of US adults had experienced worry, nervousness, and anxiety, and 5% had regularly experienced feelings of depression (Schiller & Norris, 2022).

These statistics demonstrate the prevalence of mental healthcare issues specifically in the United States, yet the growing trend of seeking out mental healthcare, and current interest in mental health and wellness exists globally (Wainberg et al., 2017 & Kuehn, 2022). The current wars that continue waging will undoubtedly increase the need for mental health services for political refugees, among other affected populations. Thus, it is important to continue to raise awareness about mental health and to provide access to mental health services for those who need them, including the MHPs who are treating those in need.

High-Level Existing Approaches

Other researchers have approached related topics by exploring self-care practices for oncology nurse practitioners and have found that they are especially vulnerable to experiencing burnout in combination with CF and are considered to be a high-risk population (Ortega-Campos, E., Vargas-Román, K., Velando-Soriano, 2019). In a 2019 study with a sample size of 900 nurses, it was found that approximately 56% of them were experiencing medium to high levels of burnout, and 60% were experiencing medium to high levels of CF (Ortega-Campos et al., 2019).

A study that was published in April 2020 indicated that nurses who were experiencing high levels of CF and burnout participated in a highly experimental pilot study in Turkey to track the effectiveness of DMT in treating their mental health conditions (Yilmazer, Buldukoglu, Tuna, & Güney, 2020). After only 8 sessions of treatment, their levels of burnout and CF had decreased

significantly, and the researchers concluded that it was necessary to understand the risk factors and symptoms associated with compassion dissatisfaction, CF, and burnout, as well as to develop coping strategies that could be implemented effectively for the nursing population (Yilmazer et al., 2020). However, they cited a lacking body of research to be able to fully understand the positive impact DMT may have as a long-term prevention method.

In 2015, a master's student from Columbia University Chicago approached the topic by reviewing prevention methods for burnout for MHPs as a general population (Abelis, 2015). The focus of her thesis was to determine viable solutions for burnout prevention. Similar to the above-mentioned study conducted in Turkey, the answer she found was implementing a body-based approach, or more specifically, DMT as a psychotherapeutic treatment.

This research of course begs the question, how can Dmts themselves prevent burnout, CF, and physical pain from their own embodied practices as Dmts when this very practice often serves as a mechanism for healing from such physical and mental turmoil?

Current Prevalence of Burnout and Compassion Fatigue Amongst Mental Healthcare and Helping Professionals

A meta-analysis study that was conducted based on research published between 1997-2017 concluded that around 40% of MHPs from 33 different studies reported emotional exhaustion, one of the determining factors of burnout (O'Connor et al., 2018). Additionally, 22% had experienced depersonalization and 19% confirmed they had low levels of personal accomplishment, two other important factors in determining burnout (O'Connor et al., 2018). Through the comprehensive analysis of multiple studies, the researchers sought to provide a nuanced understanding of the extent and factors that were contributing to burnout in this critical sector of MHPs.

The results reveal that burnout is a significant concern among MHPs and their findings emphasize the urgent need to address the well-being of caretaker professionals who play a pivotal role in delivering mental healthcare services. Additionally, the study highlights several determinants of burnout, including high workload, lack of social support, and organizational factors (O'Connor et al., 2018). Notably, the analysis elucidates the impact of these determinants on different subgroups, such as psychiatrists, psychologists, and nurses, thereby offering insights into the specific challenges faced by each profession. Dmts were not included in the results.

The study also examined the importance of gender as a determinant of burnout, with female MHPs experiencing higher rates in comparison with their male counterparts. This finding highlights potential gender-specific vulnerabilities and disparities in the workplace that demand attention and potentially targeted interventions. Importantly, the researchers note that burnout in MHPs not only affects the well-being of these individuals but can also undermine the quality of care provided to patients (O'Connor et al., 2018). Thus, it becomes imperative for healthcare organizations and policymakers to implement strategies that mitigate burnout and promote the mental health and resilience of these professionals, ultimately benefiting both the workforce and their patients.

Another study examined the pervasive issue of CF among professionals in a variety of helping professions, shedding light on its prevalence within various fields. It is important to note that this was the very first study of its kind, more specifically approaching the concept of CF, and their goal was to understand the nuanced behaviors that exist among different helping professions. The study population included doctors, nurses, paramedics, teachers, psychologists, psychotherapists, social workers, coaches, police officers, priests and pastors (Ondrejková & Halamová, 2022).

In emphasizing the prevalence of CF, the article underscores the toll it takes on mental healthcare workers. Astonishingly, existing research demonstrates that doctors are at the highest risk of having both high levels of CF in combination with low levels of compassion satisfaction, whereas psychotherapists were found to have significantly lower levels of CF and higher levels of compassion satisfaction (Ondrejková & Halamová, 2022). The researchers suggested that this could be partly due to the extensive training that psychotherapists receive in managing their emotional responses, as well as participating in supervision groups (Ondrejková & Halamová, 2022). Overall, these findings highlight the urgency of addressing CF, as failure to do so may not only affect individual well-being but could also jeopardize the stability and quality of mental healthcare services provided to patients.

Shifting attention to the high prevalence of burnout and CF among MHPs appears to be the only way forward. With only a small body of research currently existing regarding the broader audience of MHPs, it becomes of even greater importance to investigate the niche audience of Dmts within the subgroup of psychotherapists to provide an attempt at alleviating its potentially negative impact on both practitioners and patients. Understanding how the greater

population of mental healthcare and helping professionals are at risk can potentially help discover how Dmts and their counterparts can mitigate potentially negative outcomes to their mental and emotional well-being, as well as negative patient outcomes.

Purpose

This study is expected to provide an initial understanding of the causes, effects, and possible prevention methods for burnout, CF, and/or physical pain in Dmts. The goal is to first measure levels of burnout, CF, and physical pain in people who are currently working as Dmts, as well as to gain insight into what these therapists are experiencing, and what they are doing to protect themselves from experiencing burnout, CF, and physical pain as a result of working as MHPs. It also intends to gain insight into the current self-care practices of Dmts, their specific patient populations, whether a peer support system is present, if there is physical pain present in the patients, and whether they are receiving any other therapeutic interventions. It is expected to provide preliminary insight into the levels of burnout, CF, and physical pain experienced by Dmts, and may also provide insight into what methods Dmts currently use to prevent or manage physical or emotional stress related to burnout, CF, and/or physical pain.

Then, the results will be assessed and analyzed to determine what was different in the experiences of those who did and did not experience burnout, CF, and/or physical pain while working as a Dmt versus those who did, and to identify potential commonalities in routines and behaviors, then determine if any could be viable prevention methods. The findings will hopefully contribute to the initial development of potential prevention methods and realistic remedies for these issues, which could potentially benefit both the therapists and their patients while highlighting the importance of self-care practices, the role of community support, and mental/physical health support for Dmts. The results of this study may begin to inform the development of interventions to prevent burnout, CF, and physical pain in Dmts.

Research Questions

This research aims to answer the following questions:

- Can burnout and CF be avoided by having a strong self-care practice?

- Is it possible that working with patients who have experienced high degrees of trauma may adversely affect the MHP or psychotherapist?

The research study shall likely answer the question of self-care relevancy to burnout and CF once evidence is collected that affirms or negates the possibility. The literature review shall include an investigation of the topic, as well as assess what data has already been collected about the topic. Preliminary investigation has already established the possibility of self-awareness practices, such as mindfulness, having the potential to aid in addressing burnout and CF.

The literature itself shall likely address whether working with patients who have experienced high degrees of trauma may adversely affect the MHP or psychotherapist. This will be a secondary question to examine through the lens of the results of the research study to discern whether there is evidence that points to such a relationship between population/patient and MHP/psychotherapist.

Literature Review

The following literature review takes a deep dive into the targeted topics of this thesis: burnout, CF, and physical pain experienced by MHPs in general, and psychotherapists in particular, to synthesize such information and theorize as to what the impact may be on Dmts. Research that pertains specifically to the audience of Dmts about such topics is nearly nonexistent, which deems conjecture and hypothesis a necessary tool in the research process based on new and existing data. Therefore, the literature reviewed shall analyze the broader audience of MHPs, while providing insight into how these topics relate to psychotherapists as a more closely related population to that of Dmts.

Burnout

A term initially coined by the novelist Graham Greene when describing a fictional character who had lost the ability to find pleasure or meaning in his life, the term “burnout” made its way to scientific literature in 1974 by Freudenberger, an American psychologist (O’Connor, K., Muller Neff, D., & Pitman, 2018). At the time, Freudenberger (1974) defined burnout as the “state of mental and physical exhaustion caused by one’s professional life.” There was an increased interest in the subject in the 1970s, as many researchers began witnessing a correlation between similar symptoms experienced by people working in professions that provide aid to others, specifically healthcare or human services (Luken & Sammons, 2016).

Burnout is defined as “a psychological syndrome characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment” (Yang & Hayes, 2022). This literature review aims to understand burnout, its causes, symptoms, possible warning signs, possible treatments, and existing preventive methods. Additionally, it will explore the application of Maslach's multi-dimensional model of burnout and the prevalence of burnout among MHPs.

Understanding Burnout

Burnout is a complex phenomenon that, according to the World Health Organization (2019), encompasses three main dimensions: emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. Emotional exhaustion refers to the depletion of emotional resources, causing feelings of being overwhelmed and feeling drained.

Depersonalization involves developing a negative, cynical, or detached attitude towards clients or patients. A reduced sense of personal accomplishment manifests as a diminished sense of achievement and competence in one's work. Many experts do not agree on one definition, which also makes it extremely difficult to diagnose. However, it is generally related to stress caused by work, or in certain cases, related to stress that results from caring for a family member that happens gradually over time (Informedhealth.org, 2006).

Causes and Risk Factors

The causes and risk factors of burnout in MHPs are multi-faceted; however, some clear indicators are consistent across studies. Some of these factors include:

1. **Work Overload:** consistent case overload can become a chronic condition that contributes to the depletion of emotional resources while risking that the professional is unable to successfully meet the demands of their role as a caretaker (Maslach & Leiter, 2016; O'Connor et al., 2018).
2. **Lack of Control:** perceived lack of control in the workplace can lead to feelings of inefficacy, and the inability to influence decisions that relate to one's work can trigger a loss of autonomy, potentially leading to emotional exhaustion (Maslach & Leiter, 2016; O'Connor et al., 2018).
3. **Insufficient Reward:** absence of appropriate recognition or financial, institutional, or social reward contributes to stark feelings of inefficacy, leading to a sense of one's work being devalued and underappreciated (Maslach & Leiter, 2016).
4. **Lack of Community and Support:** role conflict, role ambiguity, lack of internal team support, inadequate or lack thereof supervision, lack of trust, unresolved conflict, and poor relationships with colleagues contribute to depersonalization (Maslach & Leiter, 2016; O'Connor et al., 2018).
5. **Absence of Equity or Fairness:** mistreatment or unfair handling of issues related to equity and social justice in the workplace can provoke a sense of cynicism, anger, or hostility, leading to depersonalization (Maslach & Leiter, 2016).
6. **Inadequate Organizational Values:** dissonance between personal and workplace values, or lack thereof, may result in a lack of motivation and a reduced sense of accomplishment (Maslach & Leiter, 2016).

While various factors are involved in the causes of burnout, there is a clear link between the combination of individual, organizational, and job-related factors that can increase the overall prevalence of burnout in MHPs.

Symptoms and Warning Signs

According to Informedhealth.org (2006), the symptoms of burnout can be categorized according to the three aforementioned dimensions (emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment). The following table (Table 1.0) categorizes the symptoms associated with each dimension.

Table 1.0

Burnout Symptoms Classified by Dimension

Burnout Symptoms Classified By Dimension	
Emotional Exhaustion	<ul style="list-style-type: none"> ● Feeling drained ● Feeling down ● Inability to cope ● Fatigue ● Extreme emotional, physical or mental exhaustion ● Physical pain ● Gastrointestinal issues
Depersonalization	<ul style="list-style-type: none"> ● Alienating oneself from work-related activities ● Cynicism towards working conditions ● Cynicism towards colleagues ● Becoming emotionally distant towards patients or clients ● Feeling numb towards one's work
Reduced Sense of Personal Accomplishment	<ul style="list-style-type: none"> ● Negative outlook towards work-related tasks ● Difficulty concentrating ● Lack of creativity ● Feeling listless

In a recent study conducted by Tavella, Hadzi-Pavlovic, and Parker (2021), it was proposed that the three-dimensional burnout model should be expanded to a unidimensional model that would also include cognitive impairment and social withdrawal as defining factors of the syndrome.

Warning signs may vary but could include anxiety, headaches, insomnia, detachment, absenteeism, irritability, frustration, hypertension, muscle tension, low immunity, body aches, and drug or alcohol abuse (Ada.com, 2022). Burnout syndrome is not currently listed as a mental disorder in the DSM-5; therefore, there has not yet been an established set of symptoms and warning signs agreed upon by medical experts and professionals.

Treatment and Prevention

There do not yet exist any agreed-upon methods for either treatment or prevention. Burnout is a complex issue comprised of both personal and situational factors. As a result, each case is unique in its structure and any intervention must uniquely approach the personal and situational factors present. Currently, interventions very often tend to be ad hoc and reactive, rather than preventive in nature (Johnson et al., 2018). However, evidence supports multifaceted strategies for addressing burnout, although more research is needed on a larger scale to determine effective treatments and preventive care.

According to Maslach and Goldberg (1998), several approaches to burnout prevention could be followed. However, what must happen first is a clear establishment of the definition of burnout, alongside a model that identifies specific outcomes as they relate to the factors involved, followed by a tool to assess and measure current levels of burnout present in the patient (Maslach & Golberg, 1998). Then, possible approaches can be categorized as follows:

1. **Person-focused Solutions:** this approach assumes that the individual has the power to overcome; however, it is flawed to place the full burden of responsibility on the individual alone since situational factors are always involved. Nonetheless, providing coping strategies, building resilience, and offering additional social resources is more cost-efficient and easily implemented (Maslach & Goldberg, 1998). Specific examples identified are summarized as follows.
 - a. Lessen the work or caseload or adjust work hours (Maslach & Goldberg, 1998).

