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Kate Grisard
The Role of the Body: Exploring
Clinical Social Workers' Knowledge
and Perceptions of Body-Oriented
Interventions

ABSTRACT

This study was undertaken to explore clinical social workers' knowledge and perceptions of body-oriented interventions, including how useful and appropriate they believe them to be for various client populations and what factors affect these attitudes.

Sixty-two licensed clinical social workers in the United States completed an anonymous, online survey comprised of 17 quantitative and qualitative questions regarding their views and use of the body in clinical practice and their own self-care practices; 8 additional questions gathered demographic information.

Results found that among the sample surveyed, the body is widely seen as an important source of clinical information and a potential avenue for a variety of interventions. Certain body-based self-care practices – yoga, dance and meditation – showed weak positive correlation with respondents' views of the importance of the body in clinical work.

Respondents also demonstrated significant knowledge of mind-body processes and awareness of various body-based interventions. Passive, non-touch interventions were used more often and were more likely to be viewed as appropriate than active or touch-based interventions, and barriers to working with the body included concerns about ethics, legal liability issues, and the need for greater evidence-based research on how and when to use touch-based interventions. Respondents had a high degree of professional training related to work with the body, but training most often came from outside the field of social work, and graduate school was the least

sited source of knowledge.

Further research is needed to determine if these findings are representative of the broader population of clinical social workers.

**THE ROLE OF THE BODY: EXPLORING CLINICAL SOCIAL WORKERS'
KNOWLEDGE AND PERCEPTIONS OF BODY-ORIENTED INTERVENTIONS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2013

ACKNOWLEDGEMENTS

“If the only prayer you said was thank you, that would be enough.” - Meister Eckhart

This project was made possible by the invaluable support of people to whom I wish to express my heartfelt thanks: to my thesis advisor, Gael McCarthy, for her wisdom and encouragement; to the Smith College School for Social Work class of 2013, an inspiring community of which I am humbled to have been a part; to my family, for their steady presence; and to Brian, for being my constant companion on this journey.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	i
TABLE OF CONTENTS.....	ii
CHAPTER	
I INTRODUCTION	1
II LITERATURE REVIEW	3
III METHODOLOGY	19
IV FINDINGS	24
V DISCUSSION.....	41
REFERENCES	49
APPENDICES	
Appendix A: Human Subjects Review Committee Approval Letter.....	55
Appendix B: Survey Instrument and Informed Consent.....	56

CHAPTER I

Introduction

Since the 17th century, Western thought and culture have been shaped by Cartesian dualism, which constructed “minds as separate, isolated entities residing in heads” and the body as a separate entity (Mahoney, 2005, p. 338). It was in this context that Freud first developed his “talking cure,” and while some of his theoretical constructs suggest that he saw some interaction between the mind and the body – such as the idea of psychosomatic symptoms caused by unconscious psyche – “such a model rests on the assumption that the soma is itself unconscious and an empty or disembodied space and ... this model inherently exists in a worldview inherited from a split between matter and spirit or psyche and soma” (Elisha, 2011, p. 96).

In addition, as the field of psychoanalysis continued to develop during and after Freud’s lifetime, the body – and touch in particular – acquired a particular taboo for a number of other reasons (Bonitz, 2008), and the early exclusion of the body and touch from psychoanalysis still influences the contemporary practice of psychotherapy (Feltham, 2008), as psychotherapists express a high degree of caution regarding touch with clients (Stenzel & Rupert, 2004).

However, emerging research in neurobiology has begun to challenge this traditional view by uncovering mechanisms that link the mind and body (Meissner, 2007). Many Americans today also seek body-oriented treatments for a range of psychological symptoms. One study estimated that over one third of Americans use some kind of alternative therapy each year, and found that two of the most common reasons for seeking alternative therapy are depression and

anxiety, which are typically considered psychological in nature (Astin, 1998). A recent study looking at whether clients in psychotherapy seek alternative therapies simultaneously found that the majority of respondents (64%) used at least one alternative therapy, and the most common types used were mind–body therapies (Elkins, Marcus, Rajab & Durgam, 2005). The study also found that only one third of respondents discussed their use of complementary and alternative medicine with their psychotherapist, although the reasons for this were not mentioned (Elkins, Marcus, Rajab & Durgam, 2005).

Given this context of the apparent conflict between clinicians' discomfort with touch and focus on the body in psychotherapy and clients' expressed desire for body oriented approaches, the central question of this project has been to study how psychotherapists view the use of body-oriented interventions to address psychological conditions in psychotherapy. Additionally, the project aimed to assess: whether psychotherapists are aware and knowledgeable about body-oriented interventions; whether they believe body-oriented interventions are effective for their clients, and why or why not; and what factors affect their perceptions of body-oriented interventions. Findings such as those obtained in the study reported here have obvious implications for social work education and policies related to professional practice.

CHAPTER 2

Literature Review

Early Historical Context

It is impossible to understand the role of the body in psychotherapy without also discussing the history of touch, the debates within the field about its place, and the ways these still influence attitudes today. Many authors have documented the familiar taboo on touch that stemmed from Freud's view of the analyst as a "blank slate" and the impact this has had on shaping current views of touch – and as an extension, the body – in psychotherapy (Feltham, 2008; Bonitz, 2008; Fosshage, 2000). As Feltham describes it:

The completely hands-off line taken in classical psychoanalysis is well known – no touch, no hugging, for some not even a handshake. The psychoanalytic taboo on physical contact has influenced the whole field, there being some good reasons for this, but it also sends out a mixed message: therapy is about conversation, reflection and silence, not about the body (2008, p. 135).

What may be less well-known – and perhaps surprising – are the complex historical evolution of this taboo and the debates that have occurred about the role of touch and the body.

Though known for his stance of abstinence, in fact Freud used touch with clients early in his career, sometimes massaging the neck or head, or applying pressure to the forehead in order to help memories arise, a relic from his earlier practice of hypnosis (Fosshage, 2000). A number of cultural factors influenced Freud's later decision to avoid touch. Most broadly, he developed

psychoanalytic theory “within a cultural context of Victorian sexual prudery” that affected how he and his work were viewed (Fosshage, 2000, para. 6). One of Freud’s early theories regarded childhood sexual trauma as the cause of hysteria, and within this cultural context some conservatives critiqued him as a “sexual pervert,” and this understandably led him to attempt to distance himself from those accusations and ensure that his work was seen as legitimate and professional (Bonitz, 2008). Touch was also historically tied to “traditions of religion and magic” at odds with the rational scientific approach that dominated thought at the time, and Freud naturally sought to seek association with the latter rather than the former (Fosshage, 2000, para. 7).

Aside from cultural factors, emerging elements of Freud’s psychoanalytic theory impacted his views on touch and a move towards abstinence. Specifically, his identification of transference and its central role in analysis suggested that:

For a full-fledged transference to unfold it was therefore necessary for the analyst to remain as neutral as possible, a ‘blank screen’ onto which the transference feelings could be projected; this principle of abstinence included the prohibition of self- disclosure on the part of the analyst as well as physical touch (Bonitz, 2008, p. 393).

From his theoretical perspective, Freud also viewed touch as “gratifying” the patient’s early sexual desires, keeping them stuck in an early developmental stage, unable to bring those desires into consciousness to “eventually work through them” (Bonitz, 2008, p. 394). According to his theory, refraining from touching was critical to “frustrating” the patients, so that they could develop awareness of these desires and “gain insight into their unconscious struggles” (Bonitz, 2008, p. 394). Freud’s early drive theory, which identified sexual and aggressive impulses at the core of human behavior, also led to any touch being viewed similarly as either sexual or

aggressive in nature (Fosshage, 2000), a limiting dichotomy that further fed the taboo on touch and promoted “misconceptions about the use of touch in therapy for decades to come” (Bonitz, 2008, p. 394).

Despite Freud’s position advocating abstinence from touch, a few influential students of Freud disagreed on the issue, arguing that touch could have therapeutic value (Bonitz, 2008). One of the best-known advocates of touch was Sandor Ferenczi, who felt touch could play an empathic role and believed that in some cases, withholding touch could re-enact clients’ early experiences of deprivation, in essence causing them further harm (Bonitz, 2008; Strozier, Krizek, & Sale, 2003). Freud was initially supportive, until he learned that Ferenczi had developed sexual relationships with multiple clients, which he feared would negatively impact the reputation of psychoanalysis (Zur, 2007). Ultimately, Ferenczi refused to stop using touch and was rejected from the psychoanalytic community as a way of “silencing” him, thus forcing “the issue of touch to go underground” (Fosshage, 2000, para. 2).

Willhelm Reich was also a student of both Freud and Ferenczi who sought to bring the body into therapy. Reich “developed the most comprehensive method of clinical touch” at the time (Zur, 2007, p. 170), a method that centered on the concepts of character resistance and body armoring. Reich believed that like the mind, the body manifests resistance in therapy, and by identifying and working to reduce this “body armor,” the therapist could help the client to free up energy blockages by changing the client’s “posture, breathing patterns and muscle tension” (Bonitz, 2008, p. 395). However, like Ferenczi, he suffered professionally for his stance on integrating the body into therapy, and was cast out of the International Psychoanalytic Association (Zur, 2007). In spite of this, his work continued to attract some practitioners and has led to the development of further body-oriented techniques (Bonitz, 2008), and played an

important role in establishing the value of nonverbal communication in therapy (Ehrlich, 1970).

