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An untapped body of knowledge : the use of body language in clinical social work

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ABSTRACT

This mixed-method study explores the role and relevance of nonverbal communication in the clinical encounter as perceived by clinical social workers. A survey of 54 clinical social workers currently practicing with an MSW was used to assess the perceived value, frequency, and presumed usefulness of attending to nonverbal communication between oneself and one's client. The survey also inquired into the depth and breadth of training participants had received in incorporating nonverbal communication into a therapeutic practice. Participants evaluated the quantity and quality of training they received in both MSW and other professional programs, and reflected upon the impact extracurricular, personal experiences had contributed to their sense of nonverbal communication.

The study found that clinical social workers strongly endorse the value and relevance of nonverbal communication in clinical social work. Accordingly, the participants also spoke highly of the value of systematic training in recognizing and interpreting body language in a clinical practice, and reflected positively on the opportunities they had had to develop a body-oriented sensitivity. In contrast, the participants reported that the level of attention their MSW programs placed on nonverbal communication was often peripheral and partial, which mirrors the field's lack of literature on body language. The study found participants' confidence levels in their own ability to assess and utilize nonverbal communication varied widely with a lukewarm average, and that higher confidence levels correlated to outside training with a body-oriented component.

AN UNTAPPED BODY OF KNOWLEDGE:

THE USE OF BODY LANGUAGE IN CLINICAL SOCIAL WORK

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
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“Doing good therapy is understanding that human nature is the body itself.”

(Lowen, 2004, p. 243)

CHAPTER I

INTRODUCTION

It has been said that actions speak louder than words, and that a bat of an eye speaks volumes. We drink in the raw material of a richly textured world through our five senses and concoct meaning from such plain ingredients as the turned corners of the lips or the hunch of a shoulder (Ekman, 2003). Whether you read the *Psychoanalytic Review* or *Vogue Magazine*, it is commonly accepted that humans use their bodies as much as their words to communicate (Fast, 1970). Body language, the implicit transmission of and response to messages between people that occurs on a nonverbal level, is as salient and autonomic as breathing (Siegel, 2001; Stern 1985). Evolutionarily, it predates verbal communication by millennia (Nolan, 1975). Why then does it take a back seat to speech in much of the theory, literature, and leading pedagogy of social work? If body language is in deed an underutilized pathway into the psyche, how do we as clinical social workers engage this resource and harness its Rosetta stone potential?

Traditional psychotherapy, once dubbed “the talking cure” in reference to the healing effects of discharging feelings through speech using free association (Berzoff, Flanagan, & Hertz, 2008), has built into it the presumption that verbal expression is the primary if not exclusive path to insight, emotional maturity, and psychological wellbeing. New analyses of the somatic nature of the psyche are challenging this traditional view (Levine, 1997; Rothschild, 2000; van der Kolk, 1996). This body of work is extremely important to the field of clinical

social work because its validity would require a paradigm shift that encompasses a greater sensitivity to the intertwined nature of the physical and psychological self (Applegate & Shapiro, 2005). The implications of this shift could mean that clinicians with training in body-awareness and body-based techniques may be better equipped to accurately assess and effectively treat their clients (Bloom, 2009; Forrester, 2007; Rothschild, 2000). Because of our ethical responsibility as clinical social workers to utilize the most effective methods available to us (NASW, 2008), it is not only *important* to find out if these techniques are in fact more efficacious, it is also necessary research.

Understanding the integrated nature of body and mind is particularly relevant to clinical social work with respect to the field's commitment to a systems perspective of mental health and wellbeing. Social work is distinct in its approach to psychotherapy in that it frames the mental health of an individual within the context of the family system, community structure, socio-historical setting, and political and economic systems that inform and impact one's path and presentation. We value anchoring the inner workings of one's psychological experience within a full spectrum view of one's environment. Do we, as a field, overlook a person's primary and principal environment: the body? Just as an individual is an inextricable component of a social organism, the psyche too is indivisible from the organism it inhabits. A lack of ongoing research and documentation of body-awareness in clinical social work would suggest a shortcoming in the field's commitment to holding a person-in-situation perspective. A full application of systems theory would involve incorporating nonverbal information and the body itself into theory and in therapy, and calls for further investigation into social workers' practices and regard for the body as environment.

Social work is also dedicated to working with disenfranchised populations, and directly addresses the institutional ties between poverty, racism, and oppressed peoples' access to healthy food, a clean environment, shelter, medical care, and physical safety. In many ways, the body is the battlefield for the assaults of poverty. Diabetes, asthma, pollution-related cancer and illness, violent crime, incarceration, untreated or under-treated medical conditions, food insecurity, and obesity can be considered poverty-related conditions, as they disproportionately affect members of poor and oppressed populations for reasons directly linked to income, racism, and public policy. Therefore, it is especially important for social workers to understand and acknowledge the bodily experience of the people they serve. To ignore the body of the obese diabetic who lives minutes from five corner stores but miles from a supermarket, or of the survivor of gang violence who is diagnosed as agoraphobic, or who cuts or self-medicates with drugs and alcohol, or of the single parent with chronic pain who is unable to work and struggles to support a family, is to ignore a vital aspect of that person's experience and his or her particular struggle with oppression, which is an embodied oppression. We must receive their stories whole, recognizing the physical reality of the person before us, if we hope to address the roots and repercussions of oppression in the lives of our clients in a meaningful way.

Attentiveness to nonverbal communication and embodiment in general is especially pertinent to trauma work (Levine, 2003; Rothschild, 2000; van der Kolk, 1996; Scear, 2004), and trauma work is inextricably linked to the core values stated in the Social Work Code of Ethics of service, dignity and worth of the person, and social justice for all with particular attention to "vulnerable and oppressed individuals and groups of people" (NASW, 2008). PTSD is currently understood as a physiological experience, and as such it is important to be mindful of the physical elements of the traumatized client's internal experience and external presentation.

People who are routinely exposed to dangerous environments and lack the institutional supports, such as medical, educational, and financial safety nets intended to prevent trauma or minimize its impact, are particularly vulnerable to trauma and PTSD. In our commitment to serving vulnerable populations, clinical social workers in particular must be well versed in multimodal approaches to treating trauma. To more effectively engage and treat these clients, we must recognize the ways in which victims of trauma experience living in their bodies in the aftermath of crisis, and incorporate the body as a tool and a guide in reconciling the rupture and regaining psychophysical integration.

In this work I set out to investigate the extent to which body language is spoken in clinical social work. To address this question, first I will review the research on body language itself. Intuitively we sense that we absorb a great deal of information from a person's physical presence, but is it possible to systematically analyze and codify the patterns the same way a linguist would a spoken language? What attempts have been made and what insight has been gained into the language of movement?

My next objective will be to assess the presence or absence of the utilization of body language as a clinical tool in social work. While words have been a primary focus of psychotherapy since Freud's talking cure in the late 19th century, this has often been paralleled by a discourse of body language rich with clues into the therapeutic process (Young, 2006). Recently this position is gaining a stronger voice (Totton, 2003). A number of schools of psychotherapy actively incorporate the body into their theory and practice, using sight, body awareness, movement, and sometimes touch to meet their client in a place beyond words (Johnson, 1997; Totton, 2003). Where does this research intersect clinical social work and how can the field benefit from incorporating body-oriented practices into its repertoire?

In synthesizing the current research and theories around nonverbal communication and its reliable and beneficial use in psychotherapy, this rich groundwork will serve as the backdrop of my own research question: How do clinical social workers evaluate their own use of nonverbal communication in their work with clients? My focus is on the social workers' own perception of their engagement of body language as a clinical tool. I will explore which sources they have found most useful in navigating the clinical encounter between two people, two minds, two bodies in a room. Utilizing a mixed-method study, I hope to broaden the understanding of clinical social workers' thinking around how much they can and do read nonverbal cues from their clients, on what empirical and theoretical grounds, and what moved them toward this sensibility.

CHAPTER II

LITERATURE REVIEW

A broad base of research documents the existence of nonverbal communication and its relevance and value in the context of clinical work. I will review the findings and the attempts to translate and codify body language. Next, I will survey existing psychotherapeutic models for their use of body language as a clinical tool. I will outline the overarching theoretical frameworks that privilege talk over body, and I will investigate therapeutic modalities that actively acknowledge and integrate nonverbal communication in their theory and practice. My intention is to provide a rich foundation from which to address my inquiry into clinical social workers' perceived experience of body language as a therapeutic tool.

Evidence of Nonverbal Communication: The Science of Body Language

While no one denies the existence of nonverbal communication, developmental psychology offers a particularly useful lens through which to view its essential function. Studying the preverbal infant gives us insight into adult nonverbal communication. Although infants do not begin to speak words until around one year, by 4-6 weeks they study their caregivers' faces, begin to establish eye contact, and smile; at 6-8 weeks they are highly responsive to their caregivers' facial expressions, movements, and voice tones, and they begin to express emotions in their own faces; and by 3 months they regularly recognize and respond to their caregivers' affect (Siegel, 2001). This suggests that communication begins long before speech.

Significantly, infants' sensory functioning is not impartial, and evidences an innate wiring to be relational. Research in child development has revealed that infants prefer looking at faces, especially that of their caregiver, and prefer their caregiver's voice over that of a stranger (Davies, 2011). Schore (2003) remarks, "the mother's emotionally expressive face is, by far, the most potent visual stimulus in the infant's environment," with special attention to the eyes. He describes "periods of intense mutual gaze" between mother and infant as a "potent interpersonal channel for the transmission of 'reciprocal mutual influences,'" which is to say "the pupil of the eye acts as a nonverbal communication device." This moment-to-moment state-matching process of "affect synchrony" is so rapid that it "suggests the existence of a bond of unconscious communication" (p. 13).

Attachment theory attributes this highly sensitive, social, multimodal communication apparatus to a survival-based need for infants and caregivers to bond. The entirety of the sensory body is wired to attach, as the survival of the species depends on the ability of the infant to communicate its needs and elicit attuned responses from adults (Davies, 2011, p. 10).

We can look to neurobiology to elucidate the process. The relatively recent discovery of mirror neurons has grounded the concept of empathy and social development in science. Mirror neurons in the frontal cortex allow a person to vicariously experience what they observe in another person. They cause us to wince involuntarily at the sight of a bicyclist tumbling and skinning her knee, or smile when met with the smiling face of another person. This demonstrates an innate neurological wiring for empathy and attunement, and is the basis of preverbal communication, which Stern (1985) describes as a "shared framework of meaning and means of communication using gesture, posture and facial expressions" (p. 125). Berrol (2006) cites several researchers (Gallese, 2005; Schore, 1994; Stern, 1985) who "posit that because of the

trans-modal nature of the mirror neuron system, not only can the actions of others be understood and embodied, but likewise their intentions" (p. 309). This capacity has important implications in the field of psychotherapy, and requires clinicians to consider their own relationship to embodied forms of communication.

Understanding the biological nature of attachment and nonverbal communication begs the question, how are we structuring the therapeutic encounter to mirror and support our innate modes of communication? To answer this question, it is necessary to review the conceptualization of the body in the sources from which clinical social work has built its theoretical base and continues to refine itself.

Let's Talk: Theoretical Foundations of Talk Therapy

Johannes Christian Reil coined the term psychotherapy in 1803 as "the application of psychic methods in the treatment of mental disturbances" (Guimon, 1997, p. 3). These "psychic" methods represented a radical departure from a history of physical methods such as drilling, lobotomies, and balancing humors, as well as spiritual methods such as exorcism and shamanistic practices. By the end of the century, a working model of psychotherapy existed in contrast to the prior model of materialism that "gave the body first place and relegated the psyche to the rank of something secondary and derived" from the bodily balance of humors (Jung, 1936, p. 135). However, the term "psychic" is somewhat of a misnomer in that the physical (and in some cases spiritual) aspects of humanity continued to play a key role in psychoanalytic thought.