- b. Focus on developing coping strategies that entail cognitive restructuring, enabling the patient to change how they respond to stressful situations (Maslach & Goldberg, 1998).
 - c. Seek personal support from communities, as well as professional support from colleagues to lessen feelings of isolation (Maslach & Goldberg, 1998).
 - d. Incorporate relaxation strategies, such as meditation or mindfulness, and activities/hobbies that can promote positive interests and feelings (Maslach & Goldberg, 1998).
 - e. Improve physical health through a healthy diet and regular movement practice (Maslach & Goldberg, 1998).
 - f. Increase self-analysis and self-awareness, though how this can be done is not specified (Maslach & Goldberg, 1998).
2. **Organization-focused Solutions:** this involves implementing changes that would operate at the organizational level, inherently impacting the situation that is causing high rates of burnout and potentially changing the job experience itself (Johnson et al., 2018). Some examples include the following:
- a. Offering education interventions to employees.
 - b. Implementing changes in employee work schedules.
 - c. Providing training that focuses on teamwork.

It is arguably more challenging to implement change at an organizational level, especially in individualistic Western societies where the focus is often on how an individual can better themselves. However, some evidence suggests that taking a holistic approach and implementing a non-dual psychotherapeutic methodology based on transpersonal psychology can help address the root cause of the issue (Tzu, Bannerman, & Hill, 2017). The literature theorizes that by facing existentialist factors involved, such as a loss of meaning in one's work, addressing burnout can become an opportunity for healing by accepting the totality of one's flaws and moving towards a state of wholeness (Tzu et al., 2017). Perhaps the efficacy of holistic approaches is the very reason that DMT has been implemented as a treatment option in helping the patient return to a state of wholeness.

A meta-analysis that was conducted on 15 studies and included 1,565 participants examined whether mindfulness-based training could have a positive impact on reducing stress

levels and the risk of burnout in nurses (Wang et al., 2023). The literature suggests that mindfulness-based interventions (MBIs) have been proven effective as a form of psychotherapy due to their focus on developing self-regulation tools aimed at focusing on the present moment (Wang et al., 2023). Neuroimaging studies have also successfully demonstrated its efficacy at the molecular level by observing positive changes in the brain after long-term implementation of mindfulness practices, which has led to meaningful self-improvement in practitioners (Wang et al., 2023). In conclusion, the study confirmed that mindfulness-based interventions have indeed been shown to effectively reduce burnout levels in the nursing population (Wang et al., 2023).

Maslach's Multidimensional Model of Burnout

Maslach's multidimensional model of burnout emphasizes the three key dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. It suggests that burnout arises due to a mismatch between an individual's resources and the demands placed upon them in the workplace. This model provides a conceptual framework for understanding the development of burnout and guiding interventions to prevent or treat it and led to the development of Maslach's Burnout Inventory (MBI), a tool developed to ethically measure the three dimensions of burnout separately (Maslach & Leiter, 2021).

Burnout and Mental Health Professionals

MHPs are particularly susceptible to burnout due to the nature of the work being a helping profession. A systematic analysis found that 21-67% of MHPs were likely experiencing high levels of burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Of the MHPs who were surveyed, 54% were found to be experiencing high levels of emotional exhaustion and 38% reported high levels of depersonalization (Morse et al., 2012). Burnout can negatively impact mental health, overall job satisfaction, and personal feelings of efficacy. Additionally, it can negatively impact the quality of care provided to patients, creating high risk and possible liability for organizations, suggesting that the impact of burnout is detrimental to all parties involved (Morse et al., 2012).

Compassion Fatigue

It was not until the 1980s that the term CF was first used. The term was coined by Joinson, a researcher who was investigating the effects of burnout on nurses. Initially, it was used to describe a state in which the nurses were somehow no longer capable of nurturing their patients (Stoewen, 2019). Since its first usage, the term has evolved to describe a phenomenon affecting not only nurses but anyone who works in caretaker professions, such as MHPs, social workers, police officers, and even veterinarians.

Compassion fatigue refers to “a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, persistent arousal (e.g., anxiety) associated with the patient” (Figley, 2002, p. 1435). The term can be used synonymously with secondary traumatic stress disorder (STSD), a syndrome in which a person is exposed to the suffering of another by either bearing witness, having the desire to help, or being in the position of actually helping a traumatized victim (Figley, 2002). This literature review aims to provide an overview of CF, its causes, symptoms, potential treatment or prevention methods, and how it impacts MHPs in the current landscape of caregiver work.

Understanding Compassion Fatigue

While CF is similar to burnout in terms of the manifestation of the symptoms, there is an important differentiating factor. Experts believe that CF happens as a result of both burnout and STSD, which means that one must be experiencing burnout in combination with STSD as a result of their work to reach a state of CF (Stoewen, 2019; Garnett, Hui, Oleynikov, & Boamah, 2023). When both factors are present, the afflicted person is then at risk of experiencing a lessened ability to demonstrate compassion towards patients as a result of the long-term exposure to their suffering, despite the genuine desire to alleviate the patient’s pain and suffering (Garnett et al., 2023). The inability to liberate the patient from their anguish over a prolonged period is what leaves the afflicted feeling unable to meet work demands, thus feeling unable to alleviate one’s stress load, leading to emotional exhaustion and CF (Stoewen, 2019).

Causes

Although CF is a relatively recent concept that has been circulating in the literature related to burnout and STSD, some researchers have asserted that some specific causes predispose certain individuals. Research indicates that MHPs who work with traumatized individuals are often at greater risk (Babbel, 2012). Figley (2002) has conducted extensive research on the topic and developed an etiological model, which relies on the assumption that CF is caused by both empathy and emotional energy, and can be broken down and summarized as follows:

1. **Empathic Ability:** depends on the MHP's aptitude for feeling empathy towards their patients - the ability to be empathic influences the depth at which one can experience compassion (Figley, 2002).
2. **Empathic Concern:** deals with both the motivation to help the suffering patient and the ability to feel genuine concern, which moves the MHP to action (Figley, 2002).
3. **Exposure to the Client:** direct exposure to the patient's suffering and emotional energy [which could also be viewed as transference] and its effect on the MHP (Figley, 2002).
4. **Empathic Response:** efforts made by the MHP to decrease the patient's suffering through empathic understanding and the degree to which this attempt is made through the therapeutic relationship (Figley, 2002).
5. **Compassion Stress:** impact of the patient's emotional energy as a result of the MHP's empathic response [which could be viewed as countertransference] and the never-ending need to alleviate the patient's suffering (Figley, 2002).
6. **Sense of Achievement:** when an MHP's sense of achievement is positive it can lower the risk of compassion stress (Figley, 2002), which suggests that if the opposite is true it could heighten it.
7. **Disengagement:** an MHP's ability to distance themselves from compassion stress induced by the therapeutic relationship, with a high capability of decreasing the risk (Figley, 2002) while a low capability could increase it.
8. **Prolonged Exposure:** the level of ongoing exposure to the suffering of the patient, with breaks providing respite and longer breaks yielding a higher positive impact on the MHP (Figley, 2002).

9. **Traumatic Recollection:** memories from the MHP's personal history that trigger past experiences of PTSD as a result of the MHP relating their own experiences to those of the patient (Figley, 2002).
10. **Life Disruption:** unexpected shifts or changes to the MHP's personal or work life that cause a significant level of distress (Figley, 2002).

The presence of these factors is causal in the experience of the MHP and provides a foundational model for MHPs to help diagnose those afflicted. Additionally, in a study conducted on MHPs, "burnout was found to be the strongest predictor of CF" (Ondrejková & Halamová, 2022, p. 1682). This suggests that while burnout and CF can function as two separate diagnoses, they are also in fact highly relevant to one another and can indeed impact the proliferation of CF in MHPs.

Symptoms

To understand the symptoms of CF, we must first examine the symptoms of STSD. The symptoms of STSD are almost identical to those of post-traumatic stress disorder (PTSD) - the only difference is that STSD is experienced secondhand through having access to knowledge of the initial trauma or suffering experienced by another, and PTSD is the result of trauma experienced firsthand (Figley, 2002). According to Gentry, Baranowsky, and Dunning (2002, p. 126), STSD symptoms include:

- Heightened feelings of negative arousal
- Intrusive thoughts
- Mental images of another's traumatic experiences
- Difficulty separating personal life from work life
- Lowered patience or tolerance to frustration
- Increase in angry or rage-filled outbursts
- Sense of dread when having to work with specific individuals
- Depression
- Ineffective and/or self-destructive soothing behaviors
- Hypervigilance
- Lessened feelings of competency in one's work abilities
- Diminished sense of purpose

- Decreased enjoyment of one's career
- Lessened ability to function in non-professional situations
- Hopelessness

It is important to acknowledge that STSD typically has a sudden onset, unlike burnout which displays more gradually (Beck, 2011). Also, it is important to distinguish STSD from vicarious traumatization for questions of conceptual clarity (Beck, 2011).

According to Singh, Karanika-Murray, Baguley, and Hudson (2020) CF manifests through a range of symptoms that can affect individuals physically, emotionally, and behaviorally, including:

- Chronic physical and emotional exhaustion
- Depersonalization
- Feelings of inequity
- Touchiness
- Headaches
- Weight loss
- Negative feelings towards work, life, and people outside of the therapeutic relationship
- Self-contempt
- Low levels of job satisfaction
- Psychosomatic conditions
- Absenteesim
- Substance abuse

CF can significantly impact an individual's well-being, professional performance, and overall quality of life. These effects can potentially affect the quality of care that is then delivered to the patients of the afflicted individual detrimentally.

Treatment and Prevention

While additional research is necessary to provide viable and research-backed treatment options for CF, the literature provides possible intervention methods based on systematic reviews of existing studies. The following table (Table 2.0) breaks down possible interventions according to professional, organizational, and individual strategies based on research conducted by Vu and Bodenmann (2017).

Table 2.0*Intervention Strategies for Compassion Fatigue*

Intervention Strategies for Compassion Fatigue	
Professional	<ul style="list-style-type: none"> ● Acknowledging CF as a very real possibility when working in caregiver and helping roles ● Increasing overall awareness and providing education for at-risk professionals about the signs and symptoms ● Monitoring caseloads and diversifying workloads to limit or mitigate the risk
Organizational	<ul style="list-style-type: none"> ● Providing necessary clinical skills and satisfactory knowledge of theoretical principals to lessen the risk and encourage further coping skills development ● Regular formal and informal debriefings with colleagues ● Regular individual and group supervision ● Implementing practices that can support at-risk professionals rather than creating ad hoc solutions in response to crisis management
Individual	<ul style="list-style-type: none"> ● Receiving education about CF in an effort to increase self-awareness ● Honing resiliency skills and further developing healthy coping mechanisms ● Establishing healthy self-care practices ● Focusing on self-compassion ● Setting clear boundaries between one's personal and work life ● Maintaining a healthy work-life balance ● Participating in regular movement and creative activities ● Establishing a healthy and supportive network of friends and colleagues ● Developing a spiritual practice or practicing meditation

In addition to the above-mentioned interventions, a specific program called the Accelerated Recovery Program (ARP) for Compassion Fatigue has been developed in an effort to help helping professionals access and develop comprehensive tools for combating CF (Figley, 2002; Vu & Bodenmann, 2017; Gentry et al., 2002). The program offers assessment tools, identification of symptoms and triggers, as well as ample discussion around the importance of developing a self-care plan (Vu & Bodenmann, 2017). Johnson (2020) suggests that self-care is the ultimate antidote to CF; therefore, focusing on establishing a strong individual self-care practice appears to be a clear mitigator of CF. Ondrejková and Halamová (2022) confirm that self-compassion is a potential factor that may decrease the risk of both CF and burnout.

A recent study was designed to provide an intervention that introduced mindfulness and the concept of CF to a group of educators working in a violent urban school district with the intent of testing whether mindfulness-based approaches could prove to be an effective treatment for reducing CF (Maley, 2018). The approach was to implement mindfulness-based stress reduction (MBSR), which is “an evidence-based self-care strategy that can be utilized to prevent and reduce compassion fatigue” (Maley, 2018, p. 53). Rooted in Buddhist mindfulness practices, the program is oriented toward developing self-awareness and recognition of what is occurring in the present moment (Maley, 2018). The study concluded that MBSR and mindfulness are effective interventions in reducing compassion fatigue in educators (Maley, 2018).

Impact on Mental Health Professionals

Evidence suggests that helping professionals are at a higher risk of experiencing CF and the impact can be particularly profound. Overall, there is a varying degree to which distinct helping professionals experience CF (Ondrejková & Halamová, 2022). A study conducted in 2002 found that “27% of professionals who work with the traumatized experienced extreme distress from this work” (Figley, 2002, p. 1435). Of the same population that was surveyed, 54.8% percent of the participants reported distress and another 35.1% were “very or extremely emotionally drained” (Figley, 2002, p. 1435). Considering these statistics, it is evident that addressing and preventing CF in this population is crucial. By incorporating self-care routines, professional support, and organizational and individual interventions, MHPs can mitigate the impact of CF, ensuring high-quality care and promoting their mental health.

Physical Pain During Somatic Countertransference

As psychoanalysis has evolved over the last 100 years, so have its early definitions of the many theories and concepts that shape how it is currently understood. The concept of countertransference was introduced by Freud in 1909 in a letter he wrote to Carl Jung in response to his disclosure of difficulty with his patient, Sabina Spielrein (Stefana, 2015). Unbeknownst to Freud at the time, there was an erotic countertransference happening between Jung and his patient, and they became involved in an affair (Stefana, 2015). However, Freud eventually found out about the romantic nature of their relationship and continued cultivating the concept of countertransference as a result of his observations of the Jung-Spielrein, Brauer-Pappenheim, and Ferenczi-Palos affairs, which allowed him to further develop his initial theories (Stefana, 2015).

It is evident in the literature that the concept of countertransference was initially recognized through erotic enactment. Freud formally introduced the concept at a convention in March 1910, stating, “We have become aware of the ‘counter-transference’, which arises in [the psychoanalyst] as a result of the patient’s influence on his unconscious feelings” (Stefana, 2015, p. 9). While several analysts have tried to name what happens in the process of bodily reactions in the countertransference, describing it as “embodied countertransference”, “somato-sensory countertransference”, or even “body-language countertransference”, it was Bernstein who initially coined the term “somatic countertransference” (Pallaro, 2007). This literature review offers a brief overview of the evolved concept of countertransference and SCT, how SCT can manifest as physical pain in psychotherapists, how it proliferates in the field of psychotherapy given its relation to psychodynamic theory, what may be involved in causing this phenomenon to happen, and its potential impact on the well-being of psychotherapists.