Other well-known analysts have also mentioned anecdotal use of touch with their clients. Winnicott, known for his concept of the “holding environment” described literally holding some of his psychotic clients, and Balint “advocated that touch was a valuable if not necessary component in the work with deeply regressed patients” (Bonitz, 2008, p. 395).

Despite these differing views on the role of touch in psychotherapy, the majority of Freud’s followers agreed with his position of abstinence, and the taboo against touch remained firmly in place. It became even further entrenched in part because Menninger, who played a large role in shaping the professional training for the field, came from an extremely conservative camp that viewed all touch as unacceptable, calling even common social touch such as a handshake as “‘incompetent,’ or even ‘criminal’” (Bonitz, 2008, p. 394).

Emergence of Research on Touch

As a result of this perspective, until the late 1970’s most of the discussion on the topic was based on theory and anecdote rather than empirical research (Bonitz, 2008). The sudden interest in research grew out of a large and groundbreaking study in the 1970’s on mental health practitioners’ use of touch and revealed that 12% of respondents had engaged in sexual contact with their patients (Bonitz, 2008). Although this shocking discovery was the source of much debate, it also fueled more interest in research on the subject of touch (Bonitz, 2008). While increased research was certainly needed to better understanding the phenomenon of touch, much of the research has centered on sexual contact in the therapeutic dyad, mostly to the exclusion of other types of non-sexual touch:

For the most part, research has focused on the troubling problem of sexual contact between therapist and client, with either no or very minimal attention to other forms of

physical contact that may occur within the psychotherapeutic context. (Stenzel & Rupert, 2004, p. 333).

Although it is certainly important to understand the nature, extent and causes of sexual contact between therapist and client – particularly given that the phenomenon remained an unexamined secret for decades – this research focus also seems to reflect and reinforce the problematic historical discourse inherently connecting touch and sex. Zur (2007) captures this confusion well: “Sexualizing therapeutic touch and most other forms of touch reflect modern, Western, cultural beliefs in which relationships among sensuality, physical sensation, and sexuality are intertwined” (p. 170).

Professional, Ethical and Legal Considerations

That the prevalence of touch in psychotherapy came to light in the context of revelations of ethical boundary crossings also seems to have influenced the discussion and views of therapists today... making them hesitant, cautious, suspicious, wary. One can also understand why, with this history, practitioners often consider risk management and liability when thinking about touch – clearly, it’s dangerous and leads to sex (or at least the perception of sexual intent). According to Zur (2007), since the time of Reich’s exile, in the 1970s:

...regardless of the extensive scientific data accumulated on the importance of touch for human development, for healing in general and specifically in psychotherapy, the field of psychotherapy has generally shied away from discussing touch as a clinical intervention and instead has discussed it as an ethical and risk management concern (p. 170).

While the early historical debates about touch revolved around different theoretical approaches, in the 1980s and 90s these gave way to concerns about ethics and risk management (Bonitz, 2008), perhaps stemming out of the revelations of sexual contact between clients and therapists

that came to light in the late 1970s.

Although all professional organizations have ethical rules prohibiting sexual relationships or touch between therapist and clients, there are no clearly stated guidelines around the use of therapeutic touch (Durana, 1998; Bonitz, 2008), with the exception of those set out by the US Association of Body Psychotherapy (Zur, 2007). The National Association of Social Workers' *Code of Ethics* does speak to touch, although it highlights the potential for harm and leaves open the meaning of "appropriate physical contact":

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact (NASW, 1996, p. 13).

As Strozier et al. (2003) observe, the code also requires social workers to "provide services within the boundaries of their education, training ... or other relevant professional experience" (NASW, 1996, p. 8), which begs the question: what training do students receive on touch? Although their study found that nearly all respondents used touch, 82% also reported not receiving training on touch (Strozier et al., 2003), which echoes the recommendations of a number of studies that have called for greater training on nonerotic touch (Bonitz, 2008; Burkholder et al., 2010; Durana, 1998; Milakovich, 1998). Burkholder et al. (2010) argue that the insufficient training in nonerotic touch likely stems from "confusion among helping professionals relating to touch in therapy." (p. 182) As a consequence, schools and faculty avoid teaching the topic, leading students to report "insecurity about confronting the issue of touch in therapy" (Burkholder et al., 2010, p. 181), thus creating a cyclical problem where touch remains

on the margins of professional training and discussion.

Given the documented confusion over the meaning and appropriate use of non-erotic touch in therapy (Burkholder et al., 2010), the lack of clear ethical guidance from professional organizations and the lack of curricular content on touch, it is no wonder that research has found therapists are highly cautious about touch. One study found that 90% of respondents reported offering touch rarely or never, and found that some even expressed hesitation about shaking hands (Stenzel & Rupert, 2004). Although a study of clinical social workers found that 95% did report using touch, the authors also found little consensus about when or why touch was or was not used, and suggested that even if a common practice, touch is not often discussed openly (Strozier et al., 2003).

According to Stenzel and Rupert (2004), “ethical and legal concerns have led some to adopt a risk management perspective that all physical contact beyond a formal handshake should be avoided” regardless of potential benefit, such as that advocated by Gutheil and Gabbard (1993) to avoid “even the appearance of boundary violations.” (p.189) As with the research on touch that emphasizes sexual contact and boundary violations, “these protective measures seem to reinforce a view of all touch as sexual in nature and create an atmosphere of suspicion surrounding the use of touch,” which may have a chilling effect on open discussion regarding the benefits and concerns about nonerotic touch (Stenzel & Rupert, 2004, p. 332).

Touch in Practice

Despite the prevailing cultural norms and attitudes, some psychotherapists do touch clients, and existing literature has explored when, why, how often and in what ways they do so.

Therapist characteristics: One factor that researchers have investigated is therapist characteristics which are correlated with greater or less use of touch with clients. Gender has

been found to be a relevant factor, and some studies have found that female therapists tend to touch clients more often than their male counterparts (Milakovich, 1992; Pope et al., 1987). Although another study did not find differences in touch based on therapists' gender, it did find that the gender composition of the dyad was significant, with touch more likely to occur between female dyads than in other gender pairings (Stenzel & Rupert, 2004). This is consistent with another study that found clinical social workers were less likely to touch clients if they were of the opposite gender (Strozier et al., 2003).

Research has also discovered that the practitioner's theoretical orientation is also correlated with use of touch, with humanistic practitioners (Stenzel & Rupert, 2004) and those who identify as "eclectic" (Strozier et al, 2003) the most likely to use touch and psychodynamic practitioners the least likely (Stenzel & Rupert, 2004), a finding that is consistent with the general theoretical approach to touch among those respective fields. However, there is a lack of information about what guides practitioners who identify as behaviorally, cognitively or otherwise oriented (Stenzel & Rupert, 2004).

Although research has investigated touch practices among different professional groups, such as psychologists (Stenzel & Rupert, 2004) and clinical social workers (Strozier et al., 2003), there do not appear to be any existing studies on differences between rates of touch among these groups, which may be an area for future study.

Two studies have also found that psychotherapists who have training in touch, either in modalities such as massage therapy or as a part of their clinical training in psychotherapy, are more likely to view it positively and use it within the context of psychotherapy (Stenzel & Rupert, 2004; McRae, 2009). Therapists who use touch more frequently are also more likely to view touch as healing, have experienced touch positively in therapy themselves, have had

training in touch and supervisors who supported using touch (Milakovich, 1998).

Client characteristics: Research has also focused on client characteristics to determine which clients benefit most from touch and which it is contraindicated for. Theoretically-based research has suggested that touch may be beneficial for clients with schizoid features and attachment needs, as well as those with neurotic ego structures who struggle with rigidity and obsessive tendencies and may benefit from increased spontaneity and connection and those who feel shame around their dependency needs (Glickauf-Hughes & Chance, 1998). In addition, clinical social workers report using touch more often with elders, children and those with a physical illness (Strozier et al., 2003). Halbrook (1994) also outlines some benefits of touch with elderly populations, who often suffer from touch deprivation and culturally based anxieties about aging.

On the other hand, there are clients for whom touch may not be appropriate for, including those who are “acutely hostile,” aggressive, or paranoid (Durana, 1998, p. 276); those who have borderline characteristics, struggle with boundaries or fears of engulfment, or act seductively (Glickauf-Hughes & Chance, 1998; Older, 1977); or those clients who demand touch, verbally or implicitly (Durana, 1998). These categories are consistent with the findings of a study of touch practices among clinical social workers, which found respondents used touch less often with clients diagnosed with borderline personality disorder, those with boundary issues, schizophrenia, aggressive or angry clients, and those with histories of sexual abuse (Strozier et al., 2003).

Client perceptions: A few studies have approached the topic from the point of view of the client to understand what meanings they ascribe to touch in therapy. Some have found positive associations between touch and clients’ perceptions of the therapist, such as the finding that

clients associate touch with increased therapist expertise (Hubble, Noble, & Robinson 1981) and caring for the client (Driscoll, Newman, & Seals, 1988). However, other studies have found that no relationship between the therapist's touch and the client's perceptions of either the therapist or the therapy overall (Bacorn & Dixon, 1984; Stockwell & Dye, 1980).

