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Embodied Connections: Engaging the Body in Group Work

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Embodied connections: Engaging the body in group work

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Abstract

Group work is a key modality in social work practice. In this study, we sought to explore how the growing trend toward body-oriented psychotherapy is being integrated into group work, and to identify the potential significance of this trend for social work practice with groups. We conducted in-depth interviews with 20 practitioners engaged in developing this emerging form of practice across the United States, and used thematic analysis to identify how integrating body-oriented psychotherapy may impact the nature and practice of group work from their perspectives. The overarching theme identified was that using body-oriented psychotherapy serves to Deepen the Group Process and Enhance the Therapeutic Potential of Group. This overarching theme was supported by four subthemes that describe how participants used body-oriented psychotherapy to enrich their group work. These subthemes include Coming into the Present Moment, Accessing the Body's Unconscious Knowing, Regulating Affect and Facilitating Working Through, and Enhancing Interpersonal Connection. We discuss how these findings fit with existing research on group work and body-oriented psychotherapy, and describe how they reflect recent neurobiological models of therapeutic change. We also identify potential benefits and limitations to using body-oriented psychotherapy in group work, and outline key considerations for responding to this emerging trend in the profession at large.

Keywords

Body, group, social work practice, therapy, thematic analysis

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Over the last decade or so, there has been an unprecedented interest in integrating the body into traditional talk therapy (Totton, 2003; Young, 2005). The growing number of so-called body-oriented psychotherapies (BOPs) that testify to this trend includes Bioenergetics, Focusing, Hakomi, Rubenfeld Synergy, Sensorimotor Psychotherapy, and Somatic Experiencing, each of which has a unique theory, methodology, and procedure. What brings this array of disparate approaches together is a common focus on utilizing the body as the central vehicle for healing. Clinicians in each of these approaches overtly engage the client in working with their physical sensations and experiences in order to address the presenting problem (Röhricht, 2009; Totton, 2003). In some of these approaches, clinicians also invite the client to use physical movement and expression, or even include touch as part of the therapy process (European Association for Body Psychotherapy [EABP], 2014; Young, 2005).

There is no unified theory or technique to BOP, nor is it necessarily a stand-alone treatment. Clinicians frequently integrate BOP with an existing theoretical framework such as psychodynamic, interpersonal, or humanistic approaches to working with individuals and groups (e.g., Cohen, 2011; Segalla, 2003). Common elements underlying various forms of BOP include an understanding of the functional unity of mind and body and a recognition that our psychological experiences are formed, experienced, expressed, and reshaped through the body (EABP, 2014; Totton, 2003). BOP advocates suggest that it is vital to work with the somatic imprints of negative beliefs and experiences to create lasting change (Staunton, 2002). Yet, different approaches to BOP have unique foci and suggest different specific methods of intervention. For example, Somatic Experiencing practitioners track the flow of already-occurring sensations to facilitate the resolution of trauma, while Bioenergetic analysts use movement to help clients shift habitual muscular tensions that express and maintain broader personality patterns. Although most BOPs have been developed as one-to-one treatments, clinicians are increasingly experimenting with integrating BOPs into group settings (e.g., Cohen, 2011; Segalla, 2003).

The rising interest in BOP has implications for social work practice. Social workers are among the primary providers of mental health services, including counseling and psychotherapy, to clients in the community (National Association for Social Workers [NASW], 2005). Social work services are increasingly provided in a group format, which draws on relationships of mutual aid established between participants as a key resource for change (International Association for Social Work with Groups [IASWG], 2012). Although few professional MSW schools currently offer training in BOP (Röhricht, 2009; Young, 2005), social workers are among those on the leading edge of introducing BOP into clinical social work practice with groups. This trend has widespread implications for social work practice as clinicians in the field must increasingly confront and work to understand the relevance of these emerging practices for their work with clients.