Understanding Somatic Countertransference

Firstly, various theories exist in the literature defining countertransference, thus it is challenging to discern one clear answer that describes definitively what it is. As Loewenthal (2018) suggests, perhaps the challenge originates in the difficulty of describing something that cannot be conceptually understood in its totality. As a result, there does not yet exist only one definition of SCT that is mutually agreed upon by researchers, theorists, psychoanalysts, psychotherapists, or other practitioners of the theory. However, Dosamantes-Beaudry (2007)

explains that in 1997 she defined SCT as “the somatic reactions a therapist has toward her patient at a particular moment during treatment” (p.76). Now she uses the term as such:

to refer to the totality of the patient’s bodily-felt experience and enacted behavior (experienced as bodily-felt sensations and expressed via bodily-felt expressive movement and through kinesthetic and kinetic images) that function as transitional objects for the patient and provide critical relational psychodynamic meaning that at the outset of treatment is unknown to the patient (Dosamantes-Beaudry, 2007, p. 76)

Broadly defined, countertransference is currently understood as “the therapists’ awareness of their own body, of sensations, images, impulses, feelings and fantasies that offer a link to the client's process and the intersubjective field” (Orbach & Carroll, 2014, p. 64), whereas *somatic* countertransference focuses on the reactions that are embodied by the psychotherapist in response to the patient’s enacted experience through the therapist’s bodily sensations. Bernstein recognized the need to transmute the patient’s somatic subconscious by way of embodied subjective and objective experience to catalyze, metabolize, and reintegrate parts of the patient’s self that were previously split off (Pallaro, 2007). SCT provides the psychotherapist with crucial information that is communicated through their physical bodily reactions and often aids the patient in their therapeutic process.

Contributing Factors

Multiple factors have been proposed as potential contributors to the experience of SCT in psychotherapists, including the therapist's personal history, unresolved trauma, and other factors. It can also arise from the therapist's emotional identification with the client, commonly observed in countertransference reactions. The following discusses the types of patients who are likely to elicit the SCT response, as well as the specific situations in which SCT is likely to happen.

SCT is understood to happen with two specific categories of patients. The first category is those who employ defenses to try to control the therapist or anyone else with whom they have contact (Gubb, 2014). The second category of patients who tend to evoke SCT are borderline or psychotic individuals (Gubb, 2014). Samuels (1985) researched the topic extensively and concluded that the patient was the source of SCT and especially susceptible to conjuring it if

dealing with issues related to sex, aggression, or eating (Gubb, 2014). Therefore, psychotherapists who work with these patient profiles will likely experience SCT during their patient interactions and interventions.

Additionally, there are three contexts proposed by Jacobs (1973) in which SCT would be likely to occur. The first is when the patient's disclosure of their experiences activates the therapist's physical recollection of an experience akin to the patient's (Jacobs, 1973); hence, construing a situation of emotional and empathic identification. The second scenario involves repetitive exposure to the patient's past experiences related to severe bodily struggles (Jacobs, 1973). The third, which he emphasizes demands the greatest concern, is the psychotherapist's own history of past experiences (Jacobs, 1973). Consequently, the therapist's role in SCT must be acknowledged, as their function in the dyad is highly relevant to whether the occurrence of SCT shall be embodied or not.

Manifestation of Physical Pain in Psychotherapists During Somatic Countertransference

Samuels (1993) believes that "the analyst's bodily reactions are an important part of the picture: The body is an organ of information" (p. 33). Thus, if the psychotherapist's body is the instrument that receives information and then reacts to it, how this ephemeral lived phenomenon can be better understood in its manifestation is by reviewing documented case studies. As Shaw (2004) asserts through the lens of the concept of the lived-body paradigm, "Our bodies are the means by which we engage with the world; they are how we come to understand our environment and make sense of our place in the world" (p. 274). It is through feeling, sensing, and exchanging non-verbal communication through the body that psychotherapists are capable of experiencing SCT, sometimes by manifestation of physical pain.

Findings relevant to CF consistently indicate that SCT can manifest as diverse physical symptoms, such as headaches, constriction in the body, dizziness, pain, fatigue, and hunger (Babbel, 2012). The embodiment of the MHP's patient's distress, or STSD, has been suggested as a possible explanation for this phenomenon, which also establishes a theory for how it may be linked to CF. Numerous case studies have highlighted the substantial prevalence of physical pain experienced by psychotherapists.

Stone (2006) cites two clinical cases in which physical pain was present in the therapist during SCT. In the first case, a therapist intern detailed to his supervisor a very specific and sudden pain that he felt in the upper extremity of his arm while meeting with a new patient (Stone, 2006). His supervisor's response was, "We must bear that pain in mind as the work proceeds" (Stone, 2006, p. 115). As the therapeutic relationship continued to develop, so did the intensity of the pain the therapist intern was experiencing (Stone, 2006).

Eventually, the patient shared with the therapist intern the following account from her childhood:

...when she was small, her mother would get into rages, pull her dress or top off, and holding her by her right arm would mercilessly beat her at the top of her left arm with the bristle side of a hair brush, often drawing blood and leaving her bruised and terribly sore. (Stone, 2006, p. 116)

After this disclosure, the pain dissipated and was never felt by the therapist intern again (Stone, 2006).

The second case is a firsthand account of what Stone (2006) experienced with a female patient where erotic transference was potentially present, as she divulged her anxieties that he could become disinterested and bored of her, and she had recently resented no longer attracting men with her good looks. Eventually, the patient expressed her anger that he had set boundaries and would not allow for her to see him whenever she desired (Stone, 2006). Then, Stone (2006) began experiencing severe and chronic neck pain that he associated with the patient's anger towards both him and her mother.

What is unique in Stone's experience is that he states, "These feelings resonated with my own experience of being sent away to boarding school at a young age" (Stone, 2006, p. 117). However, he never succeeded in accompanying the patient in finding resolution and the situation deteriorated in both the therapeutic relationship and his own body. He describes his bodily state as his body being "under assault: tense muscles, tight chest, headache, pain in bum - I wanted to shout to keep her away" (Stone, 2006, p. 117). The ending was traumatic for both of them, although Stone (2006) conceded that he also felt a sense of relief that it had finally ended.

As seen in the case of Stone, symptoms of SCT may become chronic and interfere with the therapist's overall functioning and quality of life. The experience of SCT can impact the therapist during sessions, and when unrecognized or unaddressed, it has the potential to hinder

the therapeutic relationship and even lead to the therapist becoming traumatized by the bodily felt experiences. Forester (2007) understood the impact that a patient's bodily experience could have on that of the therapist's body and psyche through SCT. As Shaw (2004) emphasized, bodily reactions experienced in the therapeutic relationship are most likely connected to both past and present experiences.

Mindfulness-Based Interventions as Potential Treatment Options

Although it is unknown how much of this is linked to somatic countertransference, it is documented that around 20% of the global population suffers from chronic pain (Majore-Dusele, Karkou, and Millere, 2021). In a pilot study that was conducted using mindfulness-based dance movement therapy (MBDMT) as an intervention for patients who were experiencing chronic headaches, several forms of MBIs were tested, such as mindfulness and body awareness techniques, relaxation and release exercises, and creative activities (Majore-Dusule et al., 2021). The study results indicated that MBDMT was not only effective in diminishing the intensity of chronic pain but also in decreasing depression and anxiety symptoms, both of which are also typically present in burnout and CF patients (Majore-Dusule et al., 2021).

Impact on the Well-being of Psychotherapists

The emotional intensity and empathic nature of therapeutic relationships likely heighten the occurrence of physical pain during SCT. Awareness of the potential for SCT to occur is crucial for psychotherapists to maintain their well-being and maintain therapeutic effectiveness.

Using supervision could be an effective strategy for understanding the occurrence of physical pain, as it provides therapists with an opportunity to explore their physical reactions and gain insight into the somatic manifestations of countertransference through reflection and discussion with colleagues. Seeking consultation or support from colleagues and engaging in peer supervision could be another way psychotherapists can address their overall well-being and mitigate the physical impact of SCT. However, understanding that chronic pain as a result of SCT can impact the overall quality of life is crucial (Fisher et al., 2007). Chronic pain can be life-changing and can trigger long-term emotional distress (Fisher et al., 2007). Therefore, if pain appears and persists during the therapeutic process, it is imperative to address what is behind the source of the pain.

Psychotherapists use of body awareness and the impact of unresolved life experiences on their vulnerability to developing physical symptoms during SCT are areas of concern that require additional research. The literature emphasizes the importance of therapists being aware of the SCT and the capacity to work with it, which depends on the practice of somatic awareness (Moneta et al., 2023); however, there is not much literature that discusses its impact in the form of case studies and large-scale research projects.

By recognizing the usefulness of SCT in the therapeutic relationship, psychotherapists can better navigate both the emotional and physical complexities of their work and may “increase the effectiveness of therapy and reduce the risk of vicarious traumatization to the therapist” (Rand, 2003). Moreover, fostering a culture of self-awareness, self-care, and ongoing professional support within the field can contribute to healthier therapeutic relationships and optimal outcomes for both the therapists and patients. Understanding the causes and underlying factors contributing to physical pain in the SCT can assist psychotherapists in recognizing and effectively managing these experiences to optimize their well-being and provide effective treatment to their patients.

Method

The purpose of this cross-sectional study is to understand whether having a strong support system and self-care practices in place while working with patients may be able to lower the risk of Dmts reaching a state of burnout, experiencing CF, and/or dealing with physical pain through SCT. Currently, no studies exist that have investigated methods that could be beneficial to Dmts for such issues that, as the literature demonstrates, are pervasive among psychotherapists as a broader audience and in helping professions in general.

Research Tools and Keywords

A range of online research tools have been accessed to scope out both literature and best practices for investigation methods. The specific research tools include APA, Google Scholar, Lean Library, Perplexity, Proquest, ResearchGate, Sourcley, the UAB Online Library, and Zotero. The tools were used to search for academic articles, blogs, websites, and other relevant materials.

The main keywords used were burnout, CF, SCT, and self-care practices. However, there were additional sub-topics that were researched that were related to the main topics. The following table (Table 3.0) highlights the main keywords and sub-topics targeted in the literature reviews:

Table 3.0

Keywords

Keywords	
Burnout	Maslach's model of burnout, mental health professionals
Compassion Fatigue	ProQOL, psychotherapists
Somatic Countertransference	physical pain, Numeric Rating Scale, prevalence of physical pain
Self-care Practices	mindfulness, mindfulness-based intervention

Data Collection

Data collection took place in the form of an online survey that was available from October 15th, 2023 until November 16th, 2023. The online survey was distributed online through social media (Facebook, Instagram, and LinkedIn) via posts, stories, and private messages that were sent to the Asociación de Danza Movimiento Terapia Bolivia, Colectivo de Danza Movimiento Terapia Uruguay, the Pennsylvania Chapter of the American Dance Therapy Association, the European Association of Dance Movement Therapy, and the Network of Dance Movement Psychotherapists Greece. It was also emailed to the American Dance Therapy Association, the Association for Dance Movement Psychotherapy UK, and the Asociación de Danza Movimiento Terapia de España, who then circulated the online survey within their respective networks. See Appendix A to access the link to the questionnaire.

Ethical Considerations

All participants were asked to provide consent to use their anonymous data for research purposes by selecting, “Yes, I consent” to proceed with data collection. Participants were unable to proceed if they had answered, “No, I do not consent”. Contact information was provided to participants to allow them to ask any questions deemed necessary before providing their anonymous data to the study. Since the study involved DMT students and currently practicing Dmts, their privacy must be protected. All data collected shall remain completely anonymous and no information has been included that may lead to identification of the participant. The participants’ consent to report the findings was obtained and their confidentiality shall be ensured and protected at all times.

Quantitative Data Measures

The online survey used two scales of measurement: the Professional Quality of Life Scale (ProQOL) 5 and the Numerical Rating Scale (NRS). A self-report questionnaire that included the ProQOL 5 was used to measure levels of burnout, secondary traumatic stress (STS) or CF, and compassion satisfaction in the online survey. The NRS was used to assess whether Dmts were experiencing any physical pain while currently practicing.

The ProQOL 5 was developed by Stamm (2010) to provide a measurable tool in which those who work in helping professions could assess their current (within a period of the last 30 days at the time of taking the test) levels of burnout, STS (CF), and compassion satisfaction in questionnaire format. There are 30 questions total, and each can be answered using a sliding scale of 1 to 5 with the following measurements: 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = very often. Instructions are provided for how to accurately measure the responses to categorize them and calculate the presence of burnout, STS (CF), and compassion satisfaction for each participant. Permission was obtained from www.proqol.org to use the ProQOL 5 in this research study. See Appendix B for a copy of the ProQOL 5 and Appendix C for a copy of the ProQOL 5 scoring instructions.

The NRS was used to measure levels of physical pain present within the last 24 hours using an 11-point scale of measurement. Measures correspond to the following: 0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, and 7-10 = severe pain (Williamson & Hoggart, 2005). See Appendix D for a copy of the NRS.

The questionnaire included questions about patient population demographics (type of population and age group); movement practices (boxing, dance, cycling, martial arts, Qigong, running, sports, stretching, Tai Chi, weightlifting, walking, yoga, etc.); creative and relaxation activities (coloring, deep breathing, drawing, journaling, mindfulness, meditation, painting, reading, relaxation, visualization, etc.); and therapeutic and group activities (acupuncture treatment, chiropractic treatment, intervision, osteopathic treatment, physical therapy, psychotherapy, supervision, support group, etc.). Participants were asked to respond according to activities they have participated in within the last 30 days and they were also asked to indicate how often they have engaged: once a month, twice a month, a few times a month, once a week, 2-3 times per week, 4-6 times per week, daily, or “I do not engage in any of those activities.”

Qualitative Data Measures

The participants were also asked to provide text-based responses to questions pertaining to their personal situations. The following questions were included:

- If any, which of the above-mentioned activities do you typically engage in to manage any physical or emotional stress?

- Is there anything else not mentioned above that you typically do to manage your physical or emotional stress?
- Are you typically successful in managing your physical or emotional stress with any of the activities you engage in or anything else you mentioned?
- Do you feel that you have a strong support system?
- Do you believe that your support system helps you manage your physical and emotional stress?