Sigmund Freud is often credited with galvanizing the revolutionary shift in treating the mind through mental means, yet his original conception of the psyche was in fact quite body-based. His drive theory draws on animal instinct and is visceral to the extent that his

contemporary Carl Jung laments, “Freud, unfortunately, succumbed to the medical man’s temptation to trace everything psychic to the body, in the manner of the old ‘humoral’ psychologists” (Jung, 1936, p. 138). This highlights Freud’s legacy as a neurologist investigating the nature of the human psyche from a physiological standpoint. Freud proponed that “the ego is first and foremost a body-ego. It is not merely a surface entity, but is in itself the projection of a surface” (Freud, 1927, p. 31). This conception of the body-ego influenced his contemporaries Pierre Janet and Wilhelm Reich, whose work laid the foundation for body-oriented psychotherapy.

In spite of growing “out of this basically body-oriented work,” Freud’s psychoanalytic method “ended up as a limited verbal specialization” known as the “talking cure” (Young, 2006, p. 18). This technique was “a verbal (non-corporeal) procedure of resolving unconscious conflicts through the use of transference” (Guimon, p. 3). His method privileges talk as the modality through which unconscious “memory-residues” are pulled into the preconscious where they can be examined and realigned “by coming into connection with the verbal images that correspond” to them (Freud, 1927, p. 21). It is traditionally administered to an analysand lying supine on a couch facing away from the analyst, whose position and affect are meant to reveal as little as possible so as to provide a blank screen onto which the analysand may project their own conflicts and desires. These elements of the Freudian process minimize the potential for nonverbal communication to occur while denying it’s existence, significance, and usefulness in the therapeutic encounter.

Freud’s work is foundational to all subsequent psychotherapies. His placement of the body is crucial to its current place in clinical social work. His conceptualization of the ego as “derived from bodily sensations” (Freud, 1927, p. 31) is central to body-oriented psychotherapy

(Bloom, 2009), and is very much in line with the current discourse around trauma (Rothschild, 2000; van der Kolk, 1996) and the corresponding treatments, including EMDR and Somatic Experiencing. Yet his method developed "into an approach tending to neglect the body and the importance of nonverbal communications as studied by Janet, and to concentrate on primarily verbal communication" (Boadella, 1997, pp. 47-48). "The body was at the centre of psychotherapy when it first started, and then Freud and his followers left the body out of psychotherapy" (Young, 2006, p. 18). Young dates the psychoanalytic community's disavowal of the body to around 1929-1930 with their rejection of Reich and a shift from "more instinctual, organic, and drive-based models of understanding to a more object-relational understanding" (p. 20). Since then, the body has fallen into the shadows in many schools of psychotherapy from which clinical social work constructs its theoretical framework. Today, body-oriented theories and methods remain peripheral to social work training.

There are scores of theoretical works and manuals guiding clinicians through the intricacies of the verbal encounter, with paltry exploration of the corporeal interface. Many standard psychology and social work texts include minimal mention of nonverbal aspects of clinical therapy, such as optimal proximity to the client, eye contact, and positioning. Sommers-Flanagan & Sommers-Flanagan, in one such textbook, *Clinical Interviewing* (2009), dedicate only 1 of 485 pages to the concepts of proxemics and kinetics in the context of advising trainees how to present themselves in relation to the client. Most of these discussions focus on the message the *clinician* expresses through his or her body. Cooper & Lesser's textbook, *Clinical social work practice: An integrated approach* (2008), surveys the major theoretical orientations taught in MSW programs today and makes no mention of body language or nonverbal communication whatsoever. The mental status exam – a standard part of most clinical

assessments –includes an assessment of a client's physical appearance and psychomotor activity. This is at most a superficial and peripheral engagement of body reading. In sum, my research demonstrates a rudimentary awareness of body language in standard social work texts, alongside a dearth of practical tools and discourse to promote understanding one's client through nonverbal means.

Reading Body Language

Following decades of narrow focus on the verbal, a resurging attention toward understanding nonverbal communication began to stir in the social sciences midcentury. Researchers from various disciplines began to dissect and codify the building blocks of body language. Clinical psychologist Paul Ekman (1980, 1990, 2003), whose research on facial expression spans over 60 years and is based on scrupulous empirical methods involving frame-by-frame video recordings, EEG measurements, and self-reports of subjective emotional experience, has broken down the full range of facial expressions into coded combinations. With respect to the body, Alexander Lowen (1958) built upon Wilhelm Reich's character analysis of muscular tensions to develop his own system of psycho-somatic assessment, Bioenergetic Analysis.

Interest in body language is not the sole provenance of psychology, either. Anthropologist Ray Birdwhistell (1952) founded the field of kinesics. He broke down observable human gestures from eyebrow to elbow into their individual parts, which he termed kinemes, similar to the phoneme of phonetics. Rudolf Laban (1950) was a dancer and theorist who developed a language for interpreting, describing, and notating the range and qualities of human movement called Laban Movement Analysis (LMA). His system of Labanotation provides a common language for practitioners to verbally and visually process body language. Dance

Movement Therapists use LMA to attune to their clients' affect and defense mechanisms (Govoni & Weatherhogg, 2007).

Albert Mehrabian's (1971) research on communication found that a great deal of our impressions of what others say is largely informed by nonverbal cues such as vocal tone and facial expression. He postulated that a subject's liking of a message derives from multiple sources of information: 7% verbal, 38% vocal, and 55% facial. Mehrabian's rule is frequently misinterpreted to mean that 93% of *all* communication is nonverbal. In fact he was studying the transmission of subtle emotive messages and contends that verbal language is essential to conveying messages, as anyone would know from attending a lecture with a broken microphone or listening to someone speak an unfamiliar language. Yet his research represents a significant contribution to quantifying the impact of nonverbal communication.

Paralleling the advancement of evidence-based research mapping codes and discourse onto the terrain of the unspoken, the 1960's and 70's brought with it a burgeoning of interest in the prominence and translation of body language among popular writers as well. Julius Fast (1970) is not a psychologist and did not produce original research, but his engaging writing has largely popularized the notion of body language. He draws from personal observation and the works of other social scientists, including Ekman and Birdwhistell, in devising a claim for a bona fide language of the body. The social scientists and writers of this dynamic era tilled what was at this point fertile ground for a corporeal renaissance in psychotherapy.

Talk Is Cheap: Movement Toward Engaging the Body in Therapy

In the past 40 years, an abundance of body-oriented modalities have sprung forth and embedded themselves in the discourse and practices of psychotherapy, and clinical social work has not been untouched by this flurry. For the purpose of this study, I am using the term body-

oriented psychotherapy to indicate those modalities which esteem the bodily experience as integral to one's psychic experience, and approach psychological healing through a combination of methods that may include talk, movement, visual assessments, and in some cases touch. Social workers' engagement with this trend of acknowledging the somatic aspects of the therapeutic encounter range from pursuing dual degrees in body-oriented modalities to incorporating corporeal awareness into their social work practice, or simply reframing their conceptualization of sitting with another human being. As the primary producer of research related to the integrated nature of body and mind, the burgeoning field of body-oriented psychotherapy currently holds the torch for nonverbal communication, illuminating some key findings worth outlining here.

Young (2006) considers Pierre Janet, whose work predates Freud's by a few years starting in 1889, as "the first proper body psychotherapist" (p. 17). Totton (2003) names Sigmund Freud, Wilhelm Reich, Fritz Perls, Arnold Mindell, and Carl Jung as the foundational "ancestors" (p. 27) of a body-oriented approach to psychotherapy that now encompasses Bioenergetics, Dance Movement Therapy, Gestalt, and more. Humanistic Psychology and Maslow's work in the 1960's and 1970's also eased the emergence of body-oriented psychotherapy as it exists today by "incorporat[ing] a hierarchy of human needs as well as an acknowledgement of the body, the mind, and the human spirit" into mainstream principals (Young, p. 23). From the 1990's to the current day, much of the spotlight has been on the new breakthroughs in neuroscience that illuminate the interwoven nature of body, brain, environment and psyche (Applegate & Shapiro, 2005; Cozolino, 2006; Pert, 2002; Schore, 2003; Siegel, 2001). Many body-oriented psychotherapists draw on these findings to explain and develop their own work (Berrol, 2006; Bloom, 2006, 2009).

Somatic Experiencing (Levine, 2010) and Sensorimotor Psychotherapy (Ogden, Pain, & Minton, 2006) also integrate neurobiology and observations into their formulations of how the body processes, exhibits, and heals itself from trauma. Eye Movement Desensitization & Reprocessing (EMDR) bases its practice of stimulating right and left brain processing via tapping or stimulating both sides of the body in our knowledge of the brain. These practices are compatible with clinical social work (Applegate & Shapiro, 2005). Many social workers anecdotally report seeking out training in these techniques to supplement their clinical practice where it feels deficient. Some practitioners are moved to create their own niche in the field. Ruella Frank (2001) melded her method "Developmental Somatic Psychotherapy" from contemporary developmental psychology and her study of movement patterns. Typical of the creators of these new, small schools of psychotherapy, Frank draws from multiple existing theories in psychology as well as dance and other experiential fields in developing and supporting her technique.

Of the swell of research gathered on the effectiveness of various body-oriented techniques, those that deal directly with a practitioner's use of nonverbal communication are central to answering the question of how social workers can better harness this body of knowledge. The importance of this skill is well supported. "Janet and Reich, and body psychotherapists such as Keleman, Boyesen, and Boadella (and more recently van der Kolk, 1999, and Rothschild, 2000) all affirm that we cannot do effective work in psychotherapy, especially with people with trauma, without significantly using body psychotherapy awareness" (Young, 2006, p. 24).

Many practitioners and researchers have indicated that "we need a language for describing this preverbal dialogue" that structures human patterns of engagement (Bloom, 2009,

p. 178). Trevarthen (2004), based on his studies on mother-infant communication, attests, “I am sure therapists need a model of non-verbal communication based upon acceptance of intrinsic affective states and their communication” (p. 11). Katya Bloom is a movement psychotherapist who advocates using LMA to assist clinical interviewers. She suggests that “embodied attentiveness,” a quality of apprehension and attunement on a bodily level, “offers a way to tap into the preverbal level of communication” (2009, p. 177). Bloom’s finding is that “observers may be able to tune their bodies to receive the language of nonverbal communication more acutely; and this may be an aid to thinking about the development of the emerging mind” in infants (p. 184). She suggests LMA as a suitable framework.

Arnstein, Finset and Piccolo (2011) write about the breadth and depth of nonverbal communication in the therapeutic relationship. They point out many of the subtle messages that are communicated below the conscious threshold, and give recommendations to therapists learning to harness this flow of messages for the benefit of the client’s therapy.

A number of clinicians chronicle the use of the therapist’s own body-awareness and somatic countertransference as a diagnostic tool. Cressida Forester (2007) extols the usefulness of cultivating this sensitivity, and also warns about the dangers of *not* having such an internal compass in place. Her work points to the necessity of questioning and revamping traditionally body-ignoring models on ethical grounds. Marjorie Rand (2002) also writes about “somatic tracking,” the therapists’ use of body-to-body transferred information.

Enough Talk: How Social Work Is Expanding the Discourse

The literature I reviewed revealed a lack of nuanced discussion and instruction regarding nonverbal communication and its clinical implications in the pedagogic texts written by and for social workers. However, while “the body has been increasingly remote from mainstream

psychoanalytic practice" (Totton, 2003, p. 28), there is evidence of a small movement toward applying body-oriented techniques in clinical social work, which reflects a larger cultural reinvestment of interest in the body (Totton, p. 44).