Research on BOP in individual, and especially, in group treatment is in its infancy. Investigators have initially focused on conducting clinical trials to

establish the efficacy of BOP with diverse populations. Recent international randomized control trials have provided support for the efficacy of using BOP in group settings to reduce symptoms and improve functioning for clients with chronic depression (Röhricht et al., 2013), posttraumatic stress disorder (PTSD; Gordon et al., 2008), somatoform disorders (Nickel et al., 2006), and schizophrenia (Röhricht and Priebe, 2006). Although BOP can be used to address a broad range of issues, it is most often targeted to disorders that have a significant somatic component, such as depression, anxiety, PTSD, chronic pain, somatoform disorders, eating disorders, and addictions. Researchers have shown that using BOP in group settings not only improves target symptoms but also increases clients' well-being, enhances spontaneous emotional expression, and improves quality of life (Röhricht, 2009).

The few qualitative or mixed methods studies available highlight novel benefits to BOP, as well as raising issues to consider in its implementation. These studies have focused on individual rather than group treatments. Price (2005), who analyzed participant responses to open-ended questions, found that sexual abuse survivors reported increased sensory and emotional awareness following BOP in individual psychotherapy, and actually targeted this outcome as a goal of treatment. Although increased awareness can be an important part of the healing process, focusing on the body and physical sensations is not without risk. In their analysis of in-depth interviews with clients immediately after treatment and then at one year follow-up, Berg et al. (2010) found that Affect-Focused Body Psychotherapy, while generally effective for anxiety, did serve to actually heighten anxiety, and triggered painful emotions, or traumatic memories for some clients. They linked clients' willingness to tolerate uncertainty in exploring body signals to the successful completion of treatment, and recommended that clinicians monitor BOP treatment carefully to better adapt it to their clients' needs. Additionally, female veterans reported an increase in body awareness following BOP, which they found helpful in coping with PTSD and chronic pain (Price et al., 2007). However, veterans noted that BOP required more trust in both themselves and in the clinician guiding treatment than standard talk therapy approaches. Thus, BOP may offer unique benefits and present particular challenges in working with exactly the clients for whom it is most often recommended.

Few existing studies address the potential impact of integrating BOP on the nature and practice of group work itself. Although there has always been some attention to nonverbal communication in the literature, the body has typically been neglected in group work practice (Wilder, 2008). Some BOP interventions such as exploring the discrepancy between a client's verbal and nonverbal communication may be familiar to seasoned group leaders, however, the focal attention to sensory experience itself as a primary vehicle for change in this and other interventions is new and striking. In one of the few studies to address this topic, Leirvåg and colleagues (2010) used client ratings to assess the group environment. They found that BOP groups developed stronger group cohesion, increased trust

and openness, and provided a better working environment than psychodynamic psychotherapy groups for clients with personality disorders. Clinicians working to adapt individual BOP practices to group settings are uniquely qualified to identify shifts in the nature and practice of group work as the result of integrating BOP. We were able to identify only two studies to date that included clinician perspectives (Mehling et al., 2011; Röhricht et al., 2011), and neither of these studies addressed the issue of how BOP impacts the process and possibilities of group work.

The purpose of this study is to begin to describe this emerging form of practice, and identify its potential implications for clinical social work with groups. Drawing on a realist perspective, we regarded clinicians engaged in developing BOP in group settings as key informants uniquely positioned to comment on the clinical implications and potential impact of integrating BOP into group work. Taking an inductive approach to knowledge building, we attempted to both reflect and to understand the perspectives and experiences of clinicians using BOP in group work. The primary research questions guiding us in meeting these objectives were: (1) How do clinicians conceptualize and integrate BOP into their work with clients in group settings? and (2) What is the impact of integrating BOP on the process and practice of group work from clinician perspectives?

Method

After receiving ethics approval from our institution for the study, we combined purposive and snowball sampling strategies to recruit participants through posting ads on professional listservs and bulletin boards for clinicians interested in BOP or group work. Social group work covers a broad spectrum of approaches including support, community action, psycho-educational, and psychotherapy groups. Because we were particularly interested in the clinical implications of BOP, we limited the sample to licensed, English-speaking clinicians who were actively engaged in integrating BOP into a treatment or psychotherapy group. In-keeping with IASWG standards (2012), the clinician had to view and use the group itself, and the relationships within it, as a key element of the intervention. Although we targeted social workers in particular, we did not limit the sample to social workers alone. BOP is a multidisciplinary field and we wanted to capture the breadth of current practice in the field. Participants who met the screening criteria were also asked to nominate a colleague who might qualify for the study to further expand the potential pool of participants in this new field.