These quantitative questions were asked to provide insight into what the Dmt participants are doing to effectively manage their physical or emotional stress levels or successfully avoid reaching a state of burnout or compassion fatigue if indeed their risk is low.

Research Sample

The research sample consisted of 15 female participants who were DMT students currently completing their clinical practice internships, currently practicing Dmts, or Dmts who were not currently practicing. All data collected from the non-practicing Dmts was omitted from the data analysis because the questions were contingent upon experiencing symptoms or engaging in activities within the last 24 hour to 30 day period.

Data Analysis

The following figures represent the data collected from the online survey and were categorized according to how they appeared in the online survey. The analysis has been organized into the following sections: Dmt demographics, ProQOL 5 results, NRS results, patient demographics, self-care practice results, and additional qualitative data results. The results have been quantified using Google Sheets bar graphs and pie charts.

Demographics of the participating Dmts included age (Figure 1.0), gender identity, and ethnicity (Figure 1.1). The data indicated that 23.1% of the participants were between the ages of 27-42, while 76.9% of the participants were between the ages of 43-58 at the time they completed the survey. All respondents identified as female, and 61.5% indicated their ethnicity was White or Caucasian, while 38.5% of participants indicated their ethnicity was Hispanic or Latino.

Figure 1.0
Age of Dmts

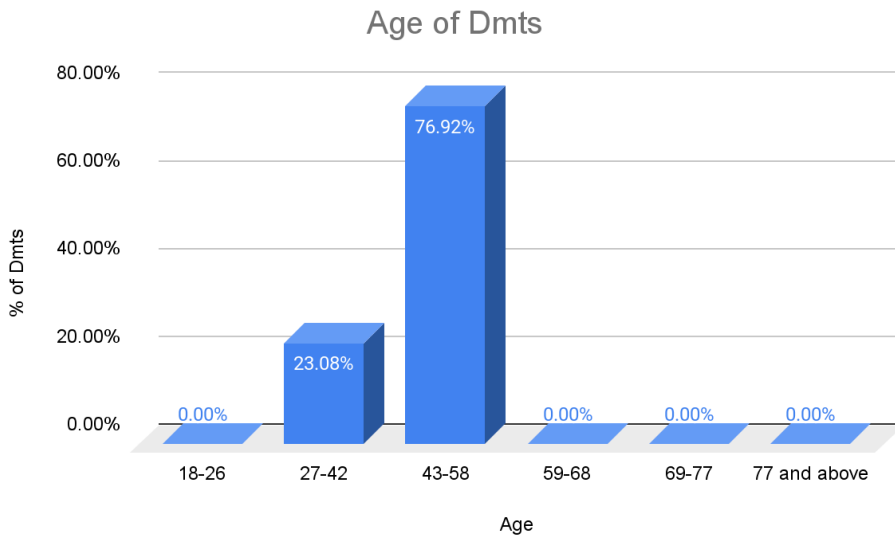
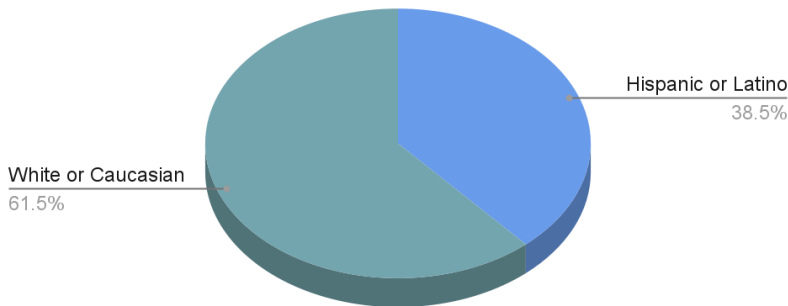


Figure 1.1
Ethnicity of Dmts

Ethnicity of Dmts

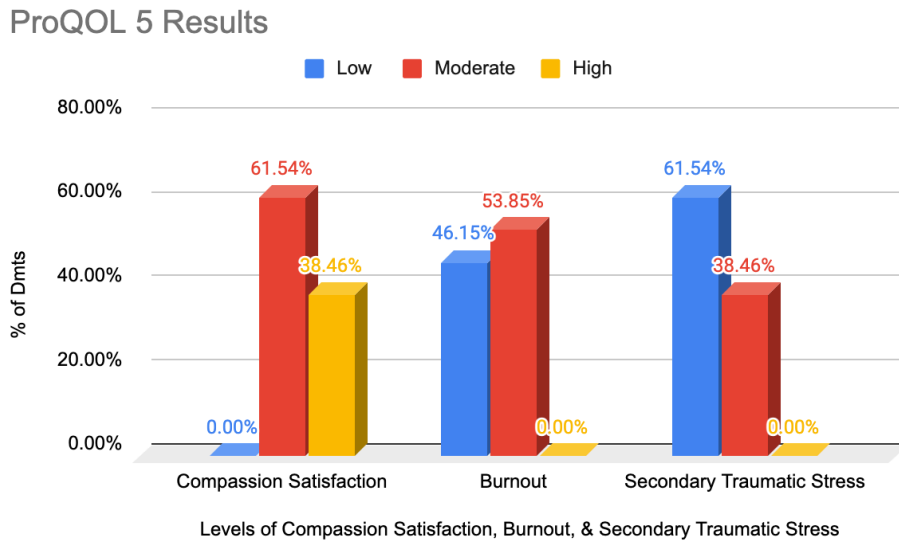


Next, the results of the ProQOL 5 (Figure 2.0) were calculated following the methodology provided by www.proqol.org for self-reporting (see Appendix C). The data measured levels of compassion satisfaction, burnout, and STS (CF) based on the Dmts' experiences from the last 30 days. The data reported that 61.54% were experiencing moderate levels of compassion satisfaction, and 38.46% indicated high levels, while none reported low levels. When measuring the results for the risk of burnout, it was found that 46.15% were experiencing low levels, while 53.85% reported moderate levels. None reported high levels of

burnout. The results for STS (CF) indicated that 61.54% were experiencing low levels of STS, 38.46% were experiencing moderate levels, and none were experiencing high levels.

Figure 2.0

ProQOL 5 Results

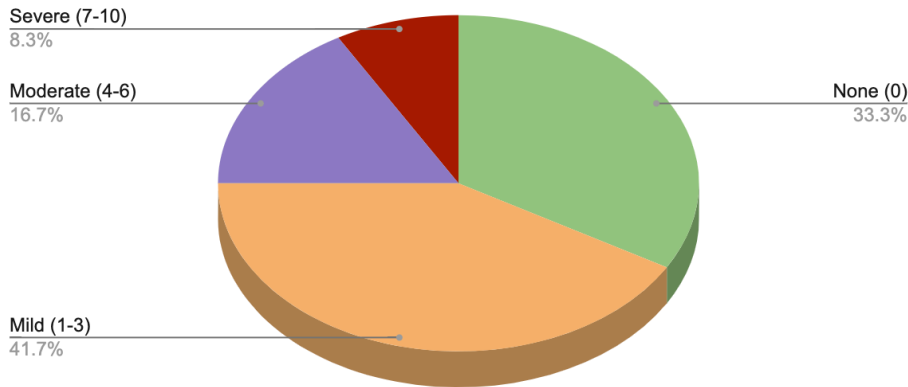


The results of the NRS (Figure 3.0) were calculated by taking the average of three figures (following the instructions in Appendix D) that measured reports of pain within the last 24 hours. The figures included current pain intensity, the best pain level, and the worst pain level. Of the Dmts who responded, 33.3% reported no current pain, 41.7% reported mild pain levels, 16.7% indicated moderate pain levels, and 8.3% were experiencing severe pain levels.

Figure 3.0

Numerical Rating Scale Results

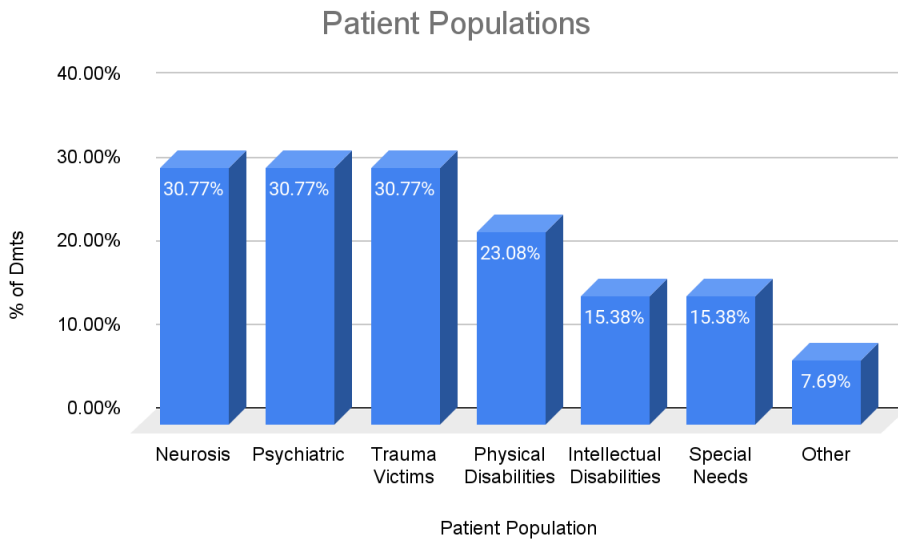
Numerical Rating Scale Results



An analysis of the Dmts' current patient populations (Figure 4.0), age of the populations (Figure 4.1), and frequency of the patients experiencing pain (Figure 4.2) before, during, or after a DMT session followed. The patient populations identified and the percentage of Dmts who were working with them are as follows: 30.77% work with neurosis patients, psychiatric patients, or trauma victims; 23.08% work with people with physical disabilities; 15.38% work with people with intellectual disabilities or special needs patients; and 7.69% work with Alzheimer's patients, cancer survivors, immigrants, families with behavioral issues, or patients with chronic or terminal illnesses. The patient age demographics and percentage of Dmts working with them were: 15.38% babies (0-1 year of age), 15.38% children (2-12 years of age), 15.38% adolescents (13-17 years of age), 92.31% adults (18-64 year of age), and 30.77% older adults (65 years of age and above). Lastly, Dmts indicated how often their patients were experiencing pain before, during or after a DMT session according to the following scale: Never = 0, Rarely = 1, Sometimes = 2, Often = 3, Almost Always = 4, and Always = 5. Of the Dmts surveyed, 30.8% indicated their patients were rarely experiencing pain, 23.1% shared that sometimes they were experiencing pain, 15.4% said the patients were often experiencing pain, and 30.8% stated that they were almost always experiencing pain.

Figure 4.0

Patient Populations



Other = Alzheimer's patients, cancer survivors, immigrants, families with behavioral issues, patients with chronic or terminal illnesses

Figure 4.1

Percentage of Dmts Working With Each Age Group

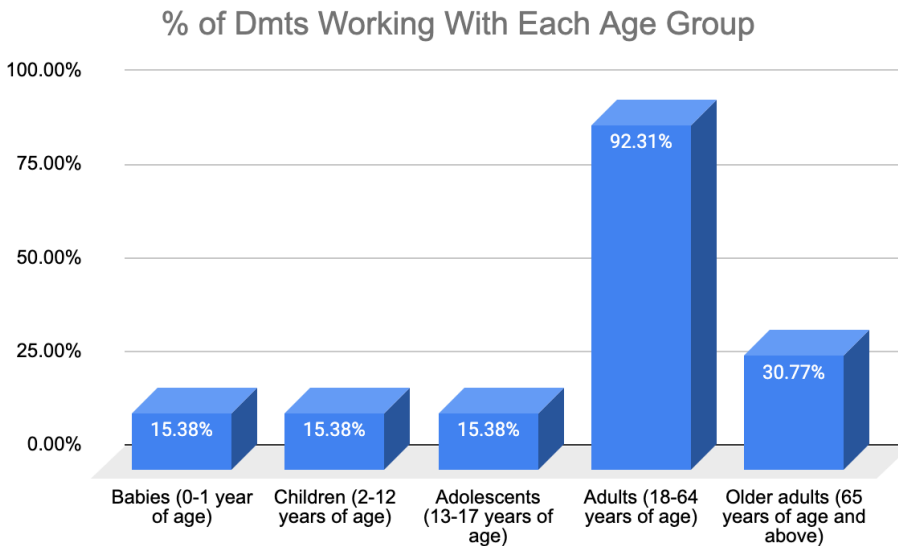
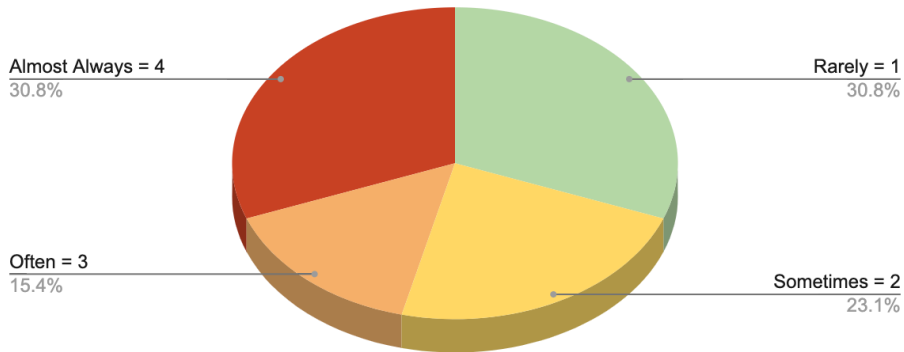


Figure 4.2

How Often Patients Reported Pain Before, During, Or After A DMT Session

How Often Patients Report Pain Before, During, Or After A DMT Session

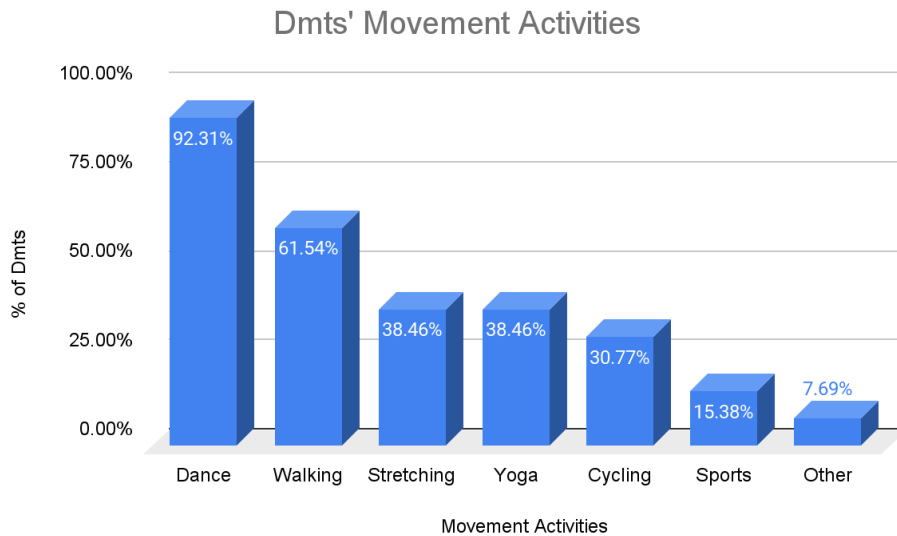


Self-care practices were analyzed according to the following categories: movement activities (Figure 5.0) and frequency (Figure 5.1); creative and relaxation activities (Figure 5.2) and frequency (Figure 5.3); treatment or group activities (Figure 5.4) and frequency (Figure 5.5); activities engaged in to manage physical or emotional stress (Figure 5.6); and other stress-management activities (Figure 5.7).