The return of the body as a legitimate focus for mental health professionals can in large part be attributed to the contributions of neuroscience over the past 20 years. The impact of this research extends beyond the body-oriented disciplines of psychotherapy into the mainstream, and recent publications include texts that explicitly apply neurobiology to social work (Applegate & Shapiro, 2005). The scientifically examined brain offers a whole new way to think and talk about the prominent role of the body in matters of the mind. My research across the disciplines of neuroscience, psychotherapy, and body-oriented psychotherapy, reveals an emergent convergence of theory that supports greater involvement of the body and body language in clinical social work.

Totton describes "the subject of body psychotherapy [as] neither the mind alone, nor the body alone, nor even the two linked or in parallel – but the *bodymind*, a unity of which 'body' and 'mind' are each partial facets" (2003, p. 29). Written in the same year but from the perspective of neuroscience, Siegel echoes Totton's "bodymind" with his "brain-body." "We must remember that we never mean to separate the brain from the body," because "the brain and … the body perform specific functions as a part of the integrated biological system that creates the experience of the mind" (Siegel, 2003, p. 13). The neurological processes out of which emerges the psyche involve the entire corpus, as the mind and body develop in tandem. Adopting the view of the brain-body as a unified co-creator of mental life endorses including corporeal information in the therapeutic process.

While social work has long accepted that human development is responsive to and dependent upon interpersonal relationships, only recently has scientific evidence of the relational dimension of brain development emerged. Interpersonal neurobiologists are just now finding scientific evidence to support Winnicott's famous statement half a century ago, "there is no such thing as a baby…a baby cannot exist alone, but is essentially part of a relationship" (1964, p. 88). They extend the concept to assert that there is no such thing as a single *brain*. "Interpersonal neurobiology assumes that the brain is a social organ that is built through experience" (Cozolino, 2006, p. 6), just as psychodynamic theory assumes that the self is a social organism that develops in relation to others. In applying Siegel's concept of the brain-body, it follows that the physical body is the experiential medium of both these internal and social interpersonal processes. It is the medium through which we connect. Thus far, much of social workers' attention has gone toward personal development in the context of interpersonal relationships and larger social systems, with little mind paid to the biophysical element of relational development. Yet attempting to treat the mind in a disembodied vacuum is paramount to treating a client without attention to attachment history, living situation, or losses and supports. As the primary medium of lived experience, the body provides crucial information.

Presenting at the International Congress on The Body in Psychotherapy held in Geneva in 1996, Barale eloquently encapsulated this concept of "intercorporeity as the basis of relationality and intersubjectivity." He invokes phenomenology and developmental psychology to aver "that on the genetic level the experience and image of the child's own body are constituted, in the child, through the intermediation of the body of the other (first that of the mother);" it is in this intercorporeal background, "which still has nothing to do with the 'mind' in the proper sense of the word, but which later will be called the self," that psychopathology may be inscribed (p.

168). In the same conference, Guimon explains how one experiences one's relationship with another "in one's own body" through "tonic states" or postures. Through "tonic dialogue," "we can therefore potentially feel and suffer in our own body the aggressiveness of others and vice versa" (p. 8). Nonverbal communication, therefore, does not end with a child's first words nor is it unilateral, but rather it is ongoing, involuntary, and demands participation; it is not as much a *component* of communication as it is the primary medium *through which* we communicate. This conference and the work cited above demonstrate a convergent recognition across the social sciences of the centrality of intercorporeity, both developmentally and within the therapeutic encounter, to the constitution and resolution of psychopathology.

So what are social workers doing about it? Some have approached reintegrating body-awareness into their practice by studying the application of body-oriented techniques to clinical social work. One studied the clinical application of Dosa therapy, a body-oriented psychotherapy developed in Japan that has been shown to effectively improve functioning in individuals with schizophrenia, obsessive-compulsive disorder, anxiety disorder, hyperventilation, psychosomatic disorder, and depression, based on case study findings in Japan. Kubota (2001) conducted a small-scale study using a single subject methodology to assess the effectiveness of the Dosa method in the treatment of a small sample (n=5) of individuals with anxiety in America. The treatment involved developing participants' own body-awareness and had positive results: Kubota surmised that the intervention facilitated an internalization of a functional, realistic body image and a relaxed state of mind that shifted their perception of outside events, facilitating a positive shift in behavior and psychological functioning. Kubota found that this body-oriented intervention might be effective tool for social work practice, although the sample was so small

and narrow it is impossible to generalize these findings without replicating the results in more diverse populations.

While there are a few studies designed to assess the effectiveness of specific body-oriented interventions in social work practice (Vandereycken, Depreitere, & Probst, 1987; Kubota, 2001), there is very little written explicating how to apply implicit nonverbal methods of attunement for social workers. Toronto (1999) outlines some body-oriented measures, couched in object relations theory, that social workers can apply in their work with clients whose "developmental deficits render the traditional verbal tools of psychoanalytic treatment ineffective" (p. 37). Another source calls attention to the importance of nonverbal attunement regarding work with couples (Pugh, 1986). Explicit theory-based recommendations around attunement to clients' body language is more likely to appear in literature regarding work with body-based diagnoses such as eating disorders and body dysmorphia (Vandereycken, Depreitere, & Probst, 1987), and clients who are preverbal or verbally-impaired. The presence of body language is also noted in work with non-English speaking clients who speak with their therapist through an interpreter (Glasser, 1983).

These articles demonstrate an interest on the part of social workers to enhance their attunement to nonverbal communication. My research shows that they are pursuing this goal via various means; while some seek and incorporate established body-oriented psychotherapeutic interventions, others view working with body language as endogenous to social work. The dearth of literature on the subject of body language from a social work perspective, however, suggests that this topic is still novel or underdeveloped in this discipline. The vast inquiry and discovery around the same topic in related fields only highlights its absence in the social work discourse.

The specialty within social work and related fields that is most involved in integrating body language and nonverbal techniques into its discourse and practice is trauma theory (Van der Kolk, 1996; Scaer, 2001; Rothschild, 2000). Understanding the way the structures of the brain physically process trauma has had an immense impact on the way clinicians conceptualize and treat trauma, and their research is showing a great need to include the body in treatment for it to be effective. In his seminal work, *The body keeps the score*, Bessel van der Kolk (1996) delivers his thesis that trauma influences and shapes basic neurological structures and, contrary to the previous belief that trauma most profoundly affects neocortical functions, in fact affects people on "multiple levels of biological functioning" (p. 215).

There exists general agreement and mounting interest around this point today amongst the overlapping fields of neurobiology (Cozolino, 2006) and psychotherapy. This view of the brain is the basis of Peter Levine's (1997) work with trauma, through which he has developed a body-oriented psychodynamic modality popular among social workers and other psychotherapists called Somatic Experiencing. Congruent with van der Kolk's findings, Levine states that "post-traumatic symptoms are, fundamentally, incomplete physiological responses suspended in fear" (p. 34). His treatment focuses on mobilizing and discharging the frozen survival stance, and the clients' and clinician's awareness of the subtle shifts and signals in the client's physical presentation are central to this process. "Body sensation," Levine states, "rather than intense emotion, is the key to healing trauma" (p. 12).

Babette Rothschild (2000) is another psychotherapist who maintains the centrality of the body in treating trauma. She explains that "trauma is a psychophysical experience" (p. 4) characterized by somatic disturbance. It is therefore essential to attend to the body in therapy. Rothschild extols the benefits of "using the body as a resource" both for the client and as a

therapeutic tool. She advises that developing and "employing the client's own awareness of the state of his body – his perception of the precise, coexisting sensations that arise from external and internal stimuli – is a most practical tool in the treatment of trauma and PTSD," and for client and clinician alike "simple body awareness makes it possible to gauge, slow down, and halt traumatic hyperarousal" and ease the effects of dissociation (p. 100). She recommends providing the client opportunities and techniques to increase "somatic resources" such as using the body as a gauge, an anchor, a brake, and a diary (a place of self-knowledge) to regulate the hyperactive stress response system of the traumatized client.

Rothschild also urges clinicians to monitor the client's bodily state to guide them in pacing the therapy. She shares vignettes to illustrate the grave importance of gauging the state of a client's autonomic nervous system (ANS) by scanning for signs of hyper- and hypo-arousal as indicated in skin tone, sweating, frozen features and tension, and reported sensations. Overlooking these nonverbal signs can impede progress and at worst can even be harmful to the client (p. 110).

Social work is beginning to take on the matter of the body's place in therapy, and produce research revealing the impact of nonverbal communication on the therapeutic encounter. A fascinating experiment comparing social work students divided into three groups who were instructed to pay attention to *the body language* in a filmed interview, pay attention to *the client* in the same clip, and pay attention to the client listening only to the *sound* from the same clip, respectively, found significant differences in the way the three groups assessed the client (Didier, 1976). The findings suggest a deeper understanding of the client when exposed to their visual cues, and the author recommends increasing mimetic involvement (actively seeing the client as

opposed to simply reading or hearing their words) into social work training. Yet studies like this are few and far between in the field of clinical social work.

This review of the literature demonstrates a vast body of research strongly rooted in the scientific method that avers the fundamental nature of nonverbal communication, postulates methods for its analysis, and even outlines its implications and practical application of these principals in clinical psychotherapy. Furthermore, I have found that many of the forerunners of modern psychotherapy drew the body into their theoretical framework. Yet my research has demonstrated a dearth of body-oriented pedagogy in the social work literature. While individual social workers may seek further training or pursue their own original research, it is important for the field as a whole to address this disconnect.

Social work is in a unique position to more fully embody its values of serving disenfranchised populations and truly treating the mind as a piece and product of its multidimensional environment. The literature reviewed demonstrates that the body is a crucial element of one's environment, replete with sensations, signs, and signals that can be harnessed to aide in the therapeutic process. It also reveals increasing movement towards integrating the body more fully into clinical praxis and theory, with neuroscience and embodied practices gaining foothold on the path lain by forerunners such as Freud and Reich. The aim of the study that follows is to give words to this movement as it exists in clinical social work. In light of sparse contributions to this end from the field itself, the question remains how clinical social workers are receiving and incorporating this body of knowledge, and the body itself, in their practices. To approach this larger question, I dug first into social workers' own consciousness around the matter. The exploratory study that follows is an investigation into the relationship between

clinical social workers and this body of knowledge as it is seen, felt, and expressed by the clinicians themselves.

CHAPTER III

METHODOLOGY

Research Design

In order to evaluate social workers' perceived use of nonverbal cues in the clinical setting, I employed an exploratory, empirical study using a mixed method research design. Using an anonymous online survey, I gathered subjective reports from practicing clinical social workers of their use and understanding of body language in their clinical work. The study also inquired into influential sources and settings that shaped their understanding and assimilation of the nonverbal elements of the therapeutic encounter. The survey included both closed and open-ended questions, cultivating sets of both quantitative and qualitative data.

The purpose of this study was to ascertain social workers' perceived awareness of the nonverbal elements of the therapeutic encounter and what training or experience has guided them in developing this clinical skill. At the outset of this study, I expected that many social workers regularly read their clients' bodily presentation out of intuition, and may have a practice of scanning their own bodily state for more information on the encounter. My suspicion, based on my literary research as well as personal and clinical experience, was that these skills were not a central or explicit feature of the standard Master's level social work education, and tend to be sought and acquired elsewhere. In response to the near-absence of literature on the subject written by and for social workers, my goals for this exploratory study were to clarify how keenly social workers attend to these intuitive processes, and how they learned to do so. Are body language and somatic countertransference on social workers' minds? Do we inherently embody

the felt sense as an inborn tool, or do we rely on certain educational experiences to provide an optimal depth of understanding and assimilation? Are we out of step with the current discourse in neuroscience and body-oriented psychology that demonstrates the centrality of intercorporeity (Barale, 1997) in the clinical encounter, and what steps would advance the field of social work?