Data were collected through in-depth, semi-structured interviews of 40–60 minutes duration conducted by the first author and digitally recorded. Because this specialized group of practitioners was spread across the country, telephone interviews were employed to access all potential participants. Talking about one's evolving clinical practice can also feel vulnerable, and we anticipated that telephone interviews may enhance disclosure from participants who feel more comfortable situated alone at home, or in their offices (Novick, 2008). A brief,

semi-structured interview guide was developed by the first author, field-tested, and refined with feedback from clinicians who had previously used BOP in group settings, as well as being reviewed for bias by the second author before implementation. Interview questions were open-ended and process oriented (e.g., How do you understand the role of the body in your therapeutic work? Could you describe what a typical group session looks like?), eliciting rich descriptions of participants' conceptualizations and experience of their work. The interview process itself was collaborative. Participants were invited to refine questions, clarify misunderstandings, and add new information beyond the scope of the original questions to better represent their experiences.

We used thematic analysis (TA) as our primary analytic strategy. Thematic analysis is a flexible method "for systematically identifying, organizing, and offering insights into patterns of meaning (themes) across a dataset" (Braun and Clarke, 2012: 57). TA delineates a systematic process for data analysis, yet it does not specify technique. We integrated the specific techniques of line-by-line in vivo coding and constant comparison from grounded theory (GT) to enhance the rigor of the study by further systematizing the process of data analysis (Charmaz, 2006). TA and GT strategies can effectively be deployed within the context of a realist epistemology, and are frequently combined at the analytic level (Braun and Clarke, 2012; Floersch et al., 2010).

Following the six steps of thematic analysis (Braun and Clarke, 2012), the first author, along with a trained research assistant, reviewed the digital recordings and transcribed the interviews verbatim, gaining familiarity with the data set as a whole (Step 1). The first author identified initial in vivo codes through a line-by-line analysis of the transcripts (Step 2), which were compared within and across interviews to identify broader potential themes (Step 3). Potential themes were selected for their relevance to the research questions, reviewed for their fit to the codes and the underlying data on the one hand, and for their fit with one another and with the data set on the other hand, and were refined accordingly (Step 4). The final selected themes were defined, delineated, and integrated into a coherent narrative in response to the research questions (Step 5), and this analysis was then situated within the context of the literature as a whole (Step 6). Table 1 (follows Findings section) provides an overview of the final themes and subthemes that were identified, as well as an indication of their representativeness across the entire sample.

We employed two additional strategies commonly used for enhancing rigor in qualitative research. The second author, who remained at arm's length from the initial process of data collection and analysis, served as an auditor, reviewing and providing feedback on the codes generated and the themes identified at each step in the analytic process to guard against bias (Creswell, 2013). We also employed a member check. Each participant was invited to a second interview to provide feedback on the themes identified in the analysis and 11 participants offered comments that were then integrated into the findings (Creswell, 2013).

Participants

In total, 20 clinicians from across the United States participated in this study. The majority of participants were either licensed clinical social workers (9) or psychologists (6), with 2 licensed counselors, 2 marriage and family therapists, and 1 psychiatrist. All participants were White and 14 were female. As a group, participants were experienced clinicians who had practiced for an average of 20.7 years, with a span of 2–40 years. They ranged in age from 29 to 73, with the majority in their 50s and 60s. Eight worked solely in private practice, three worked solely in public agencies, and nine combined work across public and private settings. Sixteen of 20 participants had specific training in at least one model of BOP, with Somatic Experiencing being the most common method (6), among a diverse range of approaches including: Rubenfeld Synergy (4), Neo-Reichian (2), Hakomi (2), and Bioenergetic Analysis (2). Two participants had prior training in body work such as massage. Eighteen participants also had specific training in various approaches to group psychotherapy including humanistic (8), interpersonal (12), psychodynamic (11), and gestalt (4). Only six participants had received any training in applying BOP in group settings. Participants led groups for clients experiencing a wide variety of disorders with the most prominent being: anxiety or depression (9), PTSD (5), addiction (4), and eating disorders (3).