The findings demonstrated that Dmts engaged in the following movement activities (Figure 5.0) within the last 30 days: 92.31% dance; 61.54% walking; 38.46% yoga or stretching; 30.77% cycling; 15.38% sports; and 7.69% boxing, cycling, Pilates, swimming, Tai Chi, or weightlifting. The results measured the frequency (Figure 5.1) of how often Dmts engaged in any of these activities within the last 30 days and the findings indicate the following: 46.15% engaged 2-3 times per week; 23.08% engaged once a week; 15.38% engaged a few times a month; 7.69% engaged 4-6 times per week or twice a month; and no participants engaged once a month, daily, or not at all.

Figure 5.0

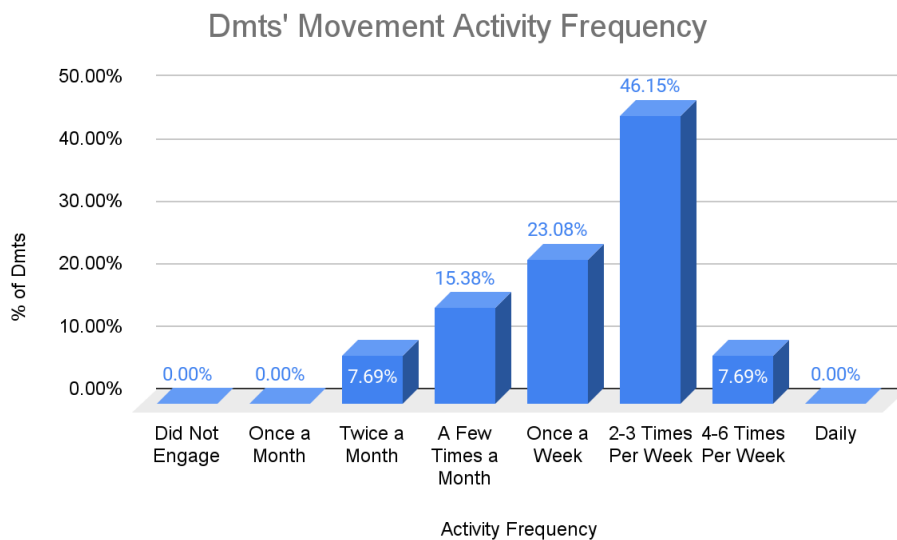
Dmts' Movement Activities



Other = boxing, cycling, Pilates, swimming, Tai Chi, and weightlifting

Figure 5.1

Dmts' Movement Activity Frequency

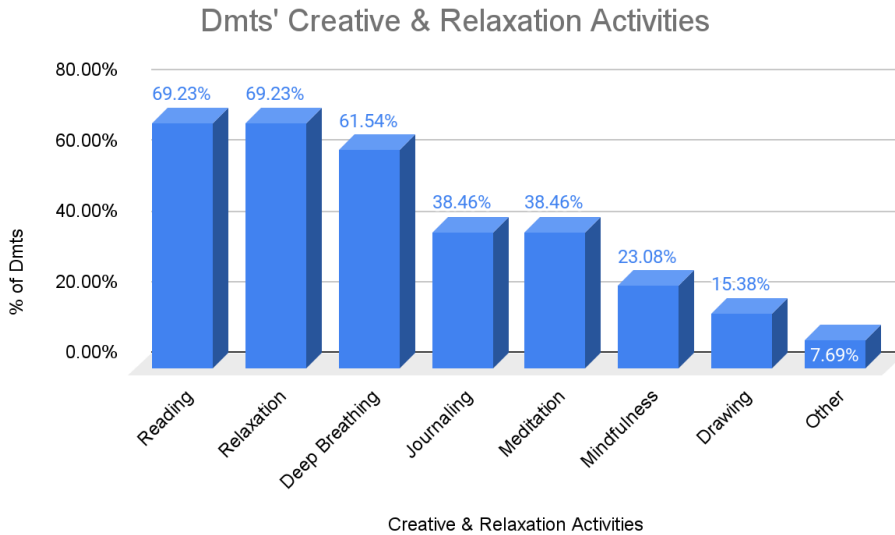


The next set of data analyzed the Dmts' participation in creative and relaxation activities (Figure 5.2) within the last 30 days and measured the frequency (Figure 5.3). The creative and relaxation activities the Dmts participated in were: 69.23% reading and relaxation; 61.54% deep breathing; 38.46% journaling and meditation; 23.08% mindfulness; 15.38% drawing; and 7.69%

percussion, Psych-K, or visualization. The frequency reports indicated the following: 23.08% participated 2-3 times per week, once a week, or a few times a month; 15.38% participated 4-6 times per week; 7.69% participated daily or twice a month; and none participated once a month or never.

Figure 5.2

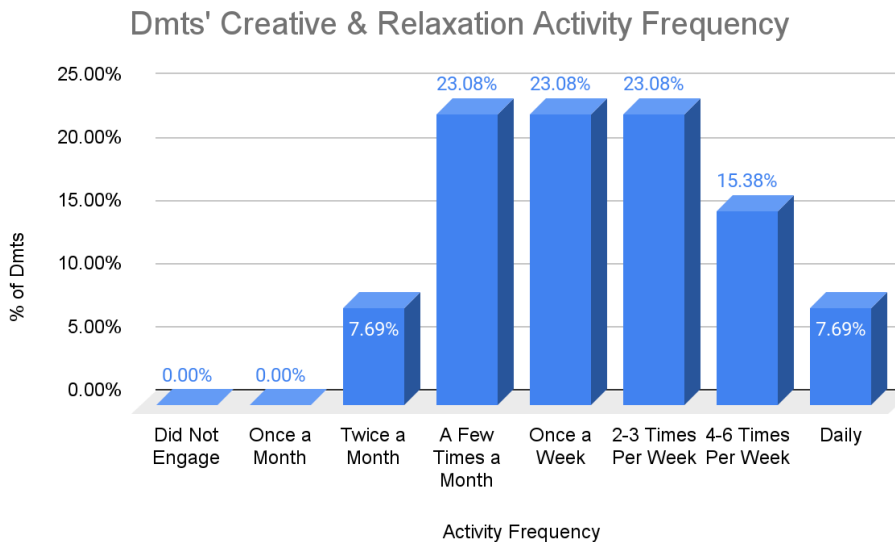
Dmts' Creative & Relaxation Activities



Other = Percussion, Psych-K, and visualization

Figure 5.3

Dmts' Creative & Relaxation Activity Frequency



The following data set examined the Dmts' engagement in treatment or group activities (Figure 5.4) and their frequency. The engagement reports in treatment or group activities are as follows: 53.85% supervision; 46.15% psychotherapy; 15.38% intervention, osteopathy, or physical therapy; 7.69% support group; and 30.77% did not engage. The engagement frequency of such activities was reported as: 23.08% a few times a month, once a week, or 2-3 times per week; 15.38% 4-6 times per week; 7.69% twice a month or daily; and none engaged only once a month or never.

Figure 5.4

Dmts' Treatment or Group Activities

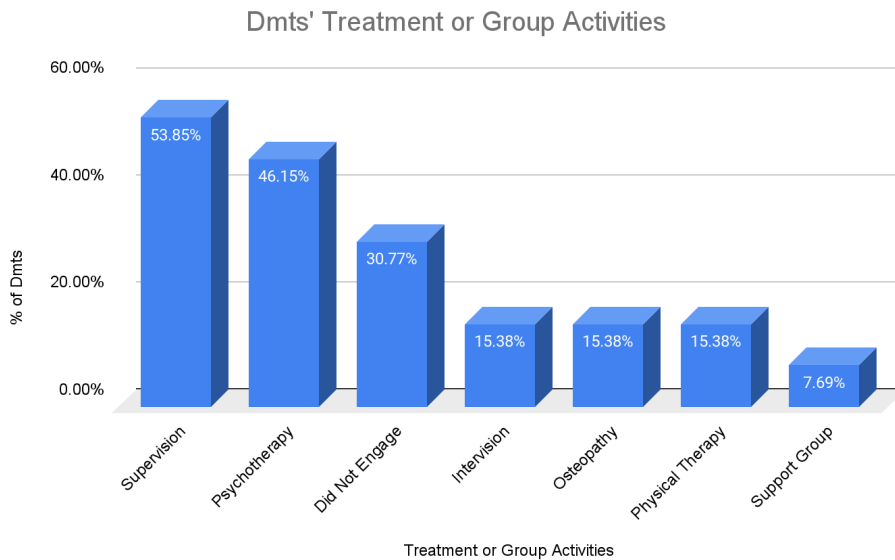
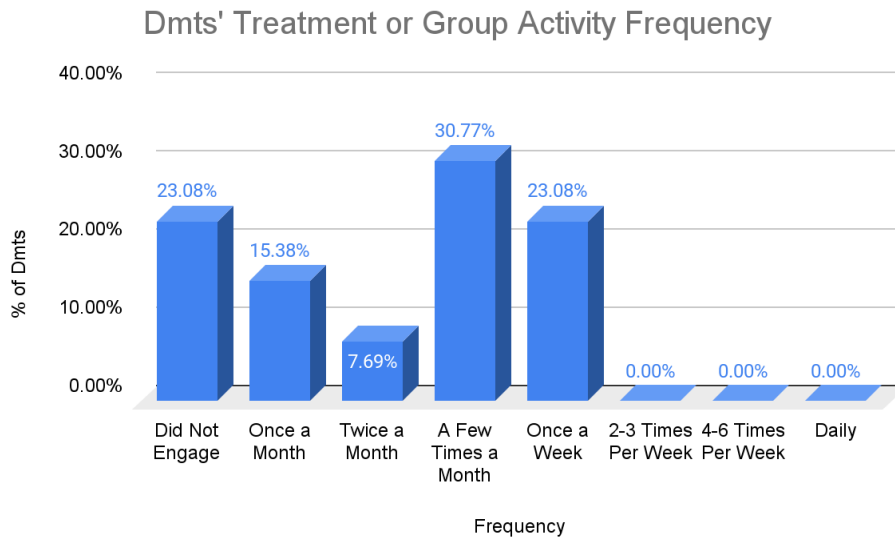


Figure 5.5

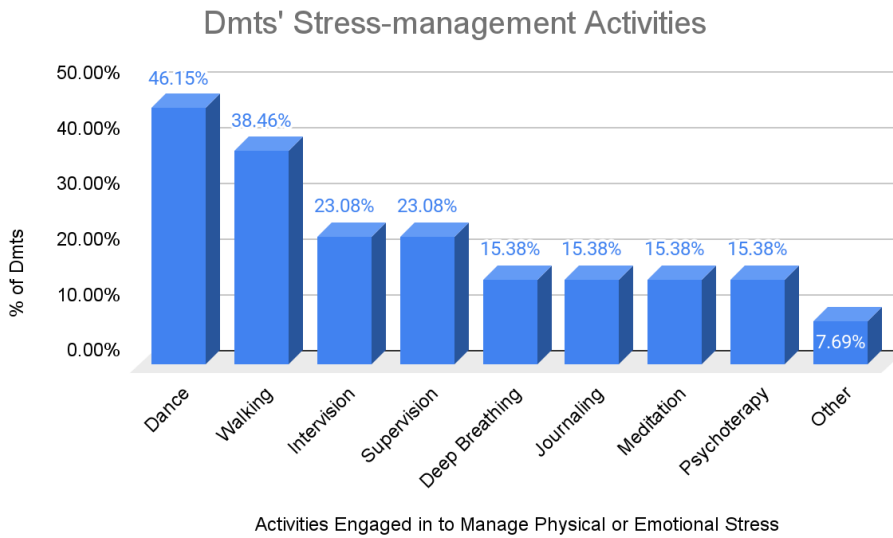
Dmts' Treatment or Group Activity Frequency



Next, the data measured which activities Dmts expressly used to manage physical or emotional stress (Figure 5.6), and gathered insight into what other stress-management activities (Figure 5.7) they had engaged in within the last 30 days that had not previously been mentioned. The activities Dmts reportedly used to manage their physical or emotional stress were: 46.15% dance; 38.46% walking; 23.08% intervision or supervision; 15.38% deep breathing, journaling, meditation, and psychotherapy; and 7.69% the company of friends, group dance, meeting friends, osteopathy, percussion, physical activity, physical therapy, relaxation, singing, attending a support group, or talking to a colleague. Other stress-management activities that the Dmts engaged in were: 23.08% comedic activities (laughing, funny podcasts, or comedy shows); 15.38% beach (sunbathing or swimming), company (embracing someone they love or spending time with friends), massage (self-massage with essential oils or massage therapy), or nature (visiting or walking); and 7.69% cleaning, cooking, crocheting, organizing, playing video games, visiting art galleries, or working with their hands.