My operational definition of nonverbal communication, as stated in the survey, is the physiological cues such as facial expression, vocal intonation, body position (i.e. crossed arms, clenched fists), proximity, quality of movement, and internally felt sensations that signal a message or feeling between people, whether consciously or otherwise, without using words.

Research Sample

I administered the survey to practicing clinical social workers with an MSW, as the relevance of the MSW training was pertinent to my research question. I disseminated the survey to personal and professional contacts as well as a few organizations' listservs, including the NASW and the alumnae associations of a couple MSW programs (Appendices A and B). I encouraged participants to forward the survey to colleagues to increase my numbers with snowball sampling. Fifty-four qualifying participants completed the survey. Their experience in the field ranged from under one year to 40 years, with an average of 12 years. Their ages ranged between 20 and 69, with the largest group in the 30's and the second largest in the 50's. 85% of respondents are female, and 93% identify as white.

Data Collection

I collected the data using an online survey (Appendix C). I used Survey Monkey to create and administer the survey, which protects the identity of the participants by displaying their responses unattached to any identifying information. In compliance with the requirements of the Human Subjects Review (HSR), the opening page of the survey outlined the provisions of

anonymity, explained how identifying information provided in written responses would be disguised if used at all, and required consent to participate in the rest of the survey (Appendix D). The methods employed were minimally invasive, and the questions were unlikely to upset the participants. This study and instrument were approved by the HSR (Appendix E).

The survey consisted of 9 demographical questions and 13 research questions that utilize a mix of Likert Scales, yes/no questions, and comment boxes. Demographics regarding the participants' involvement in a body-oriented professional or personal practice aid in isolating their social work training from other confounding variables with more accuracy, as well as track for correlations between one's background and one's use of the body in social work practice.

I acknowledge the highly subjective nature of my inquiry, and in response have deliberately structured my study around clinicians' subjective experience in an effort to produce results of authenticity and integrity. To guard the internal validity of my study against the potential vagueness of *nonverbal communication,* I included operational definitions of that and other broadly defined terms. The qualitative methods and thematic analysis I have incorporated into my research design also serve as a protective element. The narrative feature increases validity by allowing each participant to qualify his or her personal understanding and use of the concepts under investigation. My study was designed not only to analyze the *rate* of perceived awareness, but also to mete out the *meaning* this holds for clinicians.

Data Analysis

I used a combined approach of quantitative and qualitative analyses to process the completed surveys. I used inferential statistics to analyze the quantitative data, and coded the qualitative data of the comment boxes for thematic content. To accomplish this, I employed the grounded theory method of constant comparison, as the words of the participants revealed which

distinctions are most salient in the lived experience of clinical social workers. I coded the data manually, reading through each section of responses at least 3 times before selecting and coding the salient themes that emerged in the process. I drew my conclusions from an in-depth combination of the linguistic and demographic patterns revealed in this multi-prong analysis.

CHAPTER IV

FINDINGS

The purpose of this study was to explore the nature of clinical social workers' understanding and use of nonverbal communication in their work with clients. The study also inquired about their level of training and sense of mastery regarding nonverbal communication, with attention to various sources of learning and their subjective usefulness to clinical work. The findings comprise both quantitative and qualitative measures, and reflect the subjective perspective of the clinical social workers surveyed.

The survey yielded 54 participants who fit the required criteria as practicing clinical social workers with an MSW. Their experience in the field ranges from under one year to 40 years, with an average of 12 years. Their ages range between 20 and 69, with the largest group in the 30's and the second largest in the 50's. 85% of respondents are female, and 93% identify as white.

I will present the quantitative findings first, followed by the qualitative findings. For the duration of this chapter, I will present the quantitative findings as the valid percentage followed by the cumulative percentage in parenthesis. The valid percentage represents the frequency of a given response out of all the responses to a question, while the cumulative percentage includes participants who did not respond in any way to that question. In the cases where all possible participants responded to a question, only one value will be given.

Quantitative Findings

Value and implementation. The findings support the importance of nonverbal communication as a clinical tool in the context of social work. Nearly all the participants, 98%(85%), rate assessing a client's nonverbal communication in clinical work with a value above neutral, and nearly three quarters, 72%(63%), chose the highest point on a 6-point scale to indicate that nonverbal assessment is "very useful" to their work (Table 1). While only half, 48%(43%), selected the highest point to indicate that assessing their own sensations and nonverbal expression is "very useful," still 94%(83%) selected a value above neutral (Table 2), which again indicates a high valuation among social workers of assessing nonverbal communication coming from both the client and the clinician.

Table 1
Reported usefulness of assessing a *client's* nonverbal communication

Response n=47 Total n=54

Value (1=not useful, 6=very useful)	Percent (of 54)	Valid Percent (of 47)
1	0	0
2	0	0
3	1.9	2.1
4	5.6	6.4
5	16.7	19.1
6	63.0	72.3

Table 2
Reported usefulness of assessing one's *own* internal sensations and outward expressions

Response n=48 Total n=54

Value (1=not useful, 6=very useful)	Percent (of 54)	Valid Percent (of 48)
1	0	0
2	0	0
3	5.6	6.3
4	7.4	8.3
5	33.3	37.5
6	42.6	47.9

These responses are a significant indicator of the high value clinical social workers place on nonverbal communication for gathering vital information in the clinical encounter. This high score does not differ between those with or without a body-oriented professional background, and stays steady regardless of years working in the field, according to a relational analysis. Those who have supplemented their MSW education with additional training on nonverbal communication, however, on average indicated a higher value of cueing into nonverbal communication than those who did not. Across the board, this high awareness of the usefulness of sensory modes of communication such as posture and movement, the feelings that arise in one's own stomach or musculature, and the messages sent through the face, is in accord with the research on communication currently emerging in the social sciences. This finding suggests that social workers are aligned with researchers in related fields who promote greater attention to the body as a source of understanding with significant clinical implications.

The study found that 92%(82%) of the participants consciously utilize nonverbally communicated information in their clinical practice at least sometimes, as indicated by their selection of a 4 or higher on a 6-point scale of "never" to "always" (Table 3). Beyond endorsing its importance or even inherency to the work, the grand majority of social workers surveyed claim to actively engage the somatic material of the therapeutic encounter. Yet comparing the 46%(41%) of those who "always" utilize nonverbal information with the 72%(63%) who find it "very useful" (both representing the highest point on a 6-point scale) reveals a significant disparity. If this knowledge is considered so useful, why is it not being utilized to a comparable degree?

Table 3

Reported extent of use of nonverbally communicated information in clinical practice

Response n=48 Total n=54

Value (1=never, 6=always)	Percent (of 54)	Valid Percent (of 48)
1	0	0
2	1.9	2.1
3	5.6	6.3
4	5.6	6.3
5	35.2	39.6
6	40.7	45.8

The answer may lie in social workers' lack of confidence in their ability to integrate nonverbal material into their clinical work. Over half of the participants hover just above and below the midway mark on a scale of confidence in this area (Table 4). The fact that so many of the participants endorse using this body of knowledge in spite of a lack of confidence further demonstrates the high value they place on this resource, and speaks to the inherent nature of the nonverbal to therapeutic work. Yet it could also elicit concern about social workers' ability to integrate the resources of the body into their work with clients in the most skillful way with the most effective results.

This finding adds a context of urgency to the high number of participants who agree they would benefit from further training in this area. An outstanding 90%(80%) placed a value above neutral on further training in this area (a mark of 4-6), agreeing it would improve or enhance their clinical work; *over half* endorsed the *highest* value on this scale (Table 5). This strong interest in further training is not surprising in light of the high valuation and comparatively lukewarm confidence social workers have for integrating nonverbal material into their clinical practice. A relational analysis found this high level of interest to be consistent amongst social

workers *with* additional non-MSW training in nonverbal awareness and those *without* it. Similarly, social workers with three or more years in the field were just as likely to value further training than their less experienced counterparts, notwithstanding their higher reported levels of confidence. The widespread high interest in further training, seemingly unaffected by educational or professional experience, is another indication of the deep regard social workers hold for utilizing body language as a clinical tool and their desire to be taught how to wield this tool.

Table 4

Reported level of confidence in ability to integrate nonverbal material into clinical work

Response n=48 Total n=54

Value (1=not confident, 6=very confident)	Percent (of 54)	Valid Percent (of 48)
1	0	0
2	7.4	8.3
3	14.8	16.7
4	33.3	37.5
5	18.5	20.8
6	14.8	16.7

Table 5

Reported extent to which further training would improve or enhance clinical work

Response n=48 Total n=54

Value (1=not at all, 6=very much)	Percent (of 54)	Valid Percent (of 48)
1	0	0
2	3.7	4.2
3	5.6	6.3
4	20.4	22.9
5	11.1	12.5
6	48.1	54.2

Sources of Learning. The prior findings demonstrate not only an appreciation for nonverbal communication as a clinical tool, but also a desire to actively pursue a more solidly grounded attunement to and discernment of nonverbal messages. The next section of the findings pertains to social workers' evaluation of their education regarding this subject, in which the participants reflected on multiple sources of knowledge and professional development. First, I will present the findings on social workers' evaluation of the training they received from their graduate programs, followed by external training.

While 98%(85%) of the participants rated nonverbal assessment with a value above neutral, only 56%(50%) agreed that their MSW program provided any training in this area at all. This difference is noteworthy, and raises questions around these programs' alignment with the field's needs and interests. Of those whose MSW program did include some level of training in recognizing and analyzing nonverbal communication, 70% found it to be at least somewhat relevant and useful to their clinical work, with only a quarter scoring the highest "very" useful category (Table 6). This one quarter is dwarfed by the nearly three quarters of those who found assessing nonverbal communication to be "very" useful, and suggests a dissatisfaction with the quality of attention paid to nonverbal communication in Master's level curricula for clinical social work. These findings depict a disconnect in the pedagogical tools available and readily utilized in graduate programs for social workers, and help explain the high interest in further training.

Nearly half of the participants in the study have undertaken formal training outside of their MSW program that directly addresses recognizing and analyzing nonverbal communication. These trainings vary as widely as art therapy, theater, vipassana meditation, psychodynamic psychotherapy, ASL, Gestalt Therapy, and Laban analysis, to name several. Of

this group, 59% found this training to be “very” useful and relevant to their clinical social work practice, more than double the number who graded the nonverbal training provided by their MSW program with this same highest mark (Table 7). 86% deemed their non-MSW training at least somewhat useful and relevant to their clinical work. This suggests that there exist more effective curricula and relevant teachings regarding nonverbal communication directly applicable to clinical social work than are currently being utilized in social work programs.

Table 6

Reported usefulness and relevance of MSW training in nonverbal communication

n=27 (those who answered “yes” that their MSW program included some training in nonverbal)

Value	Percent	(1=not useful, 6=very useful)
1	0	
2	18.5	
3	11.1	
4	22.2	
5	22.2	
6	25.9	

Table 7

Reported usefulness and relevance of Non-MSW training in nonverbal communication

n=22 (those who answered “yes” to receiving training in nonverbal outside of MSW)

Value	Percent	(1=not useful, 6=very useful)
1	4.5	
2	4.5	
3	4.5	
4	9.1	
5	18.2	
6	59.1	

Big Picture. These findings are to be understood within the context of the sample studied. Of the 54 participants surveyed, 29%(26%) have been or were currently a practitioner of

a body-oriented psychotherapy, and 74%(67%) regularly engaged in a body-oriented practice such as athletics, dance, or massage. This sample may represent a higher level of body-oriented engagement than the larger population of clinical social workers, with nearly 1/3 professionally and 2/3 personally involved in a body-oriented practice. The sample was self-selected from a pool of my own professional and personal contacts as well as a few professional listservs. By extending my recruitment net as far as I could, I made an effort to collect as diverse a sample as possible.