Another small phenomenological study of patients in ongoing psychotherapy identified four elements that correlated with whether clients saw touch in therapy as positive or negative:

(1) clarity regarding touch, sexual feelings, and boundaries of therapy (including the patient's sense that the boundaries, when not explicitly discussed, are extremely clear and unambiguous); (2) patient control in initiating and sustaining physical contact; (3) congruence of touch with the level of intimacy in the relationship and with patient's issues; and (4) patient perception that the physical contact is for his/her benefit, rather than the therapist's. (Gelb, 1982 as cited in Horton, Clance, Sterk-Elifson & Emshoff, 1995, p. 445).

In an effort to extend and test these factors, Horton et al. (1995) conducted a larger study of psychotherapy clients and found a majority of positive views of their experiences with touch in therapy: 69% of respondents "felt touch fostered a bond, trust, and greater openness with their therapist," while 47% felt it "communicated acceptance and enhanced their self-esteem" (p. 443). However, the authors also caution that the narrative responses suggested that clients have difficulty "expressing negative reactions about the therapy," which may have skewed the results by limiting the number of negative responses (p. 453).

Neurobiology, Trauma Theory and the Body

The rational scientific approach of Freud's day was closely tied to Cartesian dualism and the view of the body and mind as separate, which is still prevalent in psychotherapy today (Rowan, 2000). According to this model, the body and mind are separate entities, and the

psychoanalyst's job is to tend to the mind, while the job of tending to the body is left to doctors or others trained in the body (Rowan, 2000; Meissner, 2007).

Despite this historical conception, a more integrated view of the body and mind as inextricably linked is gaining traction within psychotherapy, though it still remains relatively new and not well understood (Rowan, 2000). Increasing research and knowledge in the field of neurobiology is revealing the physical mechanisms that connect mental and emotional experiences to the body, and this has important implications for how the body is viewed in psychotherapy theory and practice (Meissner, 2007). However, this shift represents a major change for psychotherapists, who are “not accustomed to thinking of their analytic efforts as directed to modifying patterns of brain activation” (Meissner, 2007, p. 349).

Recent research in neuroscience has also impacted the understanding of trauma theory, and has led to a general acceptance that rather than falling solely within the domain of the mind, trauma is an embodied, “psychophysical experience” that affects the body as well, “even when the traumatic event causes no direct bodily harm” (Rothschild, 2000, p. 5). The DSM description of PTSD reflects this view, as it includes the somatic symptoms of “persistent” and “increased arousal” within the primary criteria for the diagnosis (APA, 2000, p. 468), and the disorder is also characterized by re-experiencing sensations, emotions, images or bodily responses related to the event long after it has passed (van der Kolk, 2002).

Van der Kolk (2002) delineates the difference between autobiographical memory, which allows for verbal communication of one's experiences, and implicit memory, which “contains the sensory and emotional imprints of particular events that determine the value that people attach to those imprints” (p. 60). Implicit memory also provides the foundation for understanding the phenomenon of “somatic memory” (Rothschild, 2000, p. 44). Under normal circumstances,

the two systems of implicit and autobiographical memory work together, turning the raw, body-based sensory memories into narrative, language-based memories, but trauma disrupts this process, which causes traumatic memories to be stored as “fragmented sensory and emotional traces” (van der Kolk, 2002, p. 60).

This understanding of how the brain processes trauma has also led to changes in the ways trauma is addressed in psychotherapy, including the limitations of talk-based interventions and benefits of interventions aimed at increasing body awareness (van der Kolk, 2002). Some talk therapies that encourage people to verbalize their traumatic memories have been found to be effective at combating PTSD (Foa et al., 1999; Resick & Schnicke). However, van der Kolk (2002) argues that the nature of the disorder and its disruption of normal autobiographical memory process makes talking about the trauma literally impossible for some, or for others “so painful that many patients choose not to expose themselves to situations in which they are asked to do so, including to exposure therapies” (p. 66).

For this reason, some trauma researchers argue techniques that increased body awareness can provide an effective alternative route in treating the effects of trauma (van der Kolk, 2002; Rothschild, 2000; Ogden, 2006). This perspective views “the body itself as a possible resource in the treatment of trauma” and the process of integrating the fragmented, implicit memory experienced in the body (Rothschild, 2000, p. 5). Somatic interventions can also be used to help provide a sense of safety and grounding in the present for clients who are grappling with symptoms of PTSD (Rothschild, 2000; Ogden, 2006), although some researchers also advocate abstinence from touch-based interventions when working with clients who have trauma (Rothschild, 2000).

Integrating the Body into Psychotherapy

Although there are various theories and models for integrating the body into certain modalities of psychotherapy (these are often referred to collectively as “body-oriented psychotherapies”), one literature review also noted a need for more research specifically focused on the mechanisms that make touch effective or ineffective in verbal psychotherapy and the impact of touch on client outcomes (Phelan, 2009). Even within the field of massage there is a lack of empirical evidence explaining the underlying mechanisms that make massage effective, despite many studies that do document the positive effects of massage on various physical and emotional conditions (Field, 1998).

However, touch is only one way of approaching the body in psychotherapy, despite the historical discourse connecting the body with touch and sexual contact. While touch may be indicated and beneficial in some settings, teasing apart the concepts of the body and touch reveals that there are many ways to incorporate the body into treatment that do *not* involve touch. Rothschild (2000) notes that even in the field of body psychotherapy touch is not necessarily synonymous with working with the body, and that other approaches include “integrating important aspects of muscular, behavioral, and sensory input, without intruding on bodily integrity” (p. xiv). Likewise, a qualitative study across a range of mind-body therapies found that the common ground among them was a focus on increasing body awareness, most often through non-touch practices such as focusing on the breath or the body and as noticing sensations (Mehling et al., 2011).

Efficacy of Body-Oriented Interventions

Much of the literature regarding the effectiveness of body-oriented interventions has

focused on measuring the outcomes of specific modalities on populations with certain psychological conditions, such as documenting the effects of massage on depression, PTSD, and ADHD (Field, 1998); the effects of group body psychotherapy on the negative symptoms of schizophrenia (Rohricht, Papadopoulos, Suzuki & Priebe, 2009); the effects of affect-focused body psychotherapy on generalized anxiety disorder (Levy Berg, Sandell & Sandahl, 2009); the effects of sensorimotor psychotherapy on trauma treatment in women's groups (Langmuir, Kirsh & Classen, 2012); and the effects of body-oriented therapy on recovery from sexual abuse and PTSD symptoms (Price, 2006). In the process of searching the literature for this initial review, I found that studies on the effectiveness of body-oriented therapies most often focused on trauma, schizophrenia and eating disorders.

These studies all share in common positive results that suggest body-oriented interventions were effective in reducing symptoms among the various populations studied. However, many also discussed limitations due to small sample sizes inherent in the study designs (Langmuir et al., 2012; Price, 2006; Rohricht et al. 2009) and noted that without a control group, there way no way to tease out whether measured changes were due to the intervention or to other variables (Langmuir et al., 2012).

As with the literature on massage and touch in psychotherapy, there seems to be limited empirical research on the effectiveness and mechanisms of body-oriented therapies. This makes it difficult to see how the individual studies described above fit together; while they share in common a focus on body-oriented interventions, those interventions are still distinct and different from one another. This is complicated by the fact that there has been and continues to be a proliferation of a wide variety of body-oriented interventions (Rowan, 2000; Feltham, 2008). Body-oriented therapies can focus on things as widely varied as posture, screaming,

breathing, hypnosis, dance and meditation (Feltham, 2008). And while some body-oriented therapies focus on or include touch, others use non-contact body-oriented interventions. Researchers who conducted a focus group of experienced teachers and students from various mind-body modalities including Yoga, meditation, Feldenkrais method, Alexander technique, Breath Therapy, Somatic Experiencing, Somatic Therapy, Hakomi therapy and massage found that a common element among them was a focus on enhancing body awareness, which was often done through breath monitoring (Mehling et al., 2011).

A number of studies across the literature referenced limitations regarding homogenous participant demographics that tended to include overwhelmingly white females (Horton et al., 1995; McRae, 2008) with relatively high levels of education and wealth (Horton et al., 1995). Another study did not explicitly reference this limitation, yet eight of 10 participants in the study were white women (Langmuir et al., 2012). This noticeable trend is interesting and may be an area for further investigation as well. For instance, are there structural barriers or cultural factors that prevent white men or men and women from other racial and ethnic backgrounds from accessing these services?

The limitations of homogenous samples, small sample sizes and lack of controlled experimental study designs make the findings of these studies, while important beginning points in understanding these phenomena, limited in their ability to extrapolate meaning to broader populations.

Although this literature review highlights the significant theoretical and applied research on myriad topics related to use of the body and touch in psychotherapy, to date there have been few studies on how clinical social workers view the general phenomenon of the body and touch in clinical practice. This study is particularly timely given the recent research breakthroughs in

neuroscience that reveal the inherent connections between mind and body, which challenge some of the long held views of the mind and body as separate and the body as off-limits in psychotherapy. The specific design and methods used in my study are offered in the Methodology chapter following.