Figure 5.6

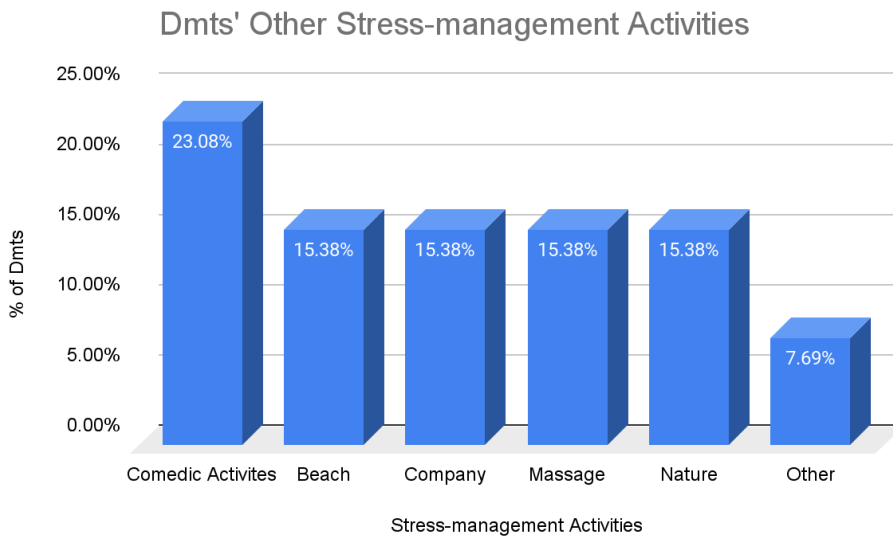
Dmts' Stress-management Activities



Other = the company of friends, group dance, meeting friends, osteopathy, percussion, physical activity, physical therapy, relaxation, singing, attending a support group, and talking to a colleague

Figure 5.7

Dmts' Other Stress-management Activities



Other = cleaning, cooking, crocheting, organizing, video games, visiting art galleries, and working with their hands

The final portion of the analysis measured the Dmts' perceived stress-management success rate (Figure 6.0) resulting from engaging in the activities they reported, perceived presence of a strong support system (Figure 6.1), and whether their support system was perceived to help them with stress-management (Figure 6.2). The perceived stress-management success rate data indicated that 76.92% of Dmts believed they were successfully managing their stress, whereas 15.8% indicated they were not, and 7.69% believed that they sometimes manage their stress successfully. When asked if they feel they have a strong support system, 53.85% reported "yes," 38.46% stated "no," and 7.69% were undecided. Finally, the Dmts were asked if they felt their support system helped them manage their physical and emotional stress, and 76.92% indicated "yes," whereas 23.08% stated that they did not believe their support system helped.

Figure 6.0

Dmts' Stress-management Success Rate

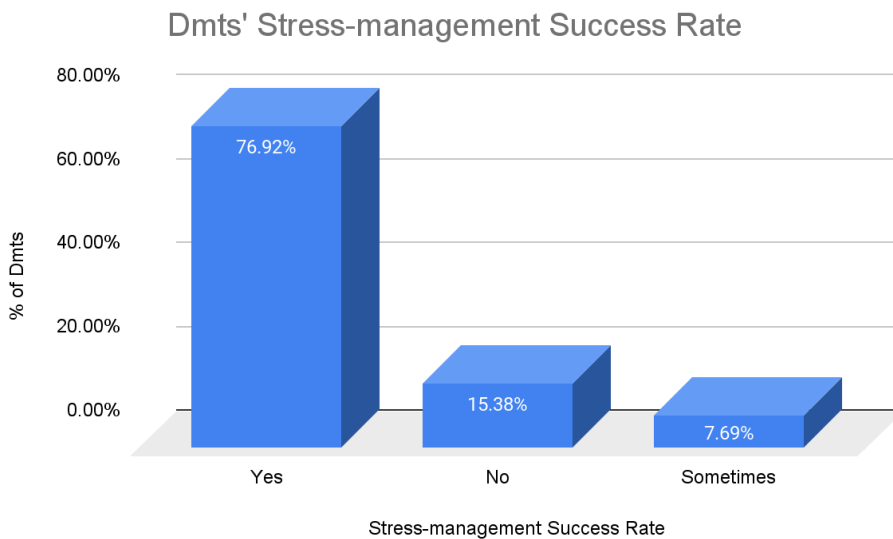


Figure 6.1

Dmts' Presence of a Strong Support System

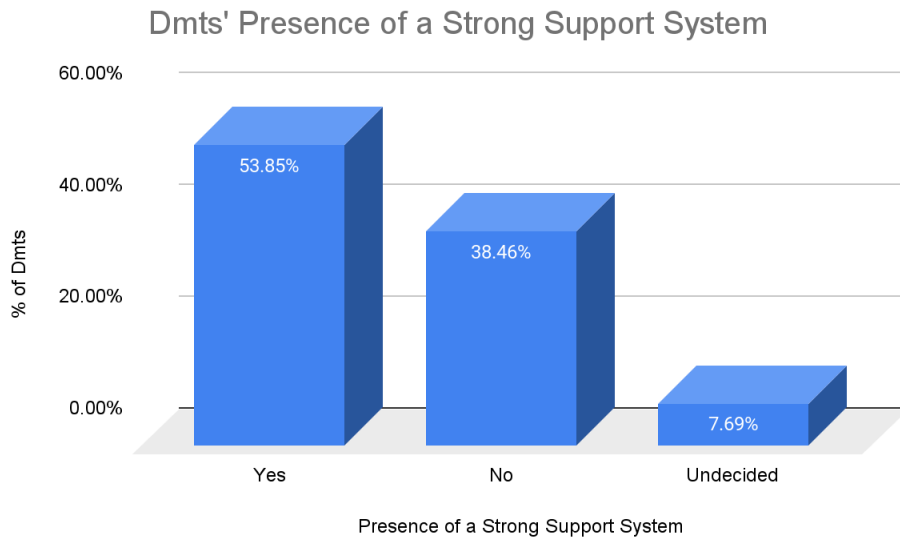
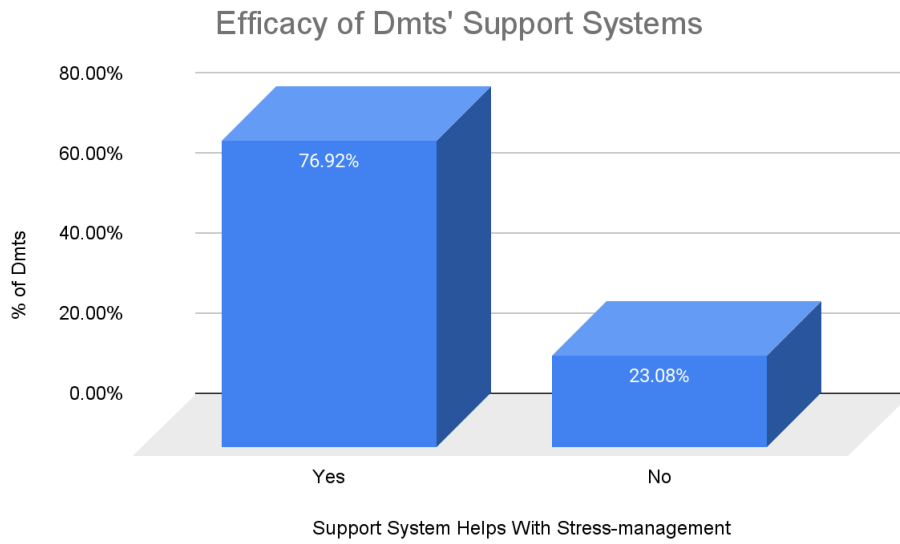


Figure 6.2

Efficacy of Dmts' Support System



Results

The population of this preliminary study consisted of 13 female-identifying participants currently working as Dmts between the ages of 27-58 who were White or Caucasian and Hispanic or Latino. The ProQOL 5 results demonstrated that the Dmts were experiencing moderate-high levels of compassion satisfaction, low-moderate levels of burnout, and low-moderate levels of STS within the last 30 days from the date they participated in the survey. The NRS results confirmed that while approximately 33% were experiencing no physical pain within the last 24 hours, the remaining estimated 67% of the Dmts were experiencing mild-severe pain.

When reviewing the results of the Dmts' patient populations, it was evidenced that the most common patient populations were neurosis patients, psychiatric patients, and trauma victims, and the most common age group was adults between the ages of 18-64, as approximately 92% reported they worked with this age group. The results showed that all patients had reported physical pain before, during, or after a DMT session at least once, with around 31% of the patient population almost always presenting with symptoms of physical pain.

An analysis of the self-care practice activities was done to determine the top activities that the Dmts participated in for each respective category (e.g. movement, creative and relaxation, treatment or group, and stress management). For movement activities, around 92% participated in dance while approximately 62% participated in walking, with about 46% taking part in movement activities 2-3 times per week. The top 3 activities for the creative and relaxation category were reading and relaxation with around 69% indicating they participated, and around 62% participated in deep breathing. The frequency was inconsistent among respondents, with approximately 23% reporting that they partake either a few times a month or 1-3 times per week. The top treatment or group activities were supervision, with around 54% participating, and psychotherapy which had about 46% of participants. Interestingly, around 31% participated in these activities a few times a month, whereas approximately 23% participated either once a week or not all. For the category of activities used to manage physical or emotional stress (stress-management activities), roughly 46% cited dance, and another estimated 38% reported walking. When asked about other stress-management activities used that were not

previously mentioned, around 23% responded with comedic activities, such as laughing, listening to a funny podcast, or watching comedy shows.

The data analysis also measured the perceived stress-management success rate, and qualities relevant to the presence of, or lack thereof a support system. Around 77% percent felt that they were typically successful in managing their physical or emotional stress through the activities they engaged in. Approximately 54% felt they had a strong support system, whereas roughly 38% did not feel they had a strong support system in place, and the remaining estimated 8% were undecided. When asked if the Dmts felt their support system helped them manage their physical and emotional stress, around 77% agreed this was the case, whereas roughly 23% did not feel supported.

During further analysis of the ProQOL data, two important relationships were established: 1) 100% of the participants who scored high for compassion satisfaction also scored low for their risk of burnout and STS (CF); and 2) 100% of the participants who scored moderately for compassion satisfaction also had a moderate risk of burnout and STS (CF). Subsequently, the results were further segmented into these two audiences to gain additional insight into what self-care practices in the categories of movement, creative and relaxation, and treatment or group activities the Dmts who had a low risk of burnout and STS (CF) were participating in versus those who had a moderate risk. Support system data was also reviewed to find out if there was any correlation.

The analysis indicated that Dmts with high compassion satisfaction and a low burnout and STS (CF) risk engaged in the following self-care practices: 1) Movement (Figure 7.0) - 75% dance, and 50% yoga and cycling; 2) Creative and Relaxation (Figure 7.1) - 75% relaxation, and 50% meditation, mindfulness and reading; and 3) Treatment or Group (Figure 7.2) - 100% supervision and 50% psychotherapy. When reviewing their results for the presence of a support system, 100% indicated the presence of a strong support system, and 100% felt that their support system helps them manage their physical and emotional stress (Figure 7.3).

Figure 7.0

Dmts' Movement Activities (High Compassion Satisfaction & Low Burnout / Secondary Traumatic Stress)

Dmts' Movement Activities

High Compassion Satisfaction & Low Burnout / Secondary Traumatic Stress

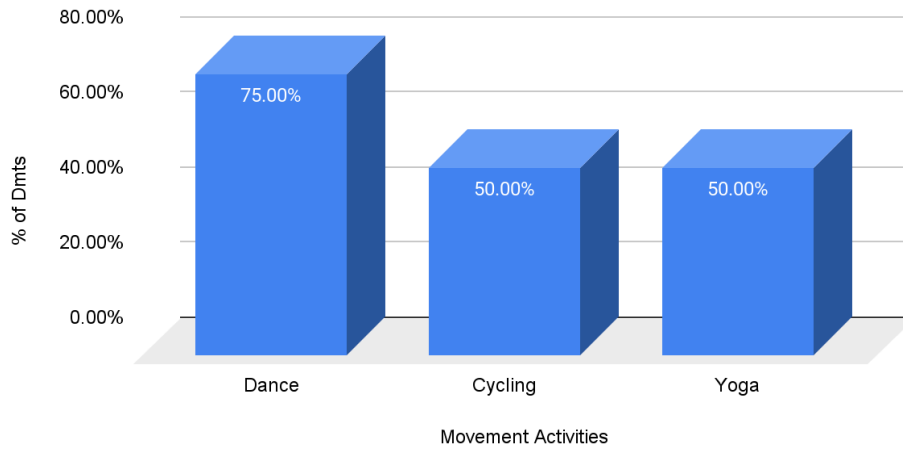


Figure 7.1

Dmts' Creative and Relaxation Activities (High Compassion Satisfaction & Low Burnout / Secondary Traumatic Stress)

Dmts' Creative & Relaxation Activities

High Compassion Satisfaction & Low Burnout / Secondary Traumatic Stress

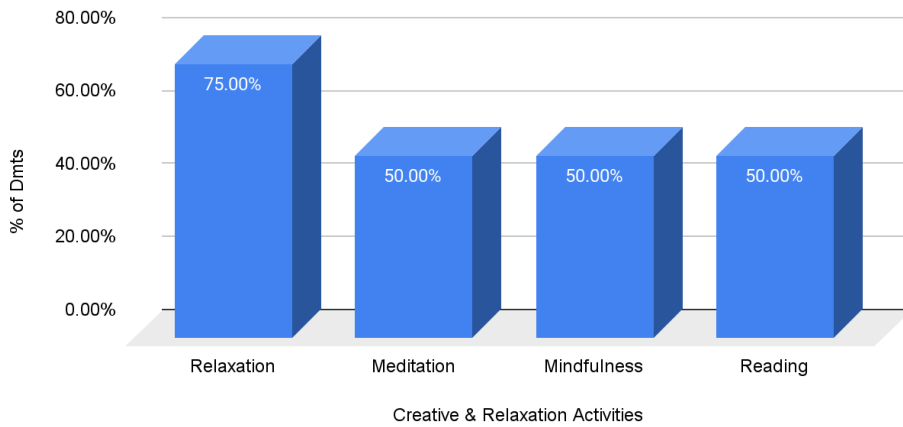


Figure 7.2

Dmts' Treatment or Group Activities (High Compassion Satisfaction & Low Burnout / Secondary Traumatic Stress)