It is possible that the snow-ball sampling from my own extended network could skew the findings to reflect a higher interest in and valuation of the nonverbal elements of the clinical encounter than exist in the general population, given my positionality in relationship to this issue. However, since there are no prior statistics on the prevalence of body-oriented practitioners amongst the general population of social workers, nor the prevalence of a personal physical practice amongst social workers, it is untenable to speculate how my findings may have differed given a randomly selected sample. Additionally, a relational analysis comparing the responses of those with and without a body-oriented professional background found no significant difference between the two groups' ratings of their value and utilization of nonverbal communication in the context of social work. Their self-reported confidence levels were also consistent. This finding bolsters an argument for the universality of a high awareness and regard for the nonverbal elements of clinical work amongst social workers representing diverse orientations and backgrounds.

In sum, the quantitative findings strongly support an argument in favor of the importance of nonverbal communication in the eyes of practicing clinical social workers, and speak to a need and desire for more in depth training on this subject. Next, I will present the qualitative findings

from this study, which support and flesh out the material covered thus far, for a more nuanced view into the perspective of clinical social workers regarding the essential nature of incorporating attention to the body in their work.

Qualitative Findings

The qualitative component of the study corroborates the quantitative findings with personal, in-depth statements of the participants' relationship to nonverbal modes of working with clients, and lends an invaluable perspective otherwise unexpressed by the numbers alone. Nonverbal expression is described as "integral," "essential," "profound," "important," and "as distinctive and as instructive" and "as important as verbal" to clinical social work. All 37 written responses regarding the usefulness of assessing a client's nonverbal cues affirm the import of this type of clinical information. Seven of them explicitly claim that nonverbal information is as important or even more important than the verbal in comprehending a client's meaning. This is not surprising given the quantitative findings, and serves to clarify how highly social workers value attunement to nonverbal communication in their work.

Client's Nonverbal Communication. The written responses extend the numerical marks with specificity and texture in a testament to the important role that nonverbal communication plays in a clinical practice. They look to it as a "major source of information" and a "gauge" that "guides" assessment and the course of treatment; as an alternate mode of communication to circumvent verbal language barriers; and as a cross-reference to the verbal material. This last theme, articulated ten times, refers to situations in which "a client will say something but their body position will indicate otherwise." One example is of a client who "is smiling while describing a tragedy, or angry in his facial expression despite sounding calm and rational." Noticing incongruence allows a clinician to "point out a facial expression" as an intervention to

"bring the client into focus about what they are feeling" and "support insight and more congruence."

A major theme emerges around the unique position of the nonverbal to access the unconscious, the fertile ground of psychotherapy first systematically mapped and mined by Sigmund Freud. Nine of the 37 responses intimate that the nonverbal can "reveal" the true feelings that a person "may not be aware of," "may have been denying," or may "have difficulty identifying, articulating, and/or exploring." "People are often unaware of their own changing emotional states," and so body language is perceived to have an edge over words in "provid[ing] insight into an individual's experience and/or emotional state, often in ways that the individual may not be aware of or capable of verbalizing." While demographic barriers such as language fluency, dementia, hearing impairment, or preverbal trauma may impinge verbal communication, even in reference to the general population the participants extol the body as the clearest conduit of the unconscious. Speech, to the contrary, is suspected to be susceptible to snaring in the defensive filters of the conscious mind on its way out. "People are often unaware of their own changing emotional states," but "nonverbal communication reveals conflicts, a sense of being understood, unconscious elements of the presenting struggle, unspoken/consciously unacknowledged anxieties, etc."

These comments demonstrate a strong faith in the body to naturally express reality in places where words are either unable or unwilling to speak, as articulated in the following statement: "I find there is valuable information in the nonverbal stuff. When it doesn't match the verbal, I expect that the nonverbal information more accurately reflects the person's true feelings/beliefs, etc, even if they don't know it." This theme of accuracy is related to but distinct from the previous theme of the unconscious, and includes 16 comments on the body as a

uniquely accurate window into another person's feelings. Half of these extend the claim of accuracy to *superior* accuracy; "nonverbal communication can often tell more truth than what a client shares verbally." This relates back to the theme of the body as the bearer of the unconscious, and therefore the more trustworthy vessel for the conflicted feelings of the defended mind. The findings show that it is common for social workers to look to the body for more accurate data than words are thought to provide.

Clinician's nonverbal messages. Similarly, the participants value awareness and use of their own nonverbal messages in session, both as a gauge for their own understanding and as a therapeutic tool for their client's benefit. Expanding the previous finding that social workers believe they *receive* more accurate messages through nonverbal means, the findings reveal the related sentiment that the clinician's nonverbal expressions also *send* a more clear and potent message "at times when words alone are not as effective," namely when dealing with feelings. This mechanism can be a help or a hindrance, depending on the emotion displayed. For example, "at times when words alone are not as effective…it is an important way of conveying empathy." Four participants express concern at the potential of their own nonverbal expressiveness to harm the therapeutic alliance. "If I am unaware of what I'm telegraphing, and it is frightening or off putting to the patient, they might not feel safe." "I think I should pay closer attention, because people pick up on nonverbal cues subconsciously, at least, and I should be careful I am not unconsciously sending a message I did not intend to send." Again, this signifies a hierarchy of expressive perspicuity that places nonverbal above verbal in various instances, particularly when dealing with emotions.

While 13 out of 37 responses to the value of attending to one's own internal and external bodily messages comprised the aforementioned category of external expression, 19 referred to

internal physiological responses. These participants reported a strong reliance on internal signals and sensations to "clue" them into transference and countertransference issues in the therapeutic relationship. A couple participants describe this embodied technique as "an enhanced way to track countertransference" and "the essence of countertransference" itself. This internally sensed form of body language is notably distinct from its expressive counterpart, in its personal rather than interpersonal nature. This process of gathering one's experience of another person through the physiological feeling-states they evoke represents another important component of nonverbal communication in the context of clinical social work, as evidenced by statements offered by over half the group. "How else would I track how I am feeling and reacting to the client and what they perceive from me?" The findings show that many clinical social workers believe that "the clinician's visceral experience is an essential diagnostic tool," and look to their felt responses to a client to hone this dynamic self-awareness that they equate with being a good clinician. "The way I feel in a session is hugely important as it allows me to be aware of my own triggers and not act them out on my clients and to hold appropriate boundaries." Along the same lines, "this provides insight and information about my experience of and reaction to an individual, which can be very useful in recognizing the way in which this individual is experienced by others." A couple say that attending their bodily responses helps them "stay grounded" and "present." The findings show that social workers value and seek a particular kind of self–awareness that involves tuning into their own bodily experience to distinguish between the client's material and the clinician's, an essential component of effective and ethical treatment.

In addition to sending and receiving messages and increasing self-awareness of counter-transference material, the findings show that nonverbal communication is also recognized as a resource for intervention. Nine participants note a technique whereby the therapist can facilitate a

client's self-awareness by reflecting the internal response their presentation evokes. Reflection can "help clients extrapolate how they engage with friends, families and colleagues." With clients who "have difficulty identifying, articulating, and/or exploring their feelings," nonverbal material "provides me with concrete examples to offer them to open a door to a conversation about their feelings." Two more note the therapeutic impact of nonverbally emitting their unconditional positive regard or loving feelings toward their client. One points out how a client's nonverbal messages can be taken as feedback to how interventions are received.

Advancing the prior finding that clinical social workers consider their client's nonverbal exchanges to hold more truth than their words, the findings support a similar view of their own nonverbal sources of knowledge. "I think my body sends me messages before I am aware of them intellectually. If I can be aware of those sensations, I am able to shift the way I am approaching an interaction or a person." Simply put, "our bodies sometimes know more than our conscious mind." These examples speak again to a commonly held belief that the body's access to interpersonal understanding is somehow more direct and accurate than the workings of the intellectual mind. Again, a chord is envisioned between the body and the emotions, those mysterious impulses from the unconscious. The connection is clear for clinicians who see that "many emotional experiences are held in the body and thus provide information that can be useful for people to bring into their awareness."

The findings reflect a consistently high valuation for the nonverbal messages exchanged within the therapeutic dyad as well as sensed within the clinician's own body. Affirmative statements such as the following are exemplary of the value the participants afford the body as a clinical tool: "Information salient to the service of the client comes in through my body." A few admit they do not tune in to their own bodies as much as they feel they should, which further

demonstrates the perceived importance of the body's role in clinical social work. The findings endorse a common understanding amongst clinical social workers that bringing the unconscious material of the body into the conscious light of the mind increases insight and opens new possibilities, facilitating therapeutic change. As one participant states in her closing comment, "I think that it is important to incorporate the body into our work. Insight is not enough. Out bodies, minds, emotions and spirits are connected, and need more integration and fluidity."

Confidence. So how confident do clinical social workers feel in their ability to interpret and integrate this material they deem invaluable? The responses vary widely. Several participants resonate self-doubt in this area, while others claim confidence. Ten humbly acknowledge "room to grow." Five mention a desire or intention to seek further training. Three cite a specific background that has aided their own professional growth in this area, including Gestalt, dance, and art therapy.

A contextualized analysis of the responses regarding confidence allows a look at the relationship between personal and professional background and reported confidence. Of the 29 written responses, I counted 8 resounding statements of confidence and 11 statements of self-doubt; the remaining 10 were neutral or mixed. It was challenging to distinguish lack of confidence from humility or an unquenchable thirst for knowledge, such as in the statements "it's so complex, there is just so much to learn, I'm not sure I would ever expect to get very confident" and "I can't say I use it with 100% effectiveness given my ongoing journey of personal awareness and growth." In the greater context of each one's comments as well as numerical response to this question, I made an effort to read responses carefully to discern which qualified as "confident" or "doubtful," and then graphed their other responses for analysis.

Of the "confident" group, all but one marked a 5 or 6 out of 6 on a scale of confidence, while the "doubtful" marked an almost even spread of 2's, 3's, and 4's, which is congruent with their statements. A comparative analysis found the confident group to have more years of experience (average 17, median 16.5) than the doubtful (average 9.5, median 5). This could suggest that social workers with more clinical experience also tend to feel more confident in their ability to integrate nonverbal material in their work, although a couple responses challenge this interpretation: one explains his uncertainty after 25 years of experience because nonverbal communication "wasn't on the radar as much then" (during his studies) and another with 40 years experience says, "with years, I find I get a bit lost – not confronting as effectively as I used to be able to." Overall, nonetheless, a correlation exists between years of experience and level of confidence.

A comparison of body-oriented background yields findings that appear saturated with import. While the confident and doubtful groups comprise proportionate numbers of social workers with professional body-oriented practices, a significant disparity is found in their reports of nonverbal training. The confident group members reported *double* the frequency of training outside of their MSW training specifically targeting recognizing nonverbal communication (88% compared to 45%). In both groups, the large majority of those who had non-MSW training evaluated the relevance of this training in their clinical work with a 6 of 6. Interestingly, the doubtful group was twice as likely to report receiving training regarding nonverbal communication in their MSW program. This may reflect greater integration of nonverbal attention in MSW curricula in more recent years, or a clearer memory due to more recent graduation, or possibly a higher evaluation of the MSW program's attention to nonverbal communication in the absence of other specialized training; these interpretations are speculations

not confirmed by the data available. However, a correlation clearly exists between receiving additional nonverbal training independent of that offered in an MSW program and reported levels of confidence.