Findings

At the heart of the diverse experiences that clinicians described was the idea that utilizing BOP served to deepen the group process and enhance the therapeutic potential of group work. Participants used the term group process to refer to the nature and the quality of the interactions that took place in the group setting. Participants reported that using BOP made richer and more meaningful interpersonal exchanges possible. For example, one participant explained that using the body in group "deepened the quality of human contact between two people." Another participant explained that integrating BOP into group work "adds clarity, it opens things up, also it deepens the experience that the group is having, the experience might be more superficial, but when the body is brought into it, it deepens the experience." In one way or another, each of the 20 group leaders expressed the idea that using BOP enriched the ability to understand and relate to oneself and to others, which catalyzed the therapeutic process in turn. We identified this theme of Deepening the Group Process and Enhancing the Therapeutic Potential of Group as the overarching theme that captures the impact of integrating BOP into group work from participant perspectives.

We identified four inter-related yet subordinate themes, each of which illustrates a different facet of the way that using BOP facilitated their therapeutic work from participants' perspectives. Participants reported that using BOP increased their ability to bring clients' attention to their present moment experiences (Coming

into the Present Moment), and allowed them to surface therapeutic material that may otherwise have remained out of awareness (Accessing the Body's Unconscious Knowing). They also reported that using BOP helped them titrate the therapeutic experience so that groups were able to approach and work with more challenging material (Regulating Affect and Facilitating Working Through), while further amplifying clients' abilities to connect with and support one another (Enhancing Interpersonal Connection). Over the next few paragraphs, we will illustrate each subordinate theme and explain how clinicians experienced their integration of BOP as enriching their work with groups.

Coming into the present moment

A defining feature of BOP interventions is that they draw the client's attention directly to an in-the-moment sensory experience. Participants observed that using BOP increased clients' availability for relating to themselves and each other by bringing the focus to "markedly more here and now experience." For example, one participant commented that integrating somatic practices "intensified the group process" because it "requires people to be present." Eighteen participants used BOP specifically to direct the group's focus to clients' present moment experiences, particularly their physical sensations and emotions. One participant described how focusing on body sensations shifted the nature of his work in group as follows:

> group members don't need to . . . go into historical material . . . in quite the same way . . . if there is historical material, it can then be brought back into working it in the body so that you don't have to go into the content as much. I think it can potentially foster more empathy for . . . others who are bearing witness to it.

By foregrounding in-the-moment sensory experiencing, participants were simultaneously backgrounding the stories about experience that have traditionally been a focus of meaning making in therapeutically oriented groups. Participants suggested that this shift to a focus on visceral experiencing helped some clients become more fully emotionally engaged with their own experience and with one another. One such clinician comments:

> Once someone commits to being with their emotions in the here and now with other people, there are less defenses. You don't have to wade through mountains of interpretations going head to head, until the person feels more real, therefore more exposed, more easily accessible, more intimate in the group setting.

Group leaders described experiencing a parallel shift in their facilitation style and sense of connection to the group. Because they were engaged in BOP, they started to attend to their own body sensations, increasingly allowing the signals they were receiving to guide their decisions as facilitators. As the result of attuning to their body signals, 17 facilitators reported that they felt considerably less anxious and

more able to be present in the body-oriented model than in traditional talk therapy models. One participant contrasts her experience of running a body-oriented versus a talk therapy group as follows:

> I feel much more relaxed and it can increase my empathy in that . . . I am not trying to come up with ways to persuade someone to feel different or propose alternatives or propose alternative cognitions. I am really sitting with the experience and so in a sense I am not working as hard. And yet I am much more present and more available and people feel that in me.