CHAPTER 3

Methodology

I received approval for my thesis project from the Smith College Human Subjects Review Committee (a copy of the approval letter is offered in Appendix A). I then conducted this study using a quantitative, cross-sectional online survey. As my purpose in this study was to better understand how clinical social workers understand the role of the body in treatment, I selected this primarily quantitative method and design in part because it allows for responses from a larger sample than traditional qualitative methods. However, the survey also included a few open-ended narrative responses to allow for gathering some qualitative information and to allow for more context in understanding participants' views and responses. The study design was also intended to increase feasibility; I am a full-time student with limited time and financial resources, and an online study design maximized the amount of data that could be gathered given these limitations. Likewise, the cross-sectional design was selected over a longitudinal design to increase the feasibility of the study, by reducing the burden on respondents and in light of the limited time available for the researcher to gather data.

This research is both descriptive and correlational. The descriptive aspect seeks to describe the phenomenon of how clinical social workers view the role of the body in treatment, the types of body-oriented interventions they use and with what types of clients and conditions they do or do not tend to apply these interventions. The correlational component aims to determine what factors influence respondents' views and practices, such as whether training,

personal experience or body-based self-care practices correlate with more positive perceptions and utilization of body-oriented interventions.

Sample

The population of this study is composed of licensed clinical social workers in the US. To be included in this study, participants had to affirm that they meet these two criteria in the online screening questions preceding the survey questions. Those who responded negatively to either of these criteria were automatically redirected to the thank you page at the end of the survey and were not able to answer the survey questions. Other exclusion criteria included limited English fluency, computer literacy and internet access, given the online nature of the survey and the study's limited financial resources that prevented translating the survey into other languages. If potential participants met the inclusion criteria, they were then directed to the Informed Consent material prior to entering the survey itself.

The study used snowball sampling to recruit participants, which is a non-probability sampling method. An anonymous internet survey was sent via email and social media websites to the researcher's social contacts, including professional colleagues, friends and family with a request to forward it on to other social contacts. Reminder emails were also sent to the initial list of contacts; however, the anonymity of the survey and the snowball method prevented me from being able to personally follow up with all potential respondents who had received the survey from someone other than myself.

I chose the snowball sampling technique for convenience and, again, to increase the feasibility of completing the study in the short time allowed. However, it is a non-probability sampling method, and as such the sample for this survey may not be representative of the overall population of licensed clinical social workers. For example, because the sample was found using

social networks, respondents may share certain traits that are more or less prevalent than in the overall clinical social work population, leading to sample bias. Although I hoped to achieve a demographically diverse sample, the nature of the snowball sampling technique prevents controlling this or taking specific steps to increase the likelihood of diversity among respondents. However, recruitment materials noted the desire to recruit participants who represent diversity in terms of age, years of experience, ethnicity, race and gender so that the findings represent the views of a broad spectrum of clinicians. Once the survey was closed, I compared the demographic traits of the sample to that of the overall population of social workers in the US, and I will discuss these findings in the next chapter.

Data Collection Methods

This study gathered demographic, quantitative and some qualitative data online using SurveyMonkey. The survey began by gathering brief demographic data including gender, race/ethnicity, years in practice and training background, including the levels of training (Master's degree or PhD), types of training (psychology, social work, marital and family counseling, etc) and whether or not respondents had training in any body-based modalities (massage therapy, yoga, somatic experiencing, etc).

After the two initial screening questions, the survey asked respondents 17 questions regarding their views about, and use of, the body in clinical practice. These included closed questions about clinical uses of body-based interventions, such as the type and frequency of body-based interventions they use; and what types of clients or mental health conditions are most indicated or contraindicated for particular body-based interventions. Other questions focused on respondents' attitudes and beliefs about body-based interventions, such as how appropriate they perceive various interventions to be in clinical practice generally; how important they feel the

body is in their practice; barriers that prevent them from using the body in ways they believe would be appropriate; and an area for narrative responses to describe how they understand the role of the body in their work. Four questions asked about respondents' perceptions of their amount of training and knowledge about the body in clinical practice. Finally, three questions asked about respondents' use of body-based self care practices, including the type and frequency of the practice and the extent to which (if any) it has shaped their views on the body in clinical practice.

The survey concluded with eight demographic questions regarding respondents' clinical practice (such as years in the field, populations served, modalities used and work setting) as well as whether they have completed professional training related to work with the body, and finally information about gender and race/ ethnicity. (A copy of the survey, including the screening and other questions, as well as the Informed Consent material are contained in Appendix B.)

Data Analysis

Data from the survey were downloaded from the SurveyMonkey website and analyzed using Excel and other statistical analysis tools as recommended by the data analyst from Smith College. This analyst remotely assisted with analyzing the quantitative data, but did not analyze the open-ended responses.

Univariate analysis was applied to demographic data to find the range, mode and frequency of each question in order to gain an understanding of the characteristics of the overall sample and to assess whether the study did, in fact, gain greater representation than past studies (for instance, whether there are greater percentages of participants who identify as men and/or people of color).

The data have also been used to calculate the correlation coefficient (using Excel or other software) between certain responses, such as reported levels of training and knowledge and reported frequency of using body-based interventions, to determine whether or not there are relationships between those variables. Although identifying correlation does not infer causation, finding correlations may provide avenues for further research on this topic.

The quantitative data were also analyzed to determine the percentages of respondents that exhibited certain beliefs or behaviors to see how prevalent they are in this population. This was also done within demographic categories to compare groups in the study – for instance, to identify differences between responses to various questions based on gender or years in practice.

CHAPTER 4

Findings

Overview

A total of 96 people opened the survey; of those, a total of 62 respondents' data were used in the following findings. Twenty-five respondents were excluded because they did not affirmatively respond to the screening question or agree to the informed consent. Nine additional respondents' data were excluded because they answered less than two questions after the screening question and informed consent.

In addition, none of the 62 respondents answered all questions in the survey. This may have been due to the fact that none of the questions were mandatory, allowing respondents to move through the survey without responding to all questions. However, nearly all of the quantitative questions received over 50 responses, with the exception of one that received only 35 responses. This question asked if certain conditions were contraindicated for a variety of body-oriented interventions and was the third question in a row using a matrix format; the lower response rate may reflect respondent fatigue or a sense that the question was duplicative of a previous question asking which conditions were indicated for various body-based interventions. Overall, qualitative questions had somewhat fewer responses, ranging between 41 and 52, which is likely due to the open-ended nature of these questions.

Respondent Characteristics

Although I had hoped to achieve a diverse sample, 93% of respondents identified as female and 100% identified as “Caucasian” or white, with an additional 6% also identifying as Hispanic. By contrast, 81% of social workers in the US are female and 86% are white (Whitaker, Weismuller, Clark, & Wilson, 2006); while the proportion of respondents in the survey identifying as white females is higher than the general population of social workers in the US, it reflects the same trend of disproportionate overrepresentation by this group.

A majority of respondents also reported currently working in primarily outpatient settings (69%), with the remaining respondents evenly split among inpatient (9%), hospital settings with a mix of inpatient and outpatient (9%), and other settings (7%). One respondent identified working in a residential setting, one identified as working in an in-home setting, and no respondents identified as working in a milieu. In terms of client populations served, 93% reported working with adults, 51% with adolescents, 36% with children, 15% with geriatrics and 2% with infants.

A majority of respondents (53%) also reported being in practice for greater than 10 years, and the largest group (31%) reported being in practice for 21 years or more; by contrast, only 11% of respondents reported being in practice for less than two years, suggesting that the sample included a relatively high number of seasoned clinicians.

In addition, 48% of respondents reported receiving professional training related to work with the body. It is unknown how this number compares to the general population of licensed clinical social workers in the US, but it is likely an over-representation due to the use of non-random sampling methods, and the findings should be read with this potential bias in mind.

Clinical use of the body

A number of questions aimed to assess how often and when clinicians use various body-oriented interventions, and found that passive, non-touch interventions (such as observing body language) were used most often, followed by active, non-touch interventions (such as meditation or movement), and interventions incorporating touch used least often.

The most frequently used intervention was observing posture and body language, which 53% of respondents reported using “always” and less than 2% reported using “rarely,” “very rarely” or “never.” Interventions to increase breath or body awareness were the second most commonly used. Although a lower number of respondents reported using these techniques “always” (6%), a majority (52%) reported using them “very frequently” or “frequently,” 25% “occasionally,” only 16% “rarely,” “very rarely” or “never.” Meditation was used slightly less often; as with breath or body awareness interventions, only a small number of respondents (5%) reported “always” using this, and fewer reported using it “very frequently” or “frequently” (30%). Twenty-eight percent reported using it “occasionally,” and a greater number reported using it “rarely,” “very rarely” or “never” (38%). Of non-touch interventions, movement was used least often, with only 2% of respondents reporting using it “always,” 21% “frequently” or “very frequently,” 28% “occasionally,” and 49% “rarely,” “very rarely,” or “never.”

By contrast, touch-based interventions were least often reported: 67% reported never using therapeutic touch-based interventions from trained clinicians, and an additional 22% reported using this “rarely” or “very rarely.” Of those who did use touch-based interventions more than rarely, 8% of respondents reported occasional use, and only 3% of reported frequent use. Those who did report using touch specified the use of techniques such as EMDR, Reiki, “Winnicottian gentle touch to reassure presence,” and “Somatic Experiencing supportive touch

techniques.” Informal non-erotic touch (i.e., to convey meaning or support) was used slightly more often than therapeutic touch: fewer respondents reported “never” using it – only 8% - but a large majority (53%) still reported using it either rarely or very rarely, 25% occasionally, 13% frequently or very frequently.