A thematic analysis of the reports of confidence again supports a high valuation of one's ability to interpret and integrate nonverbal material in clinical social work, across all three groupings of confident, doubtful, and mixed. The insecure respondents tended to couch their self-doubt in either apologetic or earnest declarations of their intentions or wishes to become more skilled in this area. A few mention specific modalities or trainings they would like to pursue. Many respondents across the three groupings simply acknowledge they could benefit from learning or practicing more. I coded for language with a connotation of *resolution*, comprising two related themes. Language like "I'm not so clear on…", "I'm still relatively new…", "I am very aware of how crucial it is, but…", "It's difficult…", "I'm not sure…", conveys an apologetic or confessional tone, while the phrases "I am trying…", "I am working on it…", "I plan to…", "I could learn…" impart a promise to strive and improve. Resonant with the penitent yet hopeful reflections of New Year's Eve, these dual threads interweave throughout the responses and comprise a theme I label *resolution*. I coded 15 such declarations in the 29 responses. This reflects the high esteem held for this skill, as well as an anxiety attached to the lack of confidence to practice it.

The confident responses reflect the same high esteem without the anxiety. A thematic analysis of these responses yields security and ease: "secure," "confident," "competent," "it comes naturally," "I know myself." The comments range from simple statements, such as "It is a regular practice and I continue to work on my skills consciously," to more value-laden statements like the following: "It [is] very congruent with what I believe makes me a highly

competent worker who provides good service. If I were lacking in confidence about this, I would question my ability to provide good service to clients and I would brush up in skills thorough coursework or supervision." This latter statement brings the issue of comfort and skill in engaging nonverbal material beyond a matter of confidence to one of *competence*, one of the seven ethical principals upheld by the NASW Code of Ethics.

Training Evaluations. The study included questions aimed to identify and evaluate the various educational, practical, and personal sources of learning in this area, with focused attention on formal training received both within and outside of MSW programs.

A quantitative analysis found about half the respondents felt their MSW program included some training in recognizing and analyzing nonverbal communication. 70% of this portion found the training they received in their MSW program at least somewhat relevant and useful to their clinical work, with a quarter selecting the highest "very" useful category. A qualitative analysis yields a more complicated story of the experiences and desires of the respondents. Several comments reflect a sense of feeling unprepared to utilize this tool: "this is something that isn't addressed much in school and it's something that clinicians often need to figure out on their own." One respondent goes as far as to say that he is trying to become more comfortable integrating nonverbal material into his clinical work as it "is somewhat against my training." Many of the 56%(50%) who said their MSW program *did* include nonverbal training comment on the peripheral nature of this subject in their program. A theme of marginality emerges in the qualifications that "very little" attention was placed here, "maybe 5-8% - mostly addressed anecdotally, not necessarily as a vigorous part of the curriculum," "I'm sure it was mentioned, but I can't say there was much focus on it," "I can't remember specific training," "indirectly," "just on a basic level," that undermines the affirmative endorsement for MSW

programs' inclusion of this important material. This theme is prominent in almost half the written responses.

A follow up question regarding the usefulness and relevancy of the nonverbal training received in the MSW program yields a couple themes, one of which is that of satisfaction/dissatisfaction. A slightly larger group expressed dissatisfaction with the level of training provided in their MSW program, portraying it in a paltry light in contrast to other sources of learning. On the other side of the spectrum, satisfaction is evident in positive reports such as "I think about the things I learned in class…almost every day." Additionally, a significant group endorses the idea that there is only so far an academic setting can go in teaching skills that inevitably must be learned and integrated primarily in the field. This theme runs across the responses independent of satisfaction. It is expressed in both satisfied phrasing, such as, "school provided a good foundation and practicing simply provides the experience to use it and put it into action," as well as less satisfied phrasing, "what I learned in my MSW program was helpful, but I still had much to learn that only came from necessary experience in the field and continued study." Overall, a thematic analysis finds a mixed and middling evaluation of the depth, breadth, and usefulness of the nonverbal training provided in an MSW educational setting.

A parallel pair of questions refers to participation in trainings independent of MSW curricula. 46%(40%) of the participants reported extracurricular training in recognizing and analyzing nonverbal communication. The types of training reported span a wide range. Some are body-oriented modalities for psychotherapy, such as Orgonomics, EMDR, workshops with Ruella Frank, Gestalt therapy, Rubenfeld Synergy Method, Equine Facilitated Psychotherapy, Tapestries/Namaste approach, Neuro-Linguistic Programming, and Dance Movement Therapy.

Other expressive therapies include Art, Drama, and Multimodal Expressive Arts Therapy. Other clinical trainings include psychoanalysis and brief psychodynamic psychotherapy. Finally, other techniques not explicitly classified as psychotherapy but applicable within a therapeutic framework include yoga, Vipassana meditation, theater, Laban Analysis, Mindfulness Stress Reduction, and ASL trainings.

Of those who underwent one or more of these trainings in addition to their MSW, 59% marked a 6 out of 6 to indicate the highest rank of usefulness and relevancy to their clinical social work practice. This is *double* the frequency of the same top ranking for the usefulness and relevancy of nonverbal training received *within* the MSW program. While only nine participants qualified their response with a written remark, of those nine, seven expressed satisfaction while the remaining two comments were neutral. The affirmative language they use is quite strong: "very helpful," "I use them all the time," and "the training I have had has changed the way that I practice. I would love to have more training to help me stay disciplined about incorporating body awareness techniques in my work." In comparing the evaluative marks and remarks on the trainings received in and outside of MSW programs, the findings suggest higher overall satisfaction with and regard for the usefulness of those learning experiences found outside of the MSW.

In light of the relatively mild satisfaction with the nonverbal training included in MSW programming matched with strong evidence of a majority-held view of skilled nonverbal attunement as essential to a competent clinical social work practice, it is not surprising that the responses regarding interest in further training were overwhelmingly affirmative. A prominent *the more the merrier* theme pops up in about half of these responses, in statements as general as "the more you know, the more you can do," and "I guess more information never hurt!" to more

specific requests and suggestions. Another set of responses are phrased as a summarizing statement of value and endorsement of training in this area: “I think more training would help me more naturally integrate body awareness into my work and to be able to utilize body work in my work with clients.” Between the general and the more formulated statements, the findings clearly support a positive opinion of and desire for more in-depth training regarding the form and function of nonverbal communication in the context of clinical social work.

The earlier theme of the inherently truth-holding capacity of the nonverbal is evident throughout the survey responses, and resurfaces in the discussion of the importance of further training. One clinician believes that further training and mastery in this area would help her to be “more aware of [her clients’] ‘true’ feelings and mood states.” Another reiterates the same notion that “there is so much that is unsaid in work with clients but people usually reveal much through their body language.” She continues, “being able to recognize what is not [said] and skillfully addressing this while maintaining (and enhancing) the therapeutic relationship is essential.” This view, as expressed in response to numerous questions on the survey, presides nearly unchallenged. The one cautionary counterpoint to this thinking in the entirety of the responses reads: “I think one can overdo any of this. If we start tracking nonverbal too much we might lose focus on what they are actually saying and be too much in the role of ‘trying to figure them out.’” The overwhelming majority of the participants who speak to this theme, however, affirms and invites the revelatory powers of the nonverbal. “We function on many levels, and to recognize this as fully as possible would be valuable to both social worker and client.”

Other sources of Learning. In addition to questions regarding preparation gained through formal trainings, the study included an open-ended question to catch all other significant sources of learning that were influential in developing the participants’ awareness of nonverbal

communication in the clinical encounter. A thematic analysis of the responses produced two major categories: clinical and personal experience. Other minor categories include educational, general, and negative themes.

Clinical experience netted 14 remarks. This category covers all activities that take place in a clinical environment, and included observation, supervision and supervising, consulting, teaching, videotaping, role plays, and work with specific populations (eating disordered, ASL) as well as with animals in a therapeutic setting. One participant writes, “I have had some sessions with clients, particularly in family sessions, where the nonverbal information was undeniable and overwhelming. It makes me more aware to pay attention to the more subtle cues.” Clearly, the lessons learned in the field are invaluable to developing clinical skills, supporting the earlier finding that a portion of the participants consider clinical experience more conducive to nonverbal learning than are academic settings. Five additional references to *educational experience* (training, seminars, and literature) constitute a separate theme, as these activities are more removed than the hands-on activities referenced above, yet the two hold in common the direct objective of professional development.

Personal experience netted a resounding 33 remarks, which can be further broken down into three subcategories: relational, therapeutic, and lifestyle/activities. Seven references to specific relationships (grandmother, wife, etc) demonstrate the significance of interpersonal learning outside of an educational setting. Six respondents cite their experience as a client in psychotherapy as an eye-opening experience in their developing awareness of the impactful nature of nonverbal communication. And finally, the 19 references to lifestyle/activities constitute the largest category of influential experiences in forming somatic awareness. All of the activities listed were physical to varying degrees, from more subtle body-oriented engagements

such as diet and “holistic health interests” to overtly physical activities such as sports and dance. The testimonials generated in this subcategory vividly speak to the value of these non-clinical daily practices in the personal and professional orientation of the participants, and demonstrate the strong influence of lifestyle independent of professional experience. I include a couple here to demonstrate the unique sources from which social workers cast their clinical tools.

> I have gotten more in touch with my body in the last few years by exercising and eating mostly whole-foods diet. Now I feel like I listen to my body more and am more in-tune with the body-mind connection in myself, which I have found has increased my ability to tune into others as well.

> I came to social work from being a dancer. While I was dancing, I knew I was dancing in an attempt to heal my own heart from things there were no words to say. From this and from my own personal experiences with trauma, I know trauma to be explicitly recorded physically. When pain is too much for words and too much to comprehend intellectually, it exists as temperature and movement, these are the way I believe we survive trauma, and thus these are the ways we remember it. And then, finally, it is through non-verbal communication, that we also heal from it.

Personal experiences clearly hold a strong position in the minds, and bodies, of the participating social workers as highly influential in their development as nonverbally aware and attuned clinicians. While many of these experiences involve a clear physical component, many do not, as was found in the range of responses already mentioned. It is interesting that even in the subcategory specifically comprising personal experiences as a client in psychotherapy, half of the therapeutic orientations noted are explicitly body-oriented (somatic experiencing, orgonomy,

hypnotherapy) while the other half is not (psychoanalysis, relationally based psychotherapy). This suggests that one's involvement in psychotherapy need not be explicitly body-oriented to provide an embodied experience and foster greater nonverbal awareness of one's self and interpersonal exchanges. In the relational subcategory too we see examples that represent an overt engagement of a body-oriented framework, such as "conversations in personal relationships with others who are aware of nonverbal communication/tuned into their bodies" and "contact with body centered therapists." Yet most of the relationships cited offered awareness and attunement in a personal rather than professional context. One participant recalls his "fantastic grandmother who could read me from 50 miles away," another adds "my family of origin promoted self-awareness in many ways," and a third states that "having a mother with a temper made me finely attuned to reading other people by the time I was 5." These statements again reflect the notion that the body records and remembers emotional experiences including trauma, as is therefore primary in reading and relating to another's emotional experience and process.

This last respondent makes the additional point that "a lot of one's ability to read nonverbal communication is decided at an early age," which frames the discussion of education regarding nonverbal communication in a larger context than graduate and post-graduate opportunities. Other responses join this voice in stretching the conventional walls of the classroom to encompass a broader life-as-a-classroom view. Crediting their nonverbal attunement and engagement to "general life experience" and "every experience I have," these voices speak to the pervasive nature of learning via the human experience. "Every experience I have and have had I can refer to in my current consciousness of the utility of nonverbal communication in my life and work and extract new additional insights for practice!"