Dmts' Treatment or Group Activities

High Compassion Satisfaction & Low Burnout / Secondary Traumatic Stress

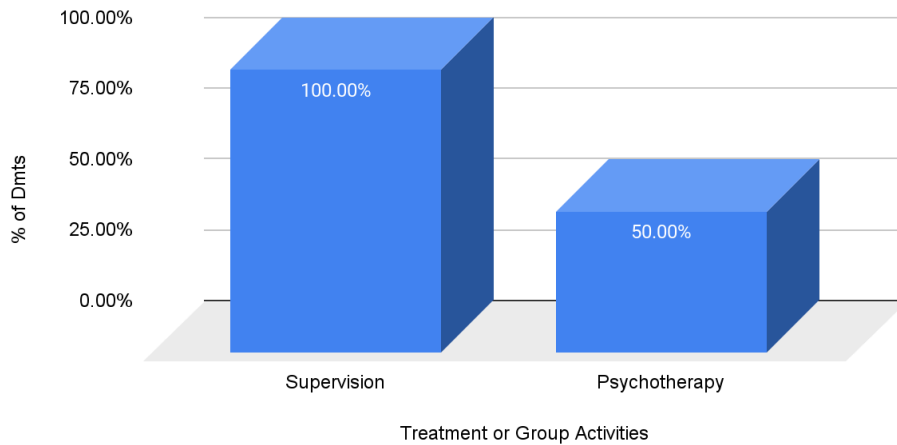
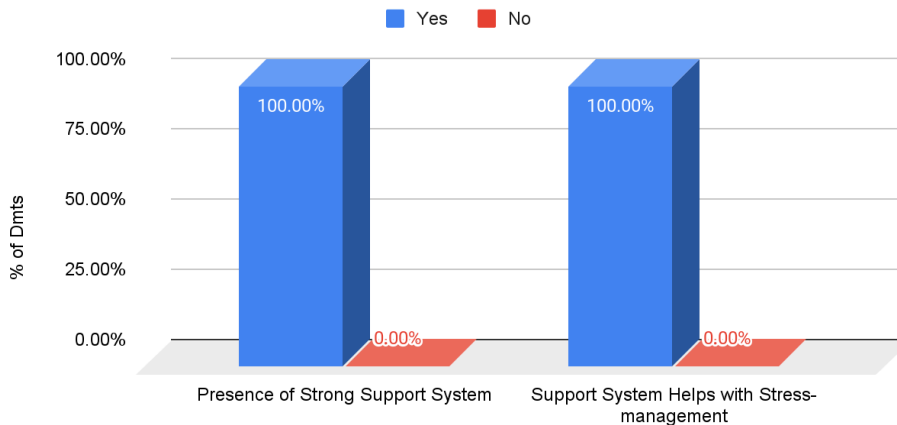


Figure 7.3

Dmts' Support System Results (High Compassion Satisfaction & Low Burnout / Secondary Traumatic Stress)

Dmts' Support System Results

High Compassion Satisfaction & Low Burnout / Secondary Traumatic Stress



When reviewing the further analysis of Dmts with moderate compassion satisfaction, burnout and STS (CF), the self-care practices they engaged in were reported as follows: 1) Movement (Figure 8.0) - 85.71% dance and walking, and 57.14% stretching; 2) Creative and

Relaxation (Figure 8.1) - 71.43% deep breathing, reading, and relaxation; and 3) Treatment or Group (Figure 8.2) - 57.14% psychotherapy and 42.86% did not engage. The results for the presence of a strong system reported that 14.23% of Dmts felt either they had one or were undecided, and 71.43% did not feel they had a strong support system (Figure 8.3). However, 71.43% did feel that their existing support system did help them manage their physical and emotional stress, whereas 28.57% believed it did not help (Figure 8.3).

Figure 8.0

Dmts' Movement Activities (High Compassion Satisfaction & Low Burnout / Secondary Traumatic Stress)

Dmts' Movement Activities

Moderate Compassion Satisfaction / Burnout / Secondary Traumatic Stress

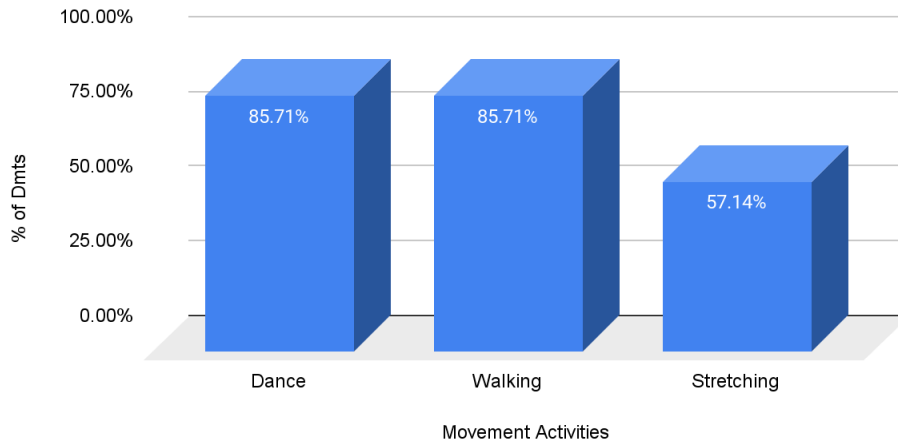


Figure 8.1

Dmts' Creative and Relaxation Activities (Moderate Compassion Satisfaction, Burnout, & Secondary Traumatic Stress)

Dmts' Creative & Relaxation Activities

Moderate Compassion Satisfaction / Burnout / Secondary Traumatic Stress

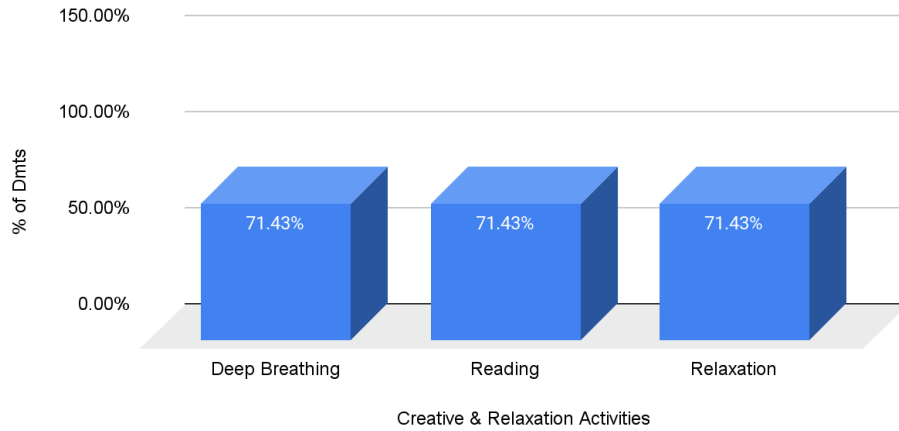


Figure 8.2

Dmts' Treatment or Group Activities (Moderate Compassion Satisfaction, Burnout, & Secondary Traumatic Stress)

Dmts' Treatment or Group Activities

Moderate Compassion Satisfaction / Burnout / Secondary Traumatic Stress

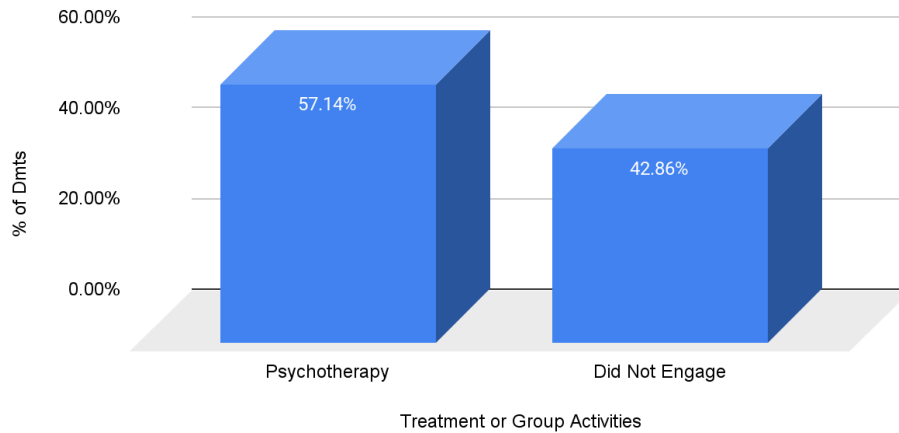
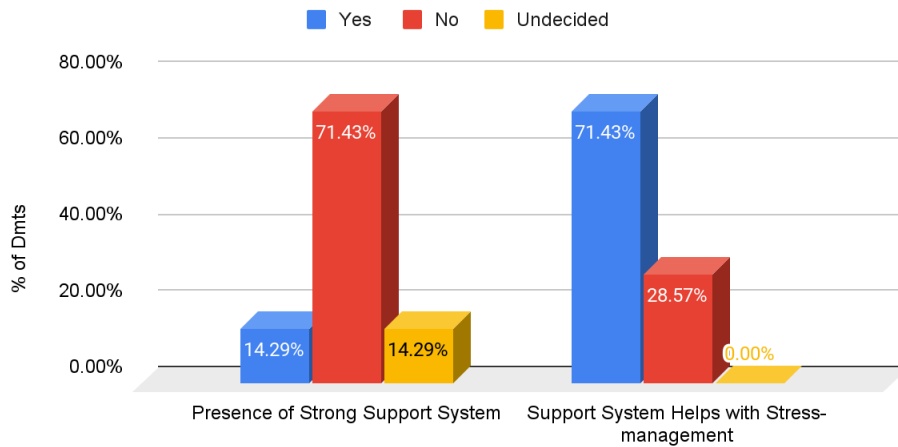


Figure 8.3

Dmts' Support System Results (Moderate Compassion Satisfaction, Burnout, & Secondary Traumatic Stress)

Dmts' Support System Results

Moderate Compassion Satisfaction / Burnout / Secondary Traumatic Stress



While the results generally varied between Dmts with high compassion satisfaction and low burnout and STS (CF) versus those with moderate compassion satisfaction, burnout and STS (CF), there were some trends identified during a side-by-side comparison. In the category of movement activities, dance was the top activity for both groups. Relaxation and reading were identified in both groups as top creative and relaxation activities that they engaged in. Both groups also identified psychotherapy as one of their top treatment or group activities.

Discussion

The main purpose of this preliminary study was to explore the prevalence of burnout, CF, and/or physical pain through the SCT in Dmts while answering the question: what self-care practices do Dmts engage in that may be able to lower or mitigate their risk of burnout, CF, and/or physical pain through SCT? It also set out to understand if the presence of a strong support system can lower the risk that Dmts face as an inherently high-risk population for burnout and CF due to the nature of the work as a helping profession (Ondrejková & Halamová, 2022).

Firstly, the study successfully established that although around 62% of Dmts were experiencing high compassion satisfaction, more than half were still at moderate risk of burnout, while 38% were experiencing a moderate risk of CF. The research also confirmed that around 67% of all Dmts had experienced physical pain within the last 24 hours, although whether it was linked to SCT or not remains undetermined as there were no explicit and conclusive measures provided to establish this relationship. However, it was conclusive that around 31% of participants worked with neurosis patients, psychiatric patients, or trauma victims, with psychiatric patients being one of the patient populations that are most likely to evoke physical pain in the therapist during SCT (Gubb, 2014). It was also determined that around 31% of the patient population almost always reported physical pain before, during, or after a DMT session, and all patients had reported at least one instance of pain, which suggests that pain was present in the patient at some point during all therapeutic processes. There is not enough evidence linking the presence of pain in the patients to the experience of the Dmts' pain during SCT, therefore, further research is necessary.

The results narrowed down the self-care practice activities that were most commonly practiced by the entire Dmt population and segmented them into four categories: 1) movement activities; 2) creative and relaxation activities; 3) treatment or group activities; and 4) other stress-management activities. The top two movement activities were dance (approximately 92% participation) and walking (around 62% participation), which provides evidence of the efficacy of dance and movement as a treatment or prevention method, and offers a plausible explanation for why DMT has been implemented as a burnout and CF intervention among the nursing population, although more research is needed (Yilmazer et al., 2020).

In the creative and relaxation category, the top three activities reported were reading and relaxation (around 69% participation for each activity), and deep breathing (around 62% participation). The literature for the treatment and prevention of burnout indicated both relaxation and deep breathing as possible intervention methods, whereas interventions for CF cited creative activities and meditation (Vu & Bodenmann, 2017). Deep conscious breathing tends to be a component of meditation and meditation was indeed listed as a separate activity with approximately 38% of Dmts indicating they participated within the last 30 days. According to Majore-Dusule et al. (2021), relaxation is an MBI that previously worked in the treatment of chronic headaches. Within the Dmt context, it appears to be a plausible intervention tool.

The results of the treatment or group activity category confirmed that supervision (around 54%) and psychotherapy (about 46%) were the top two activities. Supervision likely serves as a form of group interaction in which Dmts have a space where they can feel supported by their colleagues when discussing cases and is consistent with the CF research which indicates that feeling supported at the organizational level can help mitigate the risk (Vu & Bodenmann, 2017). It is also consistent with burnout research that suggests seeking professional support from colleagues is a person-centered solution that has the potential to lower the risk (Maslach & Goldberg, 1998). Psychotherapy is inherently therapeutic and unsurprisingly can be an effective tool for the population of Dmts, a population that understands the importance and efficacy of psychotherapeutic intervention as they operate within the field of mental health.

The final category of activities analyzed in the initial results were other activities the Dmts used to manage their physical and emotional stress. Around 23% indicated that they participated in comedic activities, such as laughing, listening to funny podcasts, or watching comedy shows. The most popular activities aside from comedic ones were beach-related activities (sunbathing and swimming in the sea), company-related activities (long embraces and spending time in the company of friends), massage activities (both self-massage with essential oils and massage therapy), and nature-related activities (spending time in nature and walking in nature). The data regarding comedic activities is interesting since there is research that supports the idea of laughter therapy as a viable treatment for stress relief (Yim, 2016).

Dmts were asked to provide insight as to which of the activities mentioned in the survey they used as a tool for stress management, or more specifically “to manage physical and emotional stress.” The activity overwhelmingly selected for stress management was dance, with

around 46% of participants suggesting they engage to manage their physical and emotional stress. This was followed by walking, where around 38% of respondents had selected this option, followed by both intervention or supervision, which had approximately 23% indicating these selections. This evidence demonstrates a trend towards high engagement in dance activities as well as conscious employment of dance as a stress-relieving activity for both physical and mental stress when paired with the results of around 92% of Dmts participating in dance as a movement practice. It should also be considered that Dmts generally possess a profound understanding of the underlying benefits of dance for the mind, body, and spirit through the nature of their work as psychotherapists who utilize dance and movement as a healing mechanism. Therefore, while the numerical data is clear about the trend dance is also an activity that is highly relevant to the self-care practices of the Dmt population. The evidence does not explore whether dance or any other activities were participated in alone or in a group (other than the activities specifically understood to be group activities), however, this should be considered and differentiated in future research studies.