Respondents were also asked which types of clients or conditions they use a variety of body-based interventions with, and the results were consistent with patterns described in the previous question: therapeutic touch-based interventions received the far fewer responses overall than the other types of interventions, regardless of condition, which implies that respondents do not use this type of intervention frequently.

The greatest number of respondents reported observing posture and body language (51); nearly all reported doing this with clients experiencing anxiety (92%), depression (88%), and PTSD or trauma (84%); fewer reported using it for clients with substance abuse (57%), or eating disorders (47%). Likewise, 50 respondents reported using breath or body awareness, most often for clients with anxiety (94%), PTSD or trauma (86%) and depression (68%), and this was the most commonly used intervention for clients with PTSD or trauma, followed closely by observing posture and body language (84%).

The fewest number of respondents reported using therapeutic touch (13); of those that did, it was most often used for clients with anxiety (54%), depression (54%) and PTSD or trauma (46%). However, over half of respondents (36) reported using non-erotic touch to convey meaning or support, and used this most often for clients with depression (75%), anxiety (69%) and PTSD or trauma (36%).

Across all types of interventions, anxiety received the highest number of responses, except for informal non-erotic touch category, which was used slightly more often for depression

(75%) than for anxiety (69%). Although this may suggest that many of these interventions are commonly used for clients with anxiety, it may also reflect that respondents work with a greater number of with clients with anxiety than other conditions, such as eating disorders.

Contraindications.

Respondents were also asked about conditions that may be contraindicated for using body-based interventions; as mentioned earlier, this question had the lowest response rate of any quantitative question in the survey, with only 35 total responses. Of those that did respond, both types of touch-based interventions received the greatest number of responses indicating that they are contraindicated for certain conditions; 25 reported some contraindications for therapeutic touch-based interventions and 21 reported contraindications for informal non-erotic touch. By contrast, 13 reported some contraindications for meditation, and only a few reported some contraindications for the remaining interventions: using breath or body awareness (5), movement (5), and observing body language or posture (4).

Particularly for the touch-based interventions, trauma or PTSD were the most commonly cited contraindications; 72% of those who responded indicated that these conditions are contraindicated for therapeutic touch-based interventions, and 76% indicated contraindication for informal non-erotic touch. PTSD or trauma was also the most commonly reported contraindication for mediation (39%), along with “other” (39%).

Following PTSD or trauma, respondents reported that therapeutic touch-based interventions are contraindicated for “other” conditions (28%), followed by substance abuse (20%), eating disorders (16%), anxiety (12%) and depression (8%). Results were fairly similar for informal, non-erotic touch: after PSTD or trauma, the most commonly reported contraindication was substance abuse (29%), followed by “other” (24%), anxiety (5%) and

eating disorders (5%). No respondents indicated that this intervention is contraindicated for working with clients with depression. Responses to meditation were somewhat different; after trauma or PTSD and “other,” the most commonly cited contraindication was anxiety (31%), followed by substance abuse (15%), depression (8%) and eating disorders (8%). The remaining interventions – breath or body awareness, movement, and observing body language or posture – all received 5 or fewer responses, and received the greatest number of responses for the category of “other” contraindicated conditions.

Participants who indicated “other” were encouraged to specify their response, and nine participants provided open-ended comments. Four respondents cited the importance of knowing each individual client well and tailoring interventions appropriately, such as “I think this all really depends on the person you are working with, and their individual circumstances and needs” and “For any of these interventions, it is important to assess the client's functioning, needs and goals. Any of these interventions could be utilized toward building a foundation of inner resources for a fragile client who is easily flooded and overwhelmed. On the other hand, any of these interventions could be employed to address defenses in a highly defended client. Assessment and moment-to-moment attention to response-to-intervention is essential.” Two of these respondents checked that “other” conditions are contraindicated for all interventions.

Respondents also indicated that clients with personality disorders are contraindicated for therapeutic touch, including borderline (3), narcissistic (1), schizoid (1) and “other personality disorders” (1), and one of these respondents reported personality disorders are also contraindicated for meditation and breath or body awareness interventions. In addition, one respondent reported that both types of touch-based interventions and meditation should be used with caution or may be contraindicated for clients with “dissociative disorders where touch has

multiple meanings, high risk to facilitate or intensify traumatic transferences and enactments, and blurs already distorted boundaries.” One respondent also noted that movement may be contraindicated for clients who are “medically ill, on contact isolation or prone to nausea (i.e., post-chemo).”

Attitudes and Beliefs

First impressions.

The survey began by asking respondents to describe what first comes to mind when thinking of how the body is considered or used in clinical social work practice, in order to gain insight into participants’ first impressions of the topic, before reading additional questions that may influence their thoughts and responses. A majority of responses indicated that the body is relevant to and useful in clinical work in a variety of ways, and qualitative analysis was used to identify a number of themes among the responses.

One of the most common themes, cited in eleven responses, was the body as a clinical tool in assessment and intervention. This is seen in responses such as “[The body is] one of many sources of information about the client's mental and emotional state, [and] sometimes an avenue for the client to identify and connect with those states in therapy,” “The body is instrumental in both providing the client and clinician with valuable information related to client's functioning. The body is also instrumental in [the] client's healing,” and “The body is a big part of the therapeutic process, from intake to termination. [This includes] watching, asking and observing how the person relates to their body, how they use their body to express themselves or how they somatize or neglect the body.”

Another nine responses referenced a general mind/body connection, with comments such as “I think about how the mind affects the body and vice versa, and how to address both areas

toward a common goal” and “The body can be important in clinical work, in that there is a mind body connection that is important for the overall health and state of mind of the client.” Three additional responses identified the body as important to general health and well being, such as “it has a fundamental role in health and disease” and “The body and mind are both to be considered for health and well being.”

Eight responses explicitly reported beliefs about the importance of the body in clinical practice, such as “It should be used all the time! Asking clients to connect to their bodies, recognizing what physical feelings come up when discussing/feeling emotions, etc.,” and “[the] mind-body connection [is] very important and woven throughout all my work and especially trauma work.”

Seven responses identified the body as the place where emotions and memories are experienced and stored, such as “Emotions are physical experiences. Therapy involves identifying and getting to know these physical experiences,” “The body is a container for our experiences throughout life. It expresses thoughts and feelings verbally and non verbally,” and “The body holds memories that we cannot articulate and cannot access through talk therapy alone.” A few of these also specifically referenced trauma: “The body remembers pre-verbal trauma. Psychosomatic symptoms are often the bubbling up of repressed trauma memories.”

Seven responses named specific body-based interventions, including “mindfulness, presence,” “Sensorimotor integration therapy,” “non-traditional interventions; moving, mindfulness, breathing; being in tuned to the body during a session, as well as times in between sessions,” and “facial expressions, body language, breathing as informative and possible sources of intervention.” In these responses, touch was only mentioned once; the remaining interventions were all non-touch in nature.

Five responses referenced the body serving as the fundamental basis for communication and building the therapeutic relationship, and emphasized the importance of the clinicians' body language and awareness: "The body of the clinician is a delivery mechanism for interventions and means by which the alliance is made tangible, both consciously and unconsciously."

Four respondents cited the importance of using the body in treating specific conditions, including eating disorders and trauma; for instance, "I work a lot with clients with disordered eating, so body is both essential and often disconnected for my clients. Grounding, meditative yoga, and breathing to build awareness of the body and connection between body/mind/spirit is a big part of my practice," and "As a clinician specializing in the treatment of eating disorders, the body is critical - its weight, one's perception of their body, their body as the place where experiences are captured, remembered."

Although a majority of responses indicated that the body is relevant and valuable, as described above, a significant number (10) also suggested that the body is generally not considered or used in clinical practice, as seen in comments such as "[The body is considered] very little other than the body mind connection and the psyche as part of that" and "[The body is] probably generally not considered anything to focus on unless someone has an illness." However, of these ten responses, half suggested that although the body is not often used in clinical practice, it *is* important and should be used more often, as seen in the comment "I think that the body is often ignored by most clinical social workers but I believe and my practice reflects the belief that the body is as important as our thoughts, feelings and behaviors. We often ignore what our body tells us about ourselves. I also believe that the body holds memories that we cannot articulate and cannot access through talk therapy alone."

Four responses also reflected either concerns about use of the body in clinical work – such as the one-word response “Uncomfortable” – or stigma related to it: “[the body is] not [considered] enough, due to the potential problem that clients may distort the purpose or meaning of any kind of ‘touch.’” Half of these responses explicitly mentioned touch, which may reflect that concerns about the role of the body in clinical work are often connected to concerns around touch in particular.

Quantitative responses.

Quantitative questions were also used to assess respondents’ attitudes and beliefs about the role of the body in clinical work, and 74% reported believing that the body is “important” (26%) or “very important” (48%) to their clinical practice. Another 15% who reported that the body is “somewhat important” to their clinical practice, and only 11% reported it as “unimportant” or “very unimportant.”

