

---

Theses, Dissertations, and Projects

---

2012

## Are we reaching the body? : a study of social workers' attitudes on the mind-body connection in trauma treatment

Samuel R. Douglas  
*Smith College*

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

---

### Recommended Citation

Douglas, Samuel R., "Are we reaching the body? : a study of social workers' attitudes on the mind-body connection in trauma treatment" (2012). Masters Thesis, Smith College, Northampton, MA.  
<https://scholarworks.smith.edu/theses/878>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact [scholarworks@smith.edu](mailto:scholarworks@smith.edu).

Samuel Reed Douglas  
Are We Reaching the Body? A  
Study of Social Workers' Attitudes  
On the Mind-Body Connection in  
Trauma Treatment

### **ABSTRACT**

A national sample of 39 social workers currently treating traumatized clients in therapy in the United States responded to an anonymous, online survey designed to gauge their attitudes toward the role of the mind-body connection in trauma treatment and recovery. The study sought to ascertain whether the most recent research in the neurobiology of trauma, and the resulting developments in the theory of trauma treatment, had significantly influenced the approach taken by social workers in clinical settings. The findings suggest that social workers have largely embraced the idea of a mind-body connection in trauma, and are inclined—in theory, if less often in practice—to direct their interventions toward that connection, rather than hewing to more traditionally cognitive or psychodynamic methods.

**ARE WE REACHING THE BODY? A STUDY OF SOCIAL WORKERS' ATTITUDES  
ON THE MIND-BODY CONNECTION IN TRAUMA TREATMENT**

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

Samuel Reed Douglas

Smith College School for Social Work  
Northampton, Massachusetts 01063

2012

## **ACKNOWLEDGEMENTS**

Thank you to Gael McCarthy for advice and encouragement, to the therapists at the Philadelphia Consultation Center for support and levity, and to Holly Westergren and Geoffrey Douglas for lessons about mind and body

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS .....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION .....	1
II LITERATURE REVIEW .....	3
III METHODOLOGY .....	20
IV FINDINGS .....	24
V DISCUSSION.....	31
REFERENCES .....	39
APPENDICES	
Appendix A: Human Subjects Approval Letter.....	46
Appendix B: Email Announcement of Survey .....	47
Appendix C: Survey Questions.....	49

## **CHAPTER I**

### **Introduction**

The treatment of trauma has been more enriched than any other area of psychotherapy by the recent flood of data about brain functioning. The refinement of brain imaging has begun to reveal the structural and functional relationship between somatic and psychological experience in traumatized people (Kerr, 2007; van der Kolk, 1996). As with any new research, however, the corresponding development and proliferation of interventions has been gradual and indirect, and it remains to be seen how these discoveries translate into effective treatment. Alongside these clinical discoveries, the ever-widening popularity of yoga, meditation and mindfulness and other Eastern mind-body practices has provided a challenge to traditional Western dualism from another angle. These combined forces have brought about the evolution of various new, somatically-oriented forms of therapy, and the integration of those methods into traditionally psychodynamic and behaviorally-oriented settings. This study explores the extent to which these developments have influenced the way social workers treat trauma. (For the purposes of this study, the terms “body-oriented” and “somatically-oriented” will be used interchangeably, as they are by most practitioners. The terms will refer herein to any psychotherapeutic intervention that begins with [or uses as a primary source of information] clients’ psychological experience of, or response to, their bodily sensations.)

By the nature of their work, social workers often constitute the front line in trauma treatment (Cunningham, 2003), and yet, little is known about the extent to which these new trauma interventions are being implemented in clinics and hospitals where social workers

comprise the majority of mental health providers. This study explored, through a survey of social workers in a variety of settings, the extent to which clients are receiving therapies that reflect the most current research on the brain-body connection in trauma. By looking at a cross-section of clinicians currently working with traumatized clients, the study examined the extent to which body-centered treatments are being practiced today. Secondly, it considered the ways in which complex (and still-inchoate) ideas about brain-body functioning have trickled down from the medical establishment into social workers' everyday assessments of their clients. My hope is that these findings will be of interest to medical researchers as well as social workers, both of which groups have a presiding interest in discovering and implementing the best care for acutely traumatized patients. Because somatically-oriented therapies are still making their way into mainstream treatment, still being tested for efficacy, and still being assessed for validity, this study has taken a broad view of current body-centered practice, and suggested avenues for further quantitative and qualitative research as the field develops.