Measures of frequency of the categories of movement, creative and relaxation, and treatment or group activities provided some initial insight as to the habits of Dmts. In the category of movement activities, the research was relatively consistent, indicating that around 69% of Dmts participated in movement activities within a range of 1-3 times per week, with the highest participation level being at 4-6 times per week, and the lowest at twice a month. This demonstrates that the majority of Dmts have a relatively consistent movement practice in place as part of their self-care routine. In the category of creative and relaxation activities, the results demonstrated that only around 23% participated in these activities within a range of a few times a month to 2-3 times per week. Thus, overall participation was much lower in these types of activities. Concerning treatment or group activities, the results were rather inconsistent, showing that around 23% did not engage at all or engaged once a week, and the majority who did engage only engaged a few times a month (around 31% of participants). Perhaps the nature of some of these activities, such as supervision, happens more infrequently, therefore decreasing the frequency of how often a Dmt can participate. As a result, no trends were identified and the treatment or group activities category appears to be engaged in more sporadically.

The results reviewed data related to whether the Dmts were successfully able to manage their physical or emotional stress by participating in the activities they selected. Around 77% of

Dmts did indeed believe they were successful at using the selected activities to manage their physical or emotional stress, whereas only around 15% believed they were unsuccessful. Around 8% were undecided, citing that “sometimes yes [they were successful] and sometimes no,” adding that if the activities were not helping they concluded that they needed to “rest and take some time off.” Another participant who responded “yes” clarified that in times when she is unsuccessful, she resorts to taking prescription medication. Unfortunately, this study did not measure the use of prescription drugs as an alternative path to stress management. However, it could be extremely beneficial to include such data in a future study.

The study measured whether the Dmts felt they had a strong support system and if their support system also helped them with stress management. More than half of the participants believed they had a strong support system in place, with one participant clarifying that her “partner, friends, colleagues, ex-teachers, [and] supervisor” collectively formed a part of her personal support system. Around 38% of participants did not feel they had a strong support system in place, with one participant sharing that she sometimes feels “a bit alone as a dance therapist [due to] not [having] many opportunities to share with colleagues who speak the ‘same language’ in the field.” This alludes to the issue of lacking support at a professional and organizational level within the field of DMT, which can contribute greatly to the risk of burnout (Maslach & Leiter, 2016; O’Connor et al., 2018). However, when asked if their support systems successfully helped them manage their physical and emotional stress, approximately 77% believed they helped, and only around 23% did not believe this was the case. This highlights the importance of having a strong support system and its relevance to mental health.

Further data analysis was conducted in the results portion of the study, which segmented the participants into two groups as a result of an important relationship identified by their results. It was established that all participants who scored high for compassion satisfaction also scored low for the risk of both burnout and STS (CF), and all participants who scored moderately for compassion satisfaction also scored moderately for burnout and STS (CF). This finding was consistent with previous research which identified that psychotherapists tend to have higher levels of compassion satisfaction and lower levels of CF (Ondrejková & Halamová, 2022).

When further examining the population of Dmts who scored high for compassion satisfaction and low for the risk of burnout and STS (CF), dance was found to be the top movement activity, followed by yoga and cycling. Yoga’s use of deep breathing and mindfulness

as some of its core principles is aligned with research that indicates yoga can be an effective tool for stress relief (Serber, 2000). However, additional research is needed to confirm its viability as an intervention for burnout and CF. In the creative and relaxation activity category, relaxation was the top activity, followed by meditation, mindfulness, and reading. This discovery was consistent with the literature that asserted that relaxation activities, such as meditation and mindfulness, and MBIs are viable person-centered or individual interventions for both burnout and CF (Maslach & Goldberg, 1998; Vu & Bodenmann, 2017; Wang et al., 2023). For the treatment or group activities category, all Dmts reported attending supervision, and half suggested they were receiving treatment in the form of psychotherapy. This emphasizes the role of supervision and psychotherapy as an integral part of the Dmt's role as a therapist - she also needs support and therapy. This information is not new, however, it serves as a valuable reminder. Lastly, in reviewing the support system data it was found that all Dmts from this group felt they had a strong one present and all believed that their support system did help them successfully manage their physical and emotional stress.

In analyzing the data for the second segmented group of Dmts, those who scored moderately for compassion satisfaction, burnout risk, and STS (CF) risk, the top movement activities were both dance and walking, followed by stretching. For creative and relaxation activities, around 71% indicated that deep breathing, reading, and relaxation were their top activities. In the treatment or group activities category, more than half of the participants confirmed psychotherapy as the top activity, yet around 43% said they did not engage in any of the activities. For this group, only about 14% of Dmts expressed that they felt had a strong support system, and around 71% did not believe they had one. Conversely, despite lacking a strong support system approximately 71% believed that their existing support system helped them manage their physical and emotional stress successfully. Despite this assertion, the evidence sheds light on how the lack of engagement in activities that provide mental and emotional support through movement, creativity, relaxation, treatment or the group dynamic, and not having a strong support system could adversely affect the well-being of the Dmt population.

The final portion of the results section consisted of conducting a side-by-side comparison of the segmented groups of Dmts with high compassion satisfaction and low burnout and STS (CF) risk versus the Dmts with moderate compassion satisfaction, burnout risk, and STS (CF) risk. In this comparison, the top activities identified by both groups were dance, relaxation,

reading, and psychotherapy. Therefore, it can be concluded that these activities are viable self-care practices, with the research supporting relaxation as an intervention. It can also be observed that the risk of moderate burnout and STS (CF) was significantly higher in the group that lacked the presence of a strong support system, which is also consistent with the research which cites lacking a support system as a risk factor for burnout (Maslach & Leiter, 2016; O'Connor et al., 2018). This group also lacked support through supervision, which had been previously determined as a burnout risk factor (Maslach & Leiter, 2016; O'Connor et al., 2018). As a result, a clear relationship between the presence of a strong support system or a lack thereof was successfully established in this study.

Figure 9.0

Raw Data Summary of the Top Activities Dmts Participated in for the Entire Group vs. the Segmented Groups

	Entire Group		High CS Low Burnout STS		Moderate CS Burnout STS	
Movement	Dance	92.31%	Dance	75.00%	Dance	85.71%
	Walking	61.54%	Cycling	50.00%	Walking	85.71%
			Yoga	50.00%	Stretching	57.14%
Creative & Relaxation	Reading	69.23%	Relaxation	75.00%	Deep Breathing	71.43%
	Relaxation	69.23%	Meditation	50.00%	Reading	71.43%
	Deep Breathing	61.54%	Mindfulness	50.00%	Relaxation	71.43%
			Reading	50.00%		
Group	Supervision	53.85%	Supervision	100.00%	Psychotherapy	57.14%
	Psychotherapy	46.15%	Psychotherapy	50.00%	Did Not Engage	42.86%

Conclusion

In conclusion, this cross-sectional study attempts to provide a deeper understanding of burnout, CF, and physical pain through SCT as it relates to the broader population of MHPs while focusing on the niche population of Dmts due to their embodied practice as psychotherapists through data analysis. The results of the study concluded that for the population of Dmts, dance was one of the most important activities for physical and emotional stress management. Therefore, not only do dance movement therapists employ the use of dance and movement for their profession as healers, but they also use it as an important self-care practice when trying to manage their mind, body, and spirit for their work. Maintaining a consistent movement practice also appears to be key in mitigating the risk for burnout and CF, as the majority of participants participated in movement activities 2-3 times per week from the full sample size, as well as the segmented group of Dmts with high compassion satisfaction and low burnout and STS (CF) risk.

Furthermore, the importance of having a strong support system was indicated by recognizing that all Dmts in the high compassion satisfaction and low burnout and STS (CF) risk category confirmed the presence of one, while the majority of Dmts in the moderate compassion satisfaction, burnout and STS (CF) risk category confirmed they did not feel a strong presence. This finding successfully demonstrated how a strong support system is a clear necessity for Dmts, while the high percentage of those lacking a strong support system identifies the need to establish support at the professional and organizational level, especially for those Dmts who do not feel supported by their personal network. Additionally, the belief that regardless of whether the Dmts had strong support systems in place or were lacking they still felt it was helpful. This underscores the overall need for ensuring that all Dmts have an adequate support system in place because whether it is a strong support system or not, it is still perceived to be helpful.

Finally, it must be ensured that Dmts specifically, due to their embodied work, and MHPs generally in their helping and caretaker roles, receive the proper resources, care, and support they need so they can successfully maintain their mental and physical health as mental healthcare providers. They are faced with a unique challenge of not only caring for the mental health and wellness of others through their felt compassion and empathy but of also deeply caring for themselves - they must learn to employ that same deep compassion and empathy towards

themselves for as long as they intend to give of themselves emotionally and physically to others. If organizations and professional Dmt networks can make a genuine effort to provide the tools, resources, education, and awareness that Dmts need to be successful in their profession without jeopardizing their own mental and physical health, then a new culture of Dmts can thrive. Hopefully, that will look like a culture of Dmts who are cared for and supported by decolonized practices within societal constructs in the mental healthcare field that focus on the collective community rather than placing the responsibility on the individual practitioners who use their bodies for their embodied work. If this can happen, it can birth a new generation of psychotherapists who have a more profound understanding of burnout, CF, and the cause of physical pain through SCT from the time they begin their training and help them achieve a higher level of self-awareness.

It is hoped that this research will help future Dmts be more mentally and physically prepared for the beautifully fulfilling yet highly demanding work that awaits them as psychotherapists and MHPs. Perhaps by having greater awareness and taking advantage of spaces provided during their training, such as supervision and other opportunities for movement in the community or group setting, Dmts can positively lower their risk of suffering from the effects of burnout, CF, and physical pain during SCT. Hopefully, this initial body of research will inspire future investigations into these topics which deserve ample time and careful attention within the field of DMT so that Dmts can live healthy and fulfilling lives through a connected mind, body, and spirit with the support of the collective field.

Limitations

There are several important limitations to this study. Firstly, the sample size is much smaller than expected. Therefore, it is important to view this study as a preliminary study and understand that additional research is necessary to gain further insight into how burnout, CF, and physical pain through SCT can impact MHPs, while also potentially understanding what can be done to help mitigate the risk in the first place. While this study offers an initial understanding through the experiences of Dmts, a broader sample size is necessary to develop a more holistic understanding, including participants from backgrounds other than White or Caucasian and Hispanic or Latino. Additionally, the response period offered to the participants between October 15th, 2023 to November 16th, 2023 was potentially too short, which may have impacted the

overall sample size. A wider data set could have potentially been collected had the online survey been distributed for longer.

This study lacks demographical information on the location of the participants. As a result, this impacts the ability to make any correlation between specific countries and the prevalence of burnout, CF, or physical pain during the SCT, or to segment the responses according to the country to measure which had higher or lower levels of burnout and CF. This is a key point that can help further the research by clarifying which countries may have preventive measures or interventions in place at the organizational level to provide additional insight into how to mitigate the risk before it becomes problematic and to observe what prevention practices are currently in place.

In addition, one variable that was absent from the data was the measurement of substance use or abuse in the form of alcohol, illicit, or prescription drugs. As discussed in the literature review, alcohol or substance use or abuse can be potential symptoms of burnout or CF (Ada.org, 2022; Singh et al., 2020). Lastly, there was an overall lack of literature that agreed on the definitions and overall concepts of burnout, CF, and SCT which likely impacts the overall results and interpretation of this study.

Implications for Practice

As the literature suggests, creating a culture of awareness around the risks of burnout and CF in helping professions at the professional and organizational level can help lower the risk of Dmts, especially those who are training, to reach a detrimental state of mental and physical health through burnout, CF, or physical pain during SCT (Johnson et al., 2018). This can be done by educating students about the importance of engaging in self-care practices, building a strong support system, having a consistent movement practice as part of self-care maintenance, and maintaining an overall awareness that risk is involved in such work from the time they begin their training. Offering Dmts in training transparent education about the risks that are involved with working in helping professions tactfully and without an alarmist mentality to not discourage therapists from pursuing such careers can potentially help construct a culture of openness, support, and acknowledgment.

Additionally, more can be done at the professional and organizational level to create communities within the DMT ecosystem that can provide an extra layer of support to Dmts who

do not feel they have an adequate support system. Observing how the increased risk of burnout and CF was directly impacted by whether the Dmts felt they had an adequate support system or lacked one suggests that a need exists, largely because around 71% of the group of Dmts who were indeed experiencing moderate levels of burnout and CF also lacked the presence of a strong support system. Hopefully, the global DMT community can be made aware of the research contained in this study so that they can begin implementing awareness tools, education, and even training within their respective communities, universities, and professional teams of Dmts to mitigate the risk of burnout, CF, and physical pain through the SCT.

Implications for Future Studies

While this study has provided some insight into how Dmts can mitigate their risk of burnout and CF, additional research is necessary with a larger study sample to gain more conclusive results. This research study was the first of its kind for the population of Dmts. However, this implies that additional research is needed to further understand how Dmts can provide compassionate support to their patients without risking reaching a state of burnout or CF. More research is needed on the topic of SCT as well, as this study did not accurately provide any conclusive results on how pain is impacted through the embodied work of the Dmt and in relation to their patient populations.

Additionally, it would be helpful to understand if the self-care practices used by Dmts served as activities in which they could engage with others or if they were practiced alone. Perhaps it could offer a more holistic perspective on the types of activities that are truly beneficial and successful in combating burnout, CF, and physical pain during SCT by understanding if there is a social component present in the activity itself or not, which could lead to the participant feeling less isolated and more supported if they were indeed participating in a greater amount of group activities that provided an opportunity for greater support or a deeper sense of community. After all, the work of the Dmt largely involves the community and a keen understanding of group dynamics. They too must be supported by their communities so that they may continue to foster healing practices without self-abandonment or running the risk of losing themselves in their profession. Hopefully, new research will be pursued so that the risk can be lessened in future generations of Dmts.

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Appendix

Appendix A: [Research Questionnaire](#)

Appendix B: [ProQOL 5](#)

Appendix C: [ProQOL 5 Scoring Instructions](#)

Appendix D: [Numerical Rating Scale](#)