Likewise, when asked to indicate which statements best described their approach the body in clinical social work practice, 76% endorsed the statement “the body is relevant to clinical practice, and some touch-based interventions are appropriate for clients who are able to benefit and for whom there is no likelihood of harm.” By contrast, none selected “the body is not relevant to clinical practice, only to physical disciplines such as medicine,” although 13% agreed with the statement “the body is relevant to clinical practice, but touch should never be used (outside of common social touch such as handshakes).” A majority (58%) also endorsed the statement “touch-based interventions may be contraindicated if clients are survivors of sexual or physical abuse or are tactile-defensive.” Only 18% of respondents agreed with the statement “the body is relevant to clinical practice, and touch-based interventions are most appropriate in work with the terminally ill or with infants and very young children whose caregivers are present.”

As in the previous section on clinical use of the body, questions aimed at ascertaining respondents' beliefs about the appropriateness of the body in clinical work found that non-touch interventions were most often viewed as appropriate, and by contrast, active touch techniques were most often viewed as inappropriate.

The passive, non-touch intervention of observing body language and posture was most often cited as "very appropriate" (76%), followed by active, non-touch interventions such as breath or body awareness (52%); meditation (44%) and movement (31%). In contrast, therapeutic touch-based interventions from trained clinicians were most often viewed as very or somewhat inappropriate (56%), followed by informal non-erotic touch to convey meaning or support (30%).

However, it is also notable that although therapeutic touch-based interventions were most often cited as inappropriate, 45% of respondents identified it as at least somewhat appropriate. Similarly, 71% of respondents identified informal non-erotic touch as at least somewhat appropriate. This suggests that although touch-based interventions are the most likely body-based intervention to be viewed as inappropriate, there are also significant numbers of respondents who do find them appropriate.

Barriers

Respondents appeared nearly evenly split on the question "Are there any barriers that prevent you from working with the body in some way that you feel would be useful in your clinical work?," with just over half responding "no" (51%) and the other half responding "yes" (49%).

Those who responded "yes" were then asked to elaborate on the barriers they perceive as preventing them from working with the body. Qualitative analysis identified a number of themes

in the responses, and some of the most commonly cited barriers cited related to ethical, legal or liability concerns, as seen in responses such as “not understanding how the law and ethics of the profession cover these types of interventions,” “[the] legality of touch with clients leads me to believe that no touch is a best practice,” and “I think the use of Therapeutic Touch would be very useful in a lot of my work [but] I'm too afraid of any repercussions.” Another closely related theme identified stigma around touch in the profession, such as in the response “Traditional clinical boundaries that have been placed in western therapies. ‘Don't touch a person for fear of lawsuit or liability.’”

Another common theme related to a variety of clinical concerns, such as “appropriateness for individual clients” and “caution around overwhelming a client” As one respondent articulated, “touch-based interventions, like any intervention, must be specifically assessed and understood within the unique context of every individual client, his/her needs, functioning, goals, the role of the therapist, the therapeutic alliance, the risks to the client and to the therapist.” Other clinical concerns related to transference (including sexual transference), blurred boundaries, and clinicians’ own histories of trauma or body-related issues.

Other themes included barriers related to lack of training or knowledge, limitations due to agency policies and norms (i.e., “it is not fully understood or welcomed across disciplines and within my department”), and concerns when working in a medical setting or with clients who have medical issues.

Training and Education

Nearly half of respondents (49%) described their knowledge of the body as “sufficient for my clinical needs,” and another 33% called their knowledge “somewhat sufficient.” While 15%

identified their knowledge as “exceeding” or “greatly exceeding my clinical needs,” only 4% identified their knowledge as “not at all sufficient.”

Sources of learning.

Another question sought to identify how much knowledge of the body respondents have gained from various sources of learning. Overall, these results suggest that respondents’ primary sources of learning about clinical use of the body came from outside the social work profession. The largest number of respondents reported learning “a lot” or “a great deal” from personal or independent study (64%) and other professional training (49%), followed by on the job training (31%), continuing social work education (24%) and graduate school (5%). Graduate school was the least cited source of learning about clinical use of the body, and had the highest number of responses (64%) citing “no” over “very little” learning from this source, although 27% of respondents indicated “some” learning.

Both on the job training and continuing social work education showed similar response patterns, with responses divided among “none” or “very little,” “some,” and “a lot” or “a great deal.” For instance, 31% of respondents reported learning “a lot” or “a great deal” about the body through on the job training, and another 26% reported learning “some.” However, a large group (44%) also reported gaining “no” or “very little” knowledge through on the job training. Similarly, 24% of respondents identified continuing social work education as a source of “a lot” or “a great deal” of knowledge, and another 38% reported learning “some” in this context, yet another third (36%) reported learning “none” or “very little” from this source.

Training needs.

Respondents were also asked in an open-ended format what additional training regarding the body they feel they most need, and qualitative analysis was used to identify a number of

themes in the responses. A large majority of respondents identified a range of specific modalities or types of training. Of these, the most commonly cited were sensorimotor psychotherapy or somatic experiencing, followed by training about the nervous system, including topics such as the neurobiology of anxiety and trauma, and the ways that “neural pathways change with psychological growth.” A few respondents also identified professional training on the use of touch in practice, alternative modalities such as EMDR, meditation, yoga and Reiki and general training in mind/ body connection.

A number of respondents also identified a need for training to better understand how to use touch safely and effectively in clinical settings, including “when it is appropriate to use supportive touch,” which “specific techniques [have been] found to work best with certain issues or diagnoses,” and “clinical evidence of clinicians who do use body work versus clinicians who do not...i.e. what are the best practices?” Two respondents also identified the need for additional training on the “legal and ethical implications before practice,” including “what is legal and appropriate in regards to client touch” and mentioning “litigious clients” specifically. Another seven respondents replied that there was no additional training they felt they needed, and one additionally replied that they were “not sure.”

In addition, although the question did not ask about sources of training, it is notable that four respondents independently reported feeling that graduate school should include training on the subject, specifically including “the physical experience of emotion” and “mind-body connections and research.” This is consistent with the finding reported above that graduate school was the least often cited source of learning about clinical use of the body, and builds on it by suggesting that this may be perceived as an unmet need in graduate training.

Influences shaping clinicians' approaches to the body.

Respondents were also asked to describe what has most influenced their understanding of and approach to the body in their clinical practice, and qualitative analysis found that most responses fell into one of three major categories: personal body-based practices or experiences; clinical or on-the-job experiences; and training or continuing education. All three categories had fairly even numbers of responses and were broken into further sub-categories to identify more specific themes.

The majority of responses in the category of body-based practices or experiences referenced personal meditation or mindfulness practices, followed by personal yoga practices. A few additional respondents referenced their experiences receiving or providing bodywork, or their experience in physical disciplines such as exercise and dance.

Within clinical or on-the-job experiences, respondents cited general practical experiences, such as “professional interaction with patients” and “trying it in practice,” as well as observing the impacts of interventions or approaches on various clients. Examples of this include “the effectiveness of breathing exercises and meditation in working with older adults who are trying to cope with serious co-morbid medical conditions” and the respondent who stated “working with eating disorders has made me very aware of the body and the usefulness of working with it in therapy.” Respondents also reported being influenced by colleagues practicing body-based approaches and clinical supervision.

Under the category of training and continuing education, respondents cited general training experiences as well as a number of specific types of clinical and alternative trainings, including EMDR, DBT, dance/movement therapy, Intensive Short Term Dynamic Psychotherapy, infant observation training, Therapeutic Touch, Reiki, yoga therapy, Somatic

Experiencing, and training in sensory integration disordered children. Four respondents also mentioned trainings specifically related to trauma. An additional four respondents identified independent reading and research as an influence, and three respondents identified professional training in other fields as an influence, including training in public health, biology and nursing.

Outside of these three major categories, five respondents also cited other personal experiences that shaped their understanding and approach to the body in clinical settings, including their own experiences in therapy as well as their own body concerns or medical issues. Another three respondents cited spirituality generally, and three more specifically mentioned Buddhist study or meditation practices.

Respondents were also asked quantitative questions about how often they engage in various body-based self-care practices, and the impact of these practices on their clinical approach to the body. A large majority (85%) reported exercising at least once a week, followed by meditation (44%), yoga (36%), dance (15%), sports (12%), receiving bodywork (4%) and martial arts (2%). Many respondents also reported that engaging in body-based self-care practices had impacted their clinical approach to the body to some degree, either “greatly” (46%) or “somewhat” (40%), which supports the qualitative findings discussed above. An additional 11% identified the impact as “little,” and 4% reported no connection between their self-care practices and clinical approach to the body.

Statistical analysis

Two types of statistical tests were used to look for correlations between respondents’ demographic characteristics and beliefs about the importance of the body in clinical practice. A Spearman rho correlation found no significant correlation between number of years in practice and beliefs about the importance of the body in clinical practice. This test was also used to

determine correlations between beliefs about the importance of the body and respondents' reported rates of body-based self care practices, and found weak positive correlations with dance ($\rho=.299$, $p=.030$, two tailed), yoga ($\rho=.348$, $p=.011$, two-tailed) and meditation ($\rho=.282$, $p=.045$, two-tailed), meaning that respondents' reports about the importance of the body increased, the frequency of their participation in these activities also increased, and vice versa. However, the test found no significant correlation with exercise, sports, martial arts, or bodywork.