## **CHAPTER 2**

### **Literature Review**

This study examined how social workers take account of the body in their treatment of traumatized clients. In order to describe the context in which social workers are currently making their treatment decisions, I have examined literature that considers the evolution of the conceptualization of the body's role in psychotherapy. My review of this literature will proceed in three sections: The first will trace the history of the body in psychotherapy, particularly in regard to trauma, attempting to draw a link between Janet and Freud and the current interest in somatically-oriented psychotherapies; the second will introduce recent discoveries in neurology and neuropsychology that indicate a complex and unique mind-body connection in the experience and treatment of trauma; and the third will assess the prevalence and efficacy of the somatically-oriented interventions most commonly practiced by social workers treating trauma.

#### **The Origins of the Body in Psychotherapy**

Psychoanalysis began with the body, and the body has always been a significant source of data for psychotherapists. Whether one locates its origins with Freud, (Freud, 1895/2000 ) or further back with Janet (Janet, 1825), the first cases to prompt the recognition of the unconscious were idiopathic physical complaints. Freud explained these first cases of hysteria as “the effects and residues of excitations which have acted upon the nervous system as traumas” (Freud & Breuer, 1895/2000, p. 16) He treated these with a combination of suggestion, physical stimulation, and the exploration of memories—the same elements that constitute EMDR, among



other current interventions. Since Freud's time, treatment of the mind-body connection has fractured and reassembled itself many times over as theorists debated the relevance and viability of body-oriented psychotherapy. The debate begins within Freud's own career, and his interpreters over the years have found evidence of everything from strict dualism (Young, 2006) to "the groundwork for a psychotherapy that would rely heavily on touch in order to provide ego-building experiences" (Smith, 1998, p. 6).

Freud's early psychoanalytic patients (or those that would come to be thought of as such) presented with somatic symptoms, or physical behaviors that appeared to arise from psychological causes. By the nature of the treatments available, his initial investigations treated the client's psycho-somatic experience as a whole (Aron, 1996), using hypnosis to address a consciousness that encompassed body and mind. Beyond that point, Freud's perspective on the body in psychotherapy becomes harder to discern. To some, the ideas that came to be known as drive theory represented the first suggestion that the essential processes of the mind could originate with body-based appetites and tendencies (Fast, 2006). Fast argues that Freud saw fantasies and dream images as embodied, figural elements of consciousness, essential to the primary process of mental organization. Not only did drive theory locate the essence of psychological functioning in the body, but dreams and fantasies presented versions of the physical form at the heart of unconscious functioning. Though psychoanalysis would soon steer away from a comprehensive attention to the mind-body connection, this early innovation was a challenge to the stricter versions of dualism that had predominated in Western thinking since Plato, who put forth that the soul preceded the existence of the body and reached a higher form with greater distance from the body and its simple, persistent urgencies.

With the abandonment of hypnosis and the elaboration of his psychoanalytic concept of the mind, Freud and his followers moved away from a study of “forms of consciousness” (Aron, 1996) to the contents and dynamics of the psyche. Because the essential revelation for Freud was the existence of intrapsychic structures causing these disruptions, his theoretical work concentrated on the articulation of these structures, and his clinical work on the externalization of distressing material. It may also be, as Cornell argues, that Freud and Breuer “frightened (even traumatized) themselves” (2008, p. 34) in their early discoveries of psychosomatic energies, and so recoiled from the aspects of the treatment that felt unmanageable. Some theorists have suggested that Freud’s theories were hemmed in by the idea of an essential divide between mind and body, and that his formulations submitted to—and ultimately reinforced—that divide. (Damasio, 1994). Elaborating this concept, Young (2006) suggests that it was actually necessary for the body to be set aside in order for psychoanalysis to progress toward what Freud hoped would be a comprehensive map of intrapsychic phenomena:

In this history we can see two main opposing factors: a growing trend of disownment of the body, paralleling the growth of understanding about the mind. It is almost as if one is necessary for the other to exist and develop.

### **The Role of the Body In 20<sup>th</sup>-Century Psychodynamic Theories**

The mind-body opposition has persisted throughout the past century, and the Cartesian template has continued to influence the thinking of many psychotherapists (Damasio, 1994). However, from the very beginning there have been dissenters, outliers, and