Accessing the body's unconscious knowing

Participants regarded the body as an essential vehicle for helping clients understand and work with their own and each other's experiences in the group setting. One participant captured this common sentiment in saying "If I don't pay attention to the body . . . I'm missing the richness of what the group could offer." The most fundamental intervention that all 20 participants used was to guide group members in exploring their own and each other's physical sensations, feelings, autonomic reactions, body posture, gestures, and facial expressions with openness and curiosity. Participants argued that using the body allowed them to shed light on aspects of the client that had been denied, disowned, or otherwise held outside of conscious awareness, inviting a truer, more authentic expression of the person. One sign that the group was maturing, according to 13 participants, was that group members were able to help one another identify and work through key experiences by noticing and responding to one another's body signals. One group leader comments:

> A member of my group was sexually abused by her grandfather . . . she began talking about it in group . . . and there was an exchange in group that was more passionate than usual . . . She was terrified, and I could see it in her face, and she described being unable to feel her arms, and group members observed that she was having trouble breathing . . . members . . . told her that she looked very frightened in her face and then she was able to acknowledge this was actually more stimulation than she could tolerate . . . and [then] she was able to let us know that it terrified her.

Paralleling their practice with clients, group leaders used the body in their role as facilitators to get a read on group dynamics. They talked about tuning into their own body signals to assess and respond to the needs of the group. Fifteen of 20 participants described how they modeled this process of exploring body signals with group members to invite a shared exploration of one another's sensory experiences. One participant provided this example:

> I might not know anything with my mind about what is going on, but I will get a feeling, like an uncomfortable feeling around my heart or in my stomach, or I may

> notice my breathing change. And so I can make self-observation comments . . . like, 'I am feeling really uncomfortable in this silence right now, I feel tension, is anyone else experiencing that?' And often, there is something there. So I use my body awareness as a barometer for group dynamics . . . I think it is really helpful in the group dynamics because the body is making conscious impressions that are often ignored by the mind.

Regulating affect and facilitating working through

Eighteen of 20 participants said they relied on BOP to help them titrate the therapeutic process, regulate the flow of affect, and keep the group on track. In addition to facilitating an awareness of body sensations, 19 of 20 participants also talked about integrating active interventions such as having clients act out feelings, experiment with a gesture, shift seats, modulate their breath or body posture, and try on new behaviors to help them make contact with challenging feelings and experiences. One participant describes using an active intervention to help the group work through an emotional block and reorient to the work at hand:

> One of my favorite things is the yoga pose called the hammer . . . And it is a wonderful anger release . . . if there's a lot of anger in the group that people are struggling with and it's not moving . . . I will do that with them. It can really dispel the anxiety, so people can stop sitting with every muscle clenched . . . it's like when the affect is overwhelming a person can't really deal with other things. They're full. So we need to purge some of that and then they're not full and they can regroup and refocus and function better group-wise.

On the other hand, when group members were vulnerable to being flooded by a rush of emotion or sensation, participants conversely described using attention to the body to slow clients down and facilitate information processing. Twelve participants talked about drawing on the body to increase self-awareness and encourage meaningful dialogue in the face of conflict. One clinician offered this example:

> a woman who was expressing some disappointment in another group member who she thought was not being genuine . . . while she was saying it she was not just tapping her foot, but actually hitting her foot against the floor, it was quite noticeable and aggressive . . . And I said, you notice Jane, that while she was talking to Tom, she was tapping her foot. And then everyone kind of perked up at that point. Yeah it is true she has been doing that, and she also realized that she has been doing that. And then she and the man that she was talking with started to process what was going on between them based on the information that he and she were getting based on this nonverbal behavior . . . and what it meant to her and what it meant to him.

One fourth of participants noted that working in a body-oriented way increased their ability to tolerate and work with affect in the group. They acknowledged that the process of regulating affect was complicated by the challenge of balancing differing needs and capacities for entertaining affect and sensation among group members. An intervention that was facilitative for one group member may serve to overwhelm another. Eighteen participants talked about the importance of regulating the flow of affect and sensation to optimize the group's capacity for therapeutic work. One participant highlighted the importance of this task as a group facilitator:

> You're kind of the affect regulator [as group leader]. You want to keep [the group] in the good zone, you don't want to get it till there's no agitation and you don't want it to get too overwhelmed. So you're constantly pulling a sailboat or something, pulling strings so you have the right tension in the room.