A t-test was run to determine if there was a difference in the mean response to the question "How important do you believe the body is to your clinical practice?" by additional training, and found no significant difference, suggesting that additional training did not correlate with increasing reports of the body as important.

CHAPTER 5

Discussion

Context

The sample used for this study is not representative of the overall population of clinical social workers, which is important to bear in mind when attempting to understand the implications of these findings. In addition to being significantly overrepresented by white women, the sample was also comprised of a high number of seasoned clinicians: 84% reported being in practice for more than ten years, compared with only 61% in the general population of licensed social workers with an MSW in the US (Whitaker, Weismuller, Clark, & Wilson, 2006).

The sample also likely had other biases due to the use of snowball sampling technique, which relied upon my professional social networks; as I am a massage therapist and yoga instructor, my contacts were likely to include more people with an interest in or knowledge of the body than exist in the general population. A number of data points seem to demonstrate this overrepresentation: 48% of respondents reported receiving professional training related to work with the body, and although it is not known how this compares to the general population, it seems quite high. Similarly, 49% of respondents described their knowledge of the body as somewhat sufficient for their clinical needs, and only 4% described their knowledge as not at all sufficient.

Due to these biases, future research is needed to determine how the findings of this study compare with the views of the broader population of clinical social workers. In addition, because

respondents typically fell into one group – white women working in outpatient settings with adults and/or adolescents – it was not possible to analyze the data for correlations between demographic characteristics such as gender, race or ethnicity, work setting or population served and attitudes about the role of the body, and this is another area for potential future study.

The body is seen as important and is often used in clinical work

One of the broadest findings from this study is that a large majority of respondents reported believing that the body is important to clinical work: 89% of respondents reported believing that the body is at least somewhat important to their clinical practice, with 48% identifying it as very important, as compared with only 11% reporting that it is unimportant or very unimportant. Similarly, when asked to indicate which statements best described their approach the body in clinical social work practice, 76% endorsed the statement “the body is relevant to clinical practice, and some touch-based interventions are appropriate for clients who are able to benefit and for whom there is no likelihood of harm,” while none selected “the body is not relevant to clinical practice, only to physical disciplines such as medicine.” Although these attitudes seem consistent with a sample that is overrepresented by those with training in the body, statistical analysis did not find a correlation between additional training and attitudes towards the importance of the body. However, future research is needed to determine if this pattern is representative of the broader population of clinical social workers.

Nearly all respondents also reported using the body in clinical practice in some manner. Although the most frequently used interventions were passive and non-touch in nature, such as observing posture and body language, 53% of respondents reported *always* using this intervention, and only 2% reported using it rarely or never. Similarly, 83% of respondents

reported using techniques to increase breath or body awareness at least occasionally, with 52% reporting using them frequently.

This was further supported in respondents' responses to the first question of the survey, which asked for their first thoughts about how the body is considered or used in clinical practice. Given the historical taboos surrounding the body in psychotherapy – in particular, its association with touch, sex, ethical and legal issues – one might expect clinicians' responses to associate the body with touch, ethical and legal issues, and consequently fear and apprehension. On the contrary, respondents' first thoughts about the role of the body were generally positive and did not mention touch, citing the body as an important tool for clinical assessment or intervention, asserting its general importance in clinical work, naming a range of specific body-based interventions, and reporting views of a mind-body connection generally, as well as specifically mentioning physical manifestations of affect and the ways the body processes and stores experiences. Ten responses did express views that that the body is generally not considered or used in clinical practice; however, half of these suggested that although the body is not often used in clinical practice, it is important and should be used more often. The seven responses that referenced particular body-based interventions encompassed a broad range, including mindfulness, sensorimotor integration therapy, movement, breathing, body awareness and body language. Notably, touch was only mentioned once, again suggesting that at least among a majority of respondents, touch was not a "first thought," even when thinking of specific interventions.

In addition, out of 52 responses, only four referenced discomfort, concerns or stigma about the use of the body in clinical work. It is also noteworthy that of these four responses, two mentioned touch explicitly. While it appears that the idea of "the body" is generally not

inherently associated with touch, taboo or fear, this suggests that concerns about the role of the body in clinical work may often still be connected to concerns around touch in particular, a theme that emerged in other areas of the survey as well.

In general, these responses reflect a relatively high level of awareness of a wide range of body-based interventions and knowledge of mind-body processes, which seems to support Rowan's (2000) contention that a more integrated view of the body and mind as inextricably linked is gaining traction within psychotherapy, replacing outmoded models rooted in Cartesian dualism of mind and body as separate entities. A number of responses also referenced the biophysical elements of affect and memory, which may be one effect of the increasing research and knowledge in the fields of neurobiology and trauma theory about the physical mechanisms that connect mental and emotional experiences to the body, and the advances in these fields may be important factors in supporting the shift toward an integrated view of the mind and body.

Cautions around the use of touch

Although there is growing awareness of the importance of the body in clinical work, incorporating touch into therapy remains an issue of concern, conflict and complexity. While the body is often used in clinical practice, this most commonly takes the form of non-touch interventions, and survey responses consistently showed significantly more hesitancy or concern about touch-based interventions. Notably, all of the non-touch interventions (observing body language and posture, breath or body awareness and movement) were used more often than either type of touch (informal, non-erotic touch or therapeutic touch from trained clinicians). Likewise, whereas 98% of respondents reported using observation of posture and body language at least occasionally, only 11% reported using therapeutic touch at least occasionally, and 67% reported never using it.

Non-touch interventions were also most often viewed as appropriate, and by contrast, touch-based interventions were most often viewed as inappropriate. The passive, non-touch intervention of observing body language and posture was most often cited as “very appropriate” (76%), followed by active, non-touch interventions such as breath or body awareness (52%); meditation (44%) and movement (31%). In contrast, therapeutic touch-based interventions from trained clinicians were most often viewed as very or somewhat inappropriate (56%), followed by informal non-erotic touch to convey meaning or support (30%).

Touch appears to be used least often and is viewed as the least appropriate type of body-based intervention, supporting the notion of a taboo around touch, yet 45% of respondents identified therapeutic touch as at least somewhat appropriate and 71% identified informal non-erotic touch as at least somewhat appropriate. In addition, only 13% agreed with the statement “the body is relevant to clinical practice, but touch should never be used (outside of common social touch such as handshakes)” indicating a sense among the majority of respondents that some types of touch, at times, may be appropriate.

These findings highlight an apparent ambivalence about touch – a sense that it may be valuable at times on the one hand and hesitancy or concern about its use on the other. Although most respondents’ first thoughts about the role of the body in clinical work were generally positive and did not revolve around touch, when asked what barriers prevent them from working with the body, touch and related concerns about ethics, legal issues or liability were common themes. Another issue seems to be respondents’ uncertainty about how and when to safely and effectively use touch-based interventions, revealing a need for greater evidence-based research and training on best practices when it comes to touch, to help clinicians ensure that they are avoiding harm to clients or professional damage to themselves.

Personal body-based experiences influence views of the role of the body in clinical work

As one might expect, many respondents reported that engaging in body-based self-care practices had impacted their clinical approach to the body to some degree, either “greatly” (46%) or “somewhat” (40%). This was further supported by statistical analysis that found positive correlations between respondents’ reported rates of practicing certain body-based activities – dance, yoga and meditation – and their views regarding the importance of the body, suggesting that as participants’ practices of these activities increased, so did their views of the importance of the body in clinical work. This also appears to be consistent with previous studies that linked various elements of personal experience with increasingly positive views of the role of touch in psychotherapy, including specific training in touch (Stenzel & Rupert, 2004; McRae, 2009) and positive experiences of touch in their own personal psychotherapy (Milakovich, 1998).

This finding suggests that there is an experiential element that supports utilizing the body in clinical social work in some capacity. Despite the sense that there is a need for more research to create an evidence base for better understanding how and when to use the body in treatment, it seems that those practitioners who “know” the importance of the body from their own personal experience are more likely to view it as clinically valuable for their clients than those who have not, regardless of how much specific training they have had in body-based interventions.

In addition, there has been a rise of popularity of yoga and meditation in the US in recent years. Between 2008 and 2012, the number of yoga practitioners in the US grew 29%, from 15.8 million to 20.4 million, and even among those who did not practice, 44% reported an interest in trying yoga (Yoga Journal, 2012). The number of people practicing meditation in the US has also grown from 7.6% in 2002 to 9.4% in 2007 (Barnes, Bloom, Nahin, & National Center for Health Statistics (U.S.), 2008). One implication of this trend may be that as increasing numbers of

clinical social workers begin to practice yoga and meditation, there may be a corresponding increase in views of the clinical importance of the body across the field.

Disconnect between practice and graduate training

Although a large number of respondents reported using the body in their clinical work, there is a gap in this area between practice and training, particularly in graduate school, which was the least cited source of learning about clinical use of the body. The largest group of respondents (64%) reported “no” or “very little” learning from this source, which is consistent with other findings that despite prevalent use of non-erotic touch among practitioners, social work graduate curricula do not address the ethical or practical considerations regarding use of touch, which likely is caused by (and then reproduces) discomfort about and uncertainty with the subject (Burkholder et al., 2010).