A thin yet evident thread throughout the survey tells a story of ubiquity in which the skills being studied are naturally acquired from so many indirect sources it mystifies the role and responsibility of the academic environment in fostering this sensibility. Comments like “I learn more from doing it, than from instruction in school,” and “I still had much to learn that only came from necessary experience in the field and continued study” point to post-graduate clinical experience as a critical learning environment. Others, for instance, “I believe that my own innate awareness as an individual has also informed my practice,” again highlight the natural talent and organic mastery of skills that is purely personal.

This theme of ubiquity is found within an overarching framework of desire for increased and improved instruction regarding nonverbal communication in the MSW setting. It is true that many of the clinical skills required of social workers are what the layperson calls *people skills*; yet it is the job of professional schools to hone, refine, and develop all of the rich life experience that brings MSW candidates to this professional field. In a plea for precisely this type of direction, one participant writes, “I wish that there was more of a focus on how to integrate that type of communication in a more practical way.” Even those who cite “all things” and “general life experience” as formative sources of learning still rate the value of further training highly; one stakes a clear stance with the bold closing comment: “Us somatically minded clinicians must band together to support one another in a minority cohort. We will be the ones to provide the evidence and scholarship that will make nonverbal communication a central component to the training of future leaders.” In this greater context, the organic nature of developing nonverbal skills does not counter but rather compliments the key findings of high value and desire for practical instruction in engaging nonverbal communication effectively in the clinical encounter.

Summary. The major qualitative findings of this study reveal that the clinical significance and utility of nonverbal communication holds a particularly high status in the perspective of practicing social workers. It is considered an essential component of therapeutic attunement, accurate assessment, effective communication, and appropriate interventions. The body is commonly believed to reveal a person's true feelings and unconscious conflicts with clearer accuracy, and therefore access to body language is coveted.

On average, social workers deemed the training they received from their MSW program regarding recognizing and analyzing nonverbal communication less relevant and useful than outside trainings in this area. Most identify extracurricular personal experiences as formative influences in developing an appreciation for and fluency in the nonverbal aspects of clinical social work. Notwithstanding, the majority of social workers studied endorse receiving more formal training regarding recognizing and analyzing nonverbal communication to improve or enhance their clinical skills. There is evidence that social workers with additional training in a body-oriented field feel more confident in their social work practice. In sum, the nonverbal component of clinical social work is an important area of interest for social workers, and may warrant greater attention from leaders in the field.

CHAPTER V

DISCUSSION

The “talking cure” that clinical social workers practice may be something of a misnomer taking into account the overwhelming trend amongst them to incorporate into their practice the unspoken communication expressed and received through the body. According to the 92%(82%) of participating clinicians who make conscious use of nonverbal information in the clinical encounter and the nearly unanimous 98%(85%) who value this awareness above neutral, the body occupies an inextricable, essential position in clinical social work. This assertion aligns seamlessly with the literature produced in the adjoining fields of mental health. Theory supporting the central role of nonverbal communication, methods for its assessment, and entire modalities formulating its effective engagement to deepen and actualize recovery has been flourishing for over a century. What sticks out as disjointed in this body of research is the pointed *lack* of literature regarding nonverbal communication coming from the field of social work itself, and the related finding that only half of the same clinicians extolling engagement of the nonverbal received any training whatsoever on the topic in their masters level social work program, with lukewarm appraisal at best. If nonverbal modes of communication were somehow less pertinent to social work than to related fields this finding would make sense. However, attunement to nonverbal expressions is in fact fundamentally aligned with the values, responsibilities, and objectives of social work, and, as evidenced by the reports of the participants, is indispensable to a sound and responsive practice.

Social work is unwavering in its commitment to social justice. We orient our clinical interventions around a culturally informed systems perspective in order to acknowledge and address the multiplicity of environmental factors that play a part in mental health. Our bio-psycho-social assessments frame psychological functioning in the context of the geographic, political, historical, social, and cultural environment, as well as genetic and medical factors. These manifest in the body. Like a body of water subject to rain, pollution, and the flora and fauna of its ecosystem, we too evince the effects of oppression, political turmoil, the fluctuations of the economy, insecure food, and an unstable or unsafe home first and foremost in our own bodies. A traumatic event, like a car accident or abuse, registers first in the musculature and nervous system before the cognitive brain gets involved. We house and process our traumas in the body, which may manifest in any number of symptoms such as panic, insomnia, flashbacks, fatigue, and chronic pain. And so too, we express our experience of our environment here, and heal here. Understanding how one's environment maps itself onto the body, and how to use this map as a guide in treatment, is imperative to clinical social work.

Recognizing the vital role of the body in our clients' lived experience as well as in their recovery does not eclipse the value of cognition and words. It does, however, demand greater attention if we are to address environmental, cultural, and interpersonal trauma. As the site of traumatic experience, the body is integral to recovery. The following excerpt from the findings speaks directly to the irreplaceable function that physical self-expression played in the speaker's own recovery:

> I came to social work from being a dancer. While I was dancing, I knew I was dancing in an attempt to heal my own heart from things there were no words to say. From this and from my own personal experiences with trauma, I know

> trauma to be explicitly recorded physically. When pain is too much for words and too much to comprehend intellectually, it exists as temperature and movement, these are the way I believe we survive trauma, and thus these are the ways we remember it. And then, finally, it is through non-verbal communication, that we also heal from it.

The pivotal function of the body in storing, processing, and healing trauma has major implications for the field of social work. On principle, we serve populations who are systematically denied various protections and more vulnerable to trauma. Trauma work, therefore, is integral to social work. Trauma itself, whether interpersonal, medical, an accident, or otherwise, is often a disembodying experience. Bringing attention to dissociated or disavowed parts of self to foster integration is a staple of clinical social work. It is a form of empowerment. To disclaim or miss the body in our clinical work would be to disclaim trauma and impede the goals of the field. Conversely, inviting one's client and oneself to fully inhabit themselves in sitting together, and holding space for the feelings that arise in this visceral connection, promotes the values and goals of social work.

Not only is nonverbal expression key to communicating and expressing the pain of trauma, but it also lends expression to populations whose access to verbal communication is impeded. Whether due to linguistic differences, autism, hearing impairment, or age, it is imperative to "meet the client where they are and communicate with other senses," as said a participant working with clients with dementia. Incorporating more body-oriented theory and technique is necessary to uphold the ethical standard of serving diverse and disenfranchised populations with dignity and competence.

The unique ability of the body to process and express the unspeakable is echoed throughout the study as a belief that generalizes beyond references to working with one population or another. Many of the participants intoned greater trust in the veracity of nonverbal messages than of verbal. They depicted bodily expressions and sensations as the guileless products of the unconscious. To link nonverbal expression to the unconscious escalates it to pedestal status, where it is understood to be a window into the rich material of transference and countertransference. Developed in Freudian psychoanalysis and foundational to the modern psychodynamic theories that orient many social workers today, awareness of transference is considered invaluable to therapeutic progress. This elucidates the initially baffling appeal made by "talk therapists" for the greater capacity of the unspeaking body to directly access to the "true" feeling state of a person than do words. The qualitative component of the study revealed that social workers' faith in the accuracy of nonverbal communication is anchored to well-established analytic concepts, and further grounds the claim for addressing nonverbal elements in the didactics of the field.

While social workers' irrefutable faith in the body to tell the truth is clearly articulated, their faith in their own ability to correctly read and respond to body language is less robust. The disparity revealed in this study between the near-unanimous affirmation of the fundamental significance of nonverbal communication to clinical social work, the middling reports of confidence, and the dismally paltry descriptions of MSW programs' integration of this subject, is both puzzling and concerning. In interpreting these results, I became curious as to whether the innate level of humility and striving involved in clinical social work is enough to account for this disparity, or if in fact these findings signal a deeper disconnect between preparatory programming and practice.

As thoroughly researched and documented as the study of body language is, there is something inherently unknowable about the phenomenon, precisely because of its link to the unconscious. It can be unsettling to venture with what amounts to a pocket flashlight into the murky expanse of the unconscious. Such a quest lends itself to feelings of inadequacy as well of great swells of faith. In reading through the comments, I would find myself momentarily overcome by overwhelm and wonder at the tender dedication social workers apply to their task of following such tenuous strands of communication between themselves and their clients to assemble into webs of meaning: “I pay attention to my client’s gait and rhythm when they walk from my waiting room to my office,” “changing body positions, keeping a coat on, fidgeting, level of eye contact, level of initiated touch,” “movements and restrictions,” “single or repetitive hand gestures.” “I also try to pay attention to feelings inside myself for clues on what they might be feeling or meaning” or “some immediate ineffable quality that the client may deposit or arouse within me that again is meaningful.” These responses represent both the breadth and specificity of the net social workers cast in each encounter with a client, and inspire in me a deep appreciation for the dutiful and resourceful efforts of my colleagues. “It’s so complex,” wrote one participant, “I’m not sure I would ever expect to get very confident.” A tension exists between the presumed readability of the body and the elusive, if not unreachable, certainty of the meaning therein.

Of course, the same tension exists in verbal exchanges as well. Holding space for the unknown and the unknowable is inherent to the deep, interpersonal work we do. It would be worthwhile to design a future study comparing confidence levels in the discernment of nonverbal material versus those in verbal material to mitigate the influence that general humility may have on the results of the current study. As they stand, however, the results demonstrate that reverence

for not knowing is present but not solely accountable for the lack of confidence expressed. The commentary on the peripheral or absent discourse engaging nonverbal communication in MSW programs, augmented with a strong expression of interest in further training in this area, sets the more ambiguous reports of confidence in a clear context of programmatic deficiency. Those with higher reported confidence tended to have more extensive training outside of their MSW program.

In reflecting on various sources of learning, many of the participants sited daily life activities and relationships as highly influential to developing attunement to body language, some experiences originating as young as preschool. Truly, body language is ubiquitous. Predating our verbal capacities, it is the earliest and sometimes only form of communication we have. The inescapable, organic acquisition of the skills to process nonverbal communication begs the question whether the educational setting is in fact the primary source of developing this particular skill set. If attunement to implicit forms of communication is absorbed simply through living in a social environment, is it a necessary focus for an MSW program?

To answer this question, I again reviewed the reports of a perceived lack of training in MSW programs, anxiety and dissatisfaction with its absence, overall higher satisfaction with outside trainings, and enthusiastic wishes for more training in nonverbal communication, in addition to a positive correlation between confidence and extracurricular nonverbal training. These findings speak to both the perceived and true value of systematic pedagogy in the acquisition and enhancement of nonverbal sensitivity and sensibility, casting off any shadows of doubt that may obscure the indication to include more training in MSW curricula. The findings demonstrate that while personal experiences greatly impact a person’s acuity to nonverbal communication, formal training is still necessary to refine and develop the foundation laid in

formative and ongoing interpersonal experiences. This will be as true for nonverbal communication as it is for verbal, as MSW candidates are expected to enter their training with a high degree of communication skills already in place and ready to be bolstered, organized, and worked into an art.

Understood in context, the narrative of ubiquity does not challenge but rather expands social worker's scope of learning and resourcefulness in building a clinical orientation and practice. Personal relationships that model the importance of the body as a sensor and a guide, as well as one's primary environment, become assets to the developing clinician. Personal experiences as a client in therapy also increases clinicians' awareness of their own bodily experience in therapy, enhancing their ability to extend attuned empathy toward their own clients and sustain self-awareness in session. The study even found that cultivating a personal relationship with one's own body, by attending to the way we feed ourselves, inhabit our physicality, and express our creativity, also engenders a deeper recognition of our clients' bodies and emotional state. It is only natural that life experiences will inform one's sensitivity to all nuances of communication; a rigorous academic integration of these nuances can guide natural intuition into a responsive, informed practice.