Fifteen group leaders reported that using BOP to regulate affect in the group helped expand clients' tolerance for exploring affect and sensation, gradually empowering the group to tackle increasingly challenging topics over time.

Enhancing interpersonal connection

Seventeen participants commented on the power of BOP to promote a sense of connection among group members. Participants observed that the process of sharing moment-by-moment sensory experiences seemed to foster an unprecedented sense of openness, genuineness, and authenticity. One participant explains the impact on her group:

> The body's experience has an authenticity to it that can bypass some of the ways that people might be hiding from each other or guarding, being guarded . . . When people are more real then everyone doesn't feel as guarded, well this person is being real, so I can be real.

Participants used this increased availability and openness to help clients connect with one another and recognize common themes and experiences. Seventeen participants routinely guided clients in attending to their emotional and sensory responses to one another and to the interactions occurring in group. One participant provides this example of an intervention that facilitated both self-awareness and promoted connection:

> How do we understand that one member of the group is talking about the death of a parent and another member of the group is crying? . . . So I might say to the person who is talking, are you aware that you have elected someone in the group to express your feelings?

Table 1. Summary table of themes.

Themes	#	Codes	#	Sub-codes	#
Over-arching Theme					
Deepen the Group Process and Enhance Therapeutic Potential of Group	20	Body and mind are not separate	20		
		Everything is in the body	20		
		Without the body we miss so much	20		
Sub-Themes					
Coming into the Present Moment	18	Less resistance	15		
		Permission to follow here and now experience	18		
		More present as leaders	17		
Accessing the Body's Unconscious Knowing	20	The body communicates	20	Physical symptoms have meaning	7
		Gateway to the unconscious	15		
		Group matures	13		
		A barometer for group dynamics	15	Therapist's own guide	15
				Need for body-oriented practice	19
				Need for body-oriented training	20
Regulating Affect and Facilitating Working Through	18	Healing through active interventions	19		
		Facilitates affect tolerance	18		
		Facilitates mutual regulation	18	Self-regulation before mutual regulation	15
				Facilitates exploring conflict	12
		Increases capacity to handle challenges	15		

(continued)

Table 1. Continued

Themes	#	Codes	#	Sub-codes	#
Enhancing Interpersonal Connection	17	Deepens connection to self	17		
		Facilitates authentic communication	15	Facilitates openness	15
		Body resonance	12		
		Increases capacity for intimacy	15	Faster group cohesion	11
				Active interventions foster cohesion	12
		Facilitates boundaries	16		

Twelve participants identified the phenomenon of body resonance as an empathic physiological response that occurs as we connect with another person's experience. They encouraged clients to notice and actively work with exploring and expressing these responses to further deepen empathy and foster group cohesion. One clinician explained it this way:

> I might ask one person what they are noticing happening in their body in response to what another person is talking about and that can be a way to articulate a felt empathy that is different than just 'I really hear what you are saying' or 'that same kind of thing has happened to me and let me tell my story.' It can be another way to express empathy and then the person who was telling the story and is now being empathized with can often really feel that.

Participants also asked group members to mirror each other's movements or body postures (nine participants), engage in a physical activity together such as yoga poses, guided sensory meditation, or physical team-building exercises (eight participants), or used touch (eight participants) to increase the felt sense of connection among group members. Although cast in hypothetical terms, one clinician offered this example of helping a client begin to break a pattern of isolation:

> I might ask the person if they're willing to see what it feels like to touch somebody in the group. I may ask another member of the group to hold their hand . . . And then I'm interested in hearing, 'how do you feel with somebody holding your hand?' Sometimes that simple act will lead the person to cry, to realize [that] human touch is something they've been terrified of, or they feel a lot of grief about not having, and maybe they grew up in a family where nobody was allowed to touch anybody else. They can experiment with the behaviours that they haven't allowed themselves to experiment with outside.