Although the role of both the body and touch in clinical practice are complex and potentially fraught, there is a clear need for the professional community to begin to find ways to address these topics explicitly, particularly in graduate school, given that both are widely used in practice in a variety of ways. Despite this absence, respondents did cite learning “a lot” or “a great deal” about clinical use of the body from sources outside the social work profession, including personal or independent study (64%) and other professional training (49%).

Although only 5% reported learning “a lot” or “a great deal” from graduate school, other sources of learning within the profession included on the job training (31%) and continuing social work education (24%), suggesting that there is some awareness and discussion of the topic within some parts of the professional community, and future research could investigate the content provided by these sources as a starting point to address integrating training into graduate school curricula.

While a majority of respondents (64%) characterized their knowledge of the body as at least sufficient for their clinical needs, this seems to likely reflect the high degree of training among this sample, 48% of whom reported completing professional training related to work with the body, and an area for future research would be to determine the level of training and need for greater training among the broader professional population.

Conclusion

Despite the conflicted nature of the history of the body in psychotherapy and lack of graduate training, this study found that the body is widely seen as an important source of clinical information and a potential avenue for a variety of interventions. Further research is needed to determine if these attitudes and practices are representative of the broader population of clinical social workers, although it seems likely that many are using the body in clinical practice in some way, even if that simply entails observing body language and posture. Additional research is also needed on how, when and why clinicians use particular body-based interventions, as well as the efficacy of these interventions, to further develop an evidence base supporting their appropriate use and to foster further dialog among the professional community on the role of the body in clinical work.

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Appendix A

Human Subjects Review Committee Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 28, 2012

Kate Grisard

Dear Kate,

You did a very nice job on your revisions. Thank you for your clear and careful effort! Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Happy New Year and good luck with your study!

Sincerely,

A handwritten signature in black ink that reads 'David L. Burton'. The signature is written in a cursive style with a long horizontal line extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Appendix B

Survey Instrument and Informed Consent

1. Are you currently a licensed clinical social worker in the United States?

Yes

No

Informed Consent

Dear Participant,

My name is Kate Grisard, and I am a graduate student at the Smith College School for Social Work. I am conducting research for my Master's thesis, which explores how clinical social workers view the role of the body in clinical practice.

To participate you must currently be a licensed clinical social worker in the United States.

The study will be conducted through a quantitative survey that will be administered via this website (SurveyMonkey.com). You will be asked approximately 20 questions regarding how, when and why you do or do not incorporate the body into your clinical practice. For this study, "the body" is broadly defined and you will also be given a list of options and asked to indicate which best describes how you understand this concept. You will then be asked a few demographic questions, such as number of years in practice, training background, primary population worked with and work setting, gender, race and ethnicity.

There is no generally held consensus about the appropriate role of the body in clinical practice, aside from taboos on sexual touch, which is not the focus of this study. However, because some perceive the role of the body to be an ethically confusing area, there is a small risk that by participating in this study and reflecting on your understanding and experiences of incorporating the body into your work may cause negative emotions to arise. Possible benefits from participating in the study include experiencing participation as informative, having the opportunity to reflect upon your practice, and knowing that your responses could be contributing to the development of knowledge regarding the role of the body in clinical work. Unfortunately, no monetary or material compensation for your participation is provided.

This survey is anonymous. Some questions will include open-ended areas for response, and in the interest of confidentiality, please do not provide any names or identifying information about yourself or your clients. Any identifying data you inadvertently include about yourself or your client will be treated confidentially and then deleted. All data from the questionnaire will be kept in a secure location for a period of three years, as required by federal guidelines for research, and data stored electronically will be fully protected. If the material is needed beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed.

Only myself and a statistician employed by Smith College will view the initial survey data. Once data have been aggregated and any identifying information has been deleted, my research advisor will also view it. Likewise, if material from this study is used for future presentation and publication, it will be presented in the aggregate and any possible identifying information will be removed from open-ended responses.

Your participation in this questionnaire is voluntary. You may refuse to answer any question on the survey. You may also withdraw from the study at any time by closing your web browser or navigating away from the webpage. If you do this, any answers you provided to any previous questions will be immediately deleted. However, once you complete and submit your answers to the questionnaire, it will not be possible to withdraw, because your responses will not be able to be identified.

If you have any concerns about your rights or about any aspect of the study, you are encouraged to contact me directly at kgrisard@smith.edu or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY CHECKING THE BOX BELOW THAT SAYS "I AGREE," YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print a copy of this page for your records.

2. Do you agree to participate in this study?

I agree

I do not agree

Clinical use of the body

3. In a few brief words, phrases or sentences, please describe what first comes to mind when you think of how the body is considered or used in clinical social work practice.

4. How often do you utilize the following types of interventions with clients in your clinical practice?

	Always	Very Frequently	Frequently	Occasionally	Rarely	Very Rarely	Never
Therapeutic touch-based interventions (please specify type below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Informal non-erotic touch to convey meaning or support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breath or body awareness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meditation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Movement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Observing posture and body language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you selected the first response, please specify type:

Clinical use of the body

5. Which types of clients or conditions do you most often use the following interventions with?

	Anxiety	Depression	PTSD/ Trauma	Substance abuse	Eating disorders	Other (please specify below)
Therapeutic touch-based interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Informal non-erotic touch to convey meaning or support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breath or body awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observing posture and body language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you selected other, please specify:

6. Are there types of clients or conditions you feel the following interventions are least beneficial or contraindicated for?

	Anxiety	Depression	PTSD/ Trauma	Substance abuse	Eating disorders	Other (please specify below)
Therapeutic touch-based interventions from trained clinicians (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Informal non-erotic touch to convey meaning or support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breath or body awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observing posture and body language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you selected other, please specify:

Attitudes and beliefs

7. In your opinion, how appropriate are the following types of interventions with clients in the type of clinical work you practice?

	Very inappropriate	Somewhat inappropriate	Appropriate	Somewhat appropriate	Very appropriate
Therapeutic touch-based interventions from trained clinicians (please specify type)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Informal non-erotic touch to convey meaning or support (such as a hug or touching a client's hand)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breath or body awareness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meditation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Movement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Observing posture and body language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please specify below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you selected other, please specify:

8. How important do you believe the body is to your clinical practice?

- Very unimportant
- Unimportant
- Somewhat unimportant
- Somewhat important
- Important
- Very important

9. Briefly describe how you understand the role of the body in your clinical work.

Attitudes and beliefs

10. Which statement best describes how you approach the body in clinical social work practice? (Choose all that apply)

- The body is not relevant to clinical practice, only to physical disciplines such as medicine
- The body is relevant to clinical practice, but touch should never be used (outside of common social touch such as handshakes)
- The body is relevant to clinical practice, and some touch-based interventions are appropriate for clients who are able to benefit and for whom there is no likelihood of harm
- The body is relevant to clinical practice, and touch-based interventions are most appropriate in work with the terminally ill or with infants and very young children whose caregivers are present
- Touch-based interventions may be contraindicated if clients are survivors of sexual or physical abuse or are tactile-defensive
- None of the above

11. Are there any barriers that prevent you from working with the body in some way that you feel would be useful in your clinical work?

- Yes
- No

12. If so, please elaborate:

Training and education

13. How would you describe your knowledge of the body?

- Not at all sufficient for my clinical needs
- Somewhat sufficient for my clinical needs
- Sufficient for my clinical needs
- Exceeding my clinical needs
- Greatly exceeding my clinical needs

14. How much knowledge of the body have you gained from the following sources:

	None	Very little	Some	A lot	A great deal	Not applicable
Graduate school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Continuing social work education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
On the job training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal/ independent study	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other professional training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. What additional training regarding the body do you feel you most need?

16. What has most influenced your understanding of and approach to the body in your clinical practice?

Self-care practices

17. How often do you engage in the following body-based self-care practices?

	Never	A few times a year	At least once a month	A few times a month	Once a week	Several times a week	Daily
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Martial arts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yoga	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meditation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Receiving bodywork	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (specify below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you selected other, please specify:

18. What are your primary reasons for this/these practice(s)? (Choose all that apply)

- Exercise/ health
- Body awareness
- Stress relief
- Pleasure
- Spirituality
- Other (please specify)

19. To what extent do you feel these practices have shaped your approach to the body in clinical work?

- Not at all
- Little
- Somewhat
- Greatly

Demographic questions

20. How many years have you been in practice?

- Less than 2 years
- 2 to 5 years
- 6 to 10 years
- 11 to 15 years
- 16 to 20 years
- 21 years or more

21. What is your current primary work setting?

- Outpatient
- In-patient
- Milieu
- Residential
- In-home
- Other (please specify)

22. What treatment modalities do you use in your practice? (Choose all that apply)

- Individual
- Dyadic
- Family
- Group
- Other (please specify)

23. Which of the following client populations do you most often work with? (Choose all that apply)

- Children
- Adolescents
- Adults
- Geriatrics
- Other (please specify)

24. Have you completed any professional training related to work with the body?

Yes

No

25. If so, please describe:

26. How do you identify in terms of gender?

- Female
- Male
- Transgender

27. How do you identify in terms of race and ethnicity? (Choose all that apply)

- White or Caucasian
- Black or African-American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native
- Hispanic
- Multiracial
- Other (please specify)