Based on the findings as a whole, I hypothesize that a shift toward integrating practical theory and methodology regarding the use of nonverbal communication into the standard social work education would yield higher overall reports of confidence in this particular area, and, if the body is as essential to social work as the participants contended, may increase confidence and competence in clinical ability overall. We expect to achieve confidence balanced with humility, as expressed simply in the self-evaluation, "very confident, though careful," through the rigor of a masters level program. Without understating the importance of continuing to undertake and

assimilate learning opportunities as long as one practices, the theoretical and practical foundation established in the context of one's graduate studies remains an anchor and a guide throughout one's career. As a fundamental aspect of clinical social work, coursework regarding nonverbal communication seems essential to a well-rounded MSW program.

The question remains why social work has thus far been so slow to respond to the growing awareness of the body as a critical aspect of and resource in clinical work, especially with diverse and disenfranchised populations. In the midst of a longstanding history alive and burgeoning with current research supporting an integrated body-mind orientation to psychotherapy, matched with the support of social workers themselves as found in this study, I was perturbed to find so little research invested in this area on behalf of our field. Further investigation into this reticence would be worthwhile to clarify the obstacles and pathways to enacting change. I wonder if the ineffable image of body language seems unwieldy and boundless in contrast to such cement-solid realities as poverty, institutional racism, and the housing crisis. Are we afraid of losing our 'edge' on the big picture issues if we zoom in to something as minute and possibly immeasurable as a "tapping foot" or one's spatial "relationships to doors"? Perhaps, also, the field's investment in proving itself as a science shies it away from assimilating soft-sounding terms and interventions. Yet incorporating body-based research might in fact bolster our efforts to cultivate evidence-based practices. I speculate that embracing this form of communication may feel like going out on a limb, yet I argue that attending to the reality of embodied experience and expression is in fact a return to, and not a digression from, the practical person-in-environment perspective social work espouses.

As stated in the NASW Code of Ethics (2008), "Social workers understand that relationships between and among people are an important vehicle for change." The relationship

we enter into and build with our clients is the primary grounds on which we support their healing and reclamation of self, and cultivating meaningful and empowering therapeutic relationships is foundational to a social work education. We reach out to find and create alliance in every instinctual and practiced way available to us, seeking common ground on which to connect. Embodiment is our common ground. It enables us to be present to others as well as our own internal state. It is through our bodies and embodied experience that we directly align with others. It is how we attempt to understand. A developed sensitivity to the story told by the body is key to clinical work.

The field of social work is in a unique position to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (NASW, 2008) through fostering a deeper understanding of the body as environment. Explicit training in reading and utilizing body language would enhance clinicians' engagement of the therapeutic relationship to promote wellbeing. "It would maximize sessions." Social workers value nonverbal communication and "would like to understand how to recognize it with greater agility." As embodied beings, we cannot help but draw on body language to form and express our impressions. We instinctually incorporate this in our practice; not one participant denied utilizing nonverbal communication in the clinical encounter. The field of clinical social work has the opportunity, and responsibility, to train and encourage social workers to tap into this vital resource, waiting literally at our fingertips, in an informed and effective manner based in science, theory, and practice. Advancing a pedagogy that claims the already popularly held view of the body-mind as interwoven would set social work apart from other practices of mental health in a strong step away from the false dichotomy between the body and the mind. Integrating the body

more fully into social work pedagogy and contributing research in this area would support a holistic approach to promoting individual and social wellbeing.

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APPENDIX A

Letter to Organizations for Permission to Post

My name is Sasha Wright and I am a second year MSW student at Smith College School for Social Work. I am conducting a research project for my MSW thesis, and possible presentation and publication. The objective of my study is to explore the ways in which clinical social workers understand and make use of nonverbal communication in their clinical work. I am interested in how clinicians think about their clients' nonverbal cues as well as their own. The existing literature is largely silent on the significance of body language in clinical social work; it is my hope that this research will illuminate the nuanced ways social workers currently engage their clients on multiple levels, adding volume and clarity to the emerging discourse on the impact of nonverbal communication in the clinical encounter.

My study will develop out of the responses I gather from clinical social workers who agree to fill out an online survey. I am seeking clinical social workers who have an MSW to complete the survey, and I would be grateful for your assistance in reaching potential participants in order to involve as wide and diverse a range of eligible participants as possible. The survey is 23 questions and participation should take around 25 minutes to complete. The questions do not contain sensitive material and I will not be collecting participants' names or contact information. Participation is voluntary, and will aid my research on the impact of educational and personal experiences on clinicians' use of nonverbal communication in the clinical encounter.

Thank you for considering my request to distribute my survey.

Sincerely,

Alexandria Wright

APPENDIX B

Recruitment Email

My name is Sasha Wright and I am a second year MSW student at Smith College School for Social Work. I am conducting a research project for my MSW thesis, and possible presentation and publication. The objective of my study is to explore the ways in which clinical social workers understand and make use of nonverbal communication in their clinical work. I am interested in how clinicians think about their clients' nonverbal cues as well as their own. The existing literature is largely silent on the significance of body language in clinical social work; it is my hope that this research will illuminate the nuanced ways social workers currently engage their clients on multiple levels, adding volume and clarity to the emerging discourse on the impact of nonverbal communication in the clinical encounter.

I am seeking participants to complete an online survey to this end. Participants must currently work with clients as clinical social workers with an MSW from an accredited program. Participation requires fluency in English and access to the internet. The survey consists of 23 questions and participation should take around 25 minutes to complete. The questions do not contain sensitive material and I will not be collecting participants' names or contact information. Participation is voluntary, and will aid my research on the impact of educational and personal experiences on clinicians' use of nonverbal communication in the clinical encounter.

If you are a clinical social worker interested in taking my survey, simply follow this link: https://www.surveymonkey.com/s/nonverbalcommunication

Please feel free to forward this message to your colleagues.

Thank you for your time,

Alexandria Wright

APPENDIX C

Survey Questions

See actual survey: https://www.surveymonkey.com/s/NonVerbalCommunication

A. Eligibility

1. Consent Page
   a. I agree
   .b I disagree

2. Did you complete an MSW program?
   a. yes
   b. no

Which MSW program did you attend? _____

3. Are you currently practicing clinical social work in a setting where you work directly with clients?
   a. Yes
   b. No

B. Demographics

4. How many years have you been practicing? _____

5. Have you ever been a practitioner of a body-oriented psychotherapy?*

* For the purpose of this survey, "body-oriented psychotherapy" refers to those modalities of psychotherapy which esteem the bodily experience as integral to one's psychic experience, and approach psychological healing through a combination of methods that may include talk, movement, visual assessments, and in some cases touch. (e.g. Dance Movement Therapy, Somatic Experiencing, EMDR, etc)

   a. yes
   b. no

If yes, please specify which modality: _____

6. Have you ever been a practitioner in a body-oriented profession?*

*For the purpose of this survey, "body-oriented profession" refers to any profession that involves a high level of body awareness and assessment of self and/or other, such as physical therapy, massage therapy and body work, body-oriented psychotherapy, yoga or dance instructor, dancer, etc.

   a. yes
   b. no

If yes, please specify which profession: _____

7. In your personal life, do you regularly engage in a body-oriented practice?*

*For the purpose of this survey, a “body-oriented practice” refers to a regular activity or practice that involves a high level of body awareness, such as athletics, yoga, tai chi, dance, vipassana meditation, etc.

a. yes
b. no

If yes, please specify what practice: _____

8. Gender
   a. female
   b. male
   c. other

9. Age
   a. 20-29
   b. 30-39
   c. 40-49
   d. 50-59
   e. 60-69
   g. 70 or above

10. Race: _____

C. Questions: Practice

For the purpose of this survey, “nonverbal communication” refers to physiological cues such as facial expression, vocal intonation, body position (i.e. crossed arms, clenched fists), proximity, quality of movement, and internally felt sensations that signal a message or feeling between people, whether consciously or otherwise, without using words.

11. To what extent do you use nonverbally communicated information in your clinical practice? 123456
    - Please describe the kinds of nonverbal cues you look for and use in your clinical practice: _____

12. How useful is it to you in your clinical practice to assess your client’s nonverbal communication? 123456 n/a
    - Please elaborate: _____

13. To what extent are you cognizant of your own internal bodily sensations during a therapeutic encounter? 123456

14. To what extent are you cognizant of your own outward nonverbal communication toward your client? 123456

15. How useful is it to you in your clinical work to assess your own internal sensations and nonverbal outward expressions? 123456 n/a

a. Please elaborate: _____

16. How confident do you feel in your ability to integrate nonverbal material into your work with clients? 123456

- Please elaborate: _____

D. Questions: Training

17. Did your MSW program include any training in recognizing and analyzing nonverbal communication?

a. yes
b. no

- Please describe: _____

18. (only if answered yes to 17) In your current practice, how useful and relevant is the training you received in your MSW program regarding nonverbal communication? 123456

- Please elaborate: _____

19. Have you had any other formal training in recognizing and analyzing nonverbal communication?

a. yes
b. no

-If so, please specify name, duration, and focus of training: ___

20. (only if answered yes to 19) In your current practice, how useful and relevant is the training you received in non-MSW trainings regarding nonverbal communication? 123456

- Please elaborate: _____

21. Have you had other experiences (professional, personal, or otherwise) that have influenced you in developing your awareness of nonverbal communication in the clinical encounter? _____

22. To what extent do you think that more training in recognizing or analyzing nonverbal communication would improve and/or enhance your clinical work? 123456

- Please explain: _____

23. Is there any other relevant information you would like to share? _____

APPENDIX D

Informed Consent

Welcome Page of Survey

Welcome and thank you for your interest in this study!

My name is Sasha Wright and I am an MSW student at Smith College School for Social Work. I am conducting a research project for my MSW thesis, and possible presentation and publication. The objective of my study is to explore the ways in which clinical social workers understand and make use of nonverbal communication in their clinical work.

To participate in this study, you must currently work directly with clients as a clinical social worker and have graduated from an accredited MSW program. Participation in this study involves completing the following survey. The survey asks 23 questions and will take approximately 25 minutes to complete.

Submitted surveys are anonymous and I will not be collecting names or email addresses. However, because the survey includes some questions that require a written response, please refrain from using any identifying information in your responses if you do not want to risk being identified. Please refrain from using any identifying information about clients. I will carefully disguise any identifying information included in written responses before sharing with my advisor or including in my writing in the form of brief illustrative quotes. The data that I collect will be presented as a whole. I am required to keep the collected data for three years in a secure location, after which point it will be destroyed.

The risk involved in participation in this study is minimal, as the questions do not contain sensitive material and I am not collecting participants' personal contact information. Possible

benefits of participation include a heightened awareness of and appreciation for the techniques you use in your work. No other compensation will be provided for participation.

Participation in this study is voluntary. You may withdraw from the study at any time and you may choose to skip any question you prefer not to answer. If you choose to complete the study, once you submit your responses on Survey Monkey you will no longer be able to withdraw your responses as the program automatically removes all identifying information from submitted responses. Should you have any concerns about your rights or any aspect of the study, please call the Chair of the Smith College for Social Work Human Subjects Review Committee at (413) 585-7974.

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

Thank you for your time,

Alexandria Wright

__ I agree

__ I do not agree

APPENDIX E

HSR Approval Letter

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

January 29, 2012

Alexandria Wright

Dear Sasha,

Nice work! Wow. You did a wonderful job and made solid arguments in your responses. Your project now meets all federal guidelines and you may get started. I think your improvements, in many cases were subtle and will improve what you are able to get from the project. I look forward to hearing what you find.

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.

Congratulations!

Sincerely,

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