Participants reported that the integration of sensory awareness and body-oriented interventions supported mutual vulnerability, encouraged risk-taking, and ultimately deepened the interpersonal learning that could take place in BOP

groups. One participant specifically linked body-based self-awareness to an increased capacity for intimacy in the group, explaining that in his experience: "people can really track the complexity of what is happening amongst several different players when they first get in touch with where they are inside." Participants emphasized the importance of respecting the gradual development of the group's capacity to engage in more intimate exchanges over time.

Discussion

The current study is among the first efforts to begin to explore how clinicians conceptualize and integrate BOP into group treatment. Participants in this study reported that integrating BOP changed the nature and practice of their work with groups. The overarching theme that was identified was that integrating BOP deepened the group process and potentiated the therapeutic work that could be accomplished. Despite the diversity of approaches to BOP represented, participants agreed that integrating the body as a focal element of the therapeutic process helped them to accomplish four key therapeutic tasks. Drawing on the body helped participants to: bring clients into the here and now (Coming into the Present Moment), identify the most relevant therapeutic material (Accessing the Body's Unconscious Knowing), more effectively manage affect and aid the processing of therapeutic material (Regulating Affect and Facilitating Working Through), and promote meaningful communication and heighten connection among group members (Enhancing Interpersonal Connection). For these reasons, participants saw BOP as a powerful new approach that could enhance the effectiveness of their work with groups.

Existing research on group therapy and on BOP lends support to participant perspectives and helps to explain their experiences. Evidence-based practice guidelines name attending to the here and now, encouraging open communication and self-disclosure, promoting self-awareness and interpersonal learning, managing emotion in the therapeutic process, and facilitating a sense of connection among group members as key elements of effectiveness in group therapy (American Group Psychotherapy Association [AGPA], 2007; Leszcz and Kobos, 2008). To the extent that BOP enhanced participants' abilities to perform each of these tasks, it would be expected to enrich the therapeutic process. Similarly, in two separate BOP studies, Price (2005) and Price and colleagues (2007) found that BOP facilitated clients' awareness of their emotions and body sensations in individual therapy. Nickel and colleagues (2006) and Segalla (2003) reported that using BOP increased openness and emotional expression in group. Similarly, Leirvåg and colleagues (2010) found that the use of BOP encouraged openness, facilitated trust, and enhanced group cohesion. Thus, BOP may provide a new tool to help group leaders tap into key mechanisms of change in group work.

Emerging science on the neurobiology of psychotherapy further supports and helps to explain participants' observations. The capacity for self-regulation has been recognized as a key building block of mental health and a core target of

effective psychotherapy (Schore, 2003). We now know that self-regulation is developed and promoted through implicit nonverbal communication in the context of caring relationships. When clinicians unconsciously use their own body signals to read and respond empathically to a client's nonverbal behaviors such as changes in facial expression and body posture, they are actively helping the client to manage their emotions and, at times, even their physiological responses, thereby facilitating self-regulation (Schore and Schore, 2014). Indeed, the clinician's ability to respond effectively to the client's nonverbal communication is increasingly thought to reside "at the core of the psychotherapeutic change process" on a neurobiological level (Schore and Schore, 2014: 186).

Integrating BOP brings this largely implicit process of facilitating client self-regulation to the forefront of the therapeutic process and makes it an explicit target of group work. Participants reported that they consciously used their own body signals to increase their ability to attune and respond to the needs of the group and its members. They also deliberately focused on tracking and interpreting their clients' nonverbal communication, potentially enhancing their ability to promote clients' self-regulation within the group. Participants also went further than standard talk therapy approaches by inviting clients to notice and work with their own sensory and affective experiences, which may further enhance clients' capacities for self-regulation (Badenoch and Cox, 2010). As clients' capacities for self-regulation grow, the clinician can gradually surface and help clients to work through experiences that were previously too overwhelming to acknowledge (Badenoch and Cox, 2010; Schore and Schore, 2014). Indeed, participants reported that integrating BOP enabled them to help clients gain access to implicit knowledge and work with more challenging material, which expanded the reach of the therapeutic work that they could accomplish in group.

Integrating BOP also introduces new possibilities for facilitating mutual affect regulation in group settings. The discovery of mirror neurons has demonstrated that we are hardwired to empathize with and learn from mirroring one another at a biological and affective level throughout our lifetimes (Schermer, 2010). Groups offer enormous potential for vicarious learning (AGPA, 2007). Simply witnessing the group leader supporting other group members in working with their own sensory and affective experiences may facilitate self-regulation among group members. Yet, participants did not simply attend to the needs of individual group members, they also consciously worked to read, explore, and respond to the nonverbal communication of the group as a whole. Participants used BOP interventions such as "the hammer" to promote affect regulation for the group as a whole. Participants also explicitly taught group members to support each other in affect regulation. By inviting group members to notice, explore, express, and work through their somatic responses to one another, participants actively facilitated a process of collaborative affect regulation among group members. In this way, introducing BOP may have helped participants capitalize on the potential for mutual affect regulation that is available in the group setting.

On the other hand, integrating BOP may pose particular challenges for affect regulation in group settings. Prior research on BOP in individual therapy suggests that clients can become overwhelmed by tuning into their sensory experiences, or may be triggered to recall negative experiences (Berg et al., 2010). They can also find it difficult to cope with the uncertainty involved in working with body sensations (Berg et al., 2010; Price et al., 2007). These challenges may be exacerbated in a group setting. Clients can be triggered by hearing one another's stories (Badenoch and Cox, 2010), and the trigger may be even more impactful when they are focusing on the visceral experience of sensation and affect. In addition, as clients become more empathically attuned to one another at a sensory level, they may concomitantly be more vulnerable to being triggered by each other. Participants reported that one of the key challenges they encountered was working to balance clients' competing needs and levels of tolerance for affective experience in the group setting. Thus, the group leader's skill in managing affect may be particularly important to the success of BOP groups.

Limitations and future research

In the current study, we provide a snapshot of an emerging form of group treatment. Our findings are limited by a relatively modest sample size and a restricted range of diversity among informants. The themes identified may point to potential mechanisms of action in BOP groups. Further qualitative research should identify whether the same themes emerge with diverse samples. Adding observations of the group process itself, comparing client and practitioner perspectives, and considering negative case examples may further expand our understanding of the potential benefits, challenges, and considerations relevant to integrating BOP in group settings.

Implications for social work practice with groups

As interest in BOP continues to grow, practitioners are increasingly pioneering innovative approaches to integrating BOP into their clinical work with groups (e.g., Cohen, 2011; Segalla, 2003). Social workers are among those leading this charge in both public and private settings. Our findings in this study build on prior work in the literature to suggest that BOP holds some promise for fostering openness and cohesion, catalyzing the group process, and deepening the nature of the therapeutic work that can take place. Integrating BOP may provide a new tool to help group leaders tap into identified mechanisms of action in group therapy. Integrating BOP further places the implicit processes of self-regulation and mutual regulation that underlie therapeutic change at a neurobiological level squarely at the center of the explicit techniques of intervention in group work. In so doing, integrating BOP may enhance clinical social work practice with groups.

At the same time, working directly at the visceral level of affect and sensation may leave clients particularly vulnerable to being impacted by the group process

for good or for ill. The careful development of trusting relationships and skillful facilitation is critical to mining the potential benefits of BOP and avoiding possible iatrogenic effects. Social workers typically serve highly vulnerable clients in great need with few alternative resources. Although the majority of practitioners engaged in this work are experienced clinicians with specialized training in both group psychotherapy and BOP, there are no accepted standards for integrating BOP into social work practice with either individuals or groups. Participants drew on a variety of interventions involving body awareness, body movement, and sometimes including touch, for which we have few disciplinary guidelines. Social work associations should begin to address this emerging trend by developing standards of practice that can guide an ethical and effective integration of BOP within the broader scope of clinical social work practice. Social workers interested in integrating these strategies in group settings should seek appropriate professional training and knowledgeable supervision, carefully adapt the interventions they select to the needs and capacities of all group members, and continuously monitor the effects of their interventions to fine tune them to the changing needs of the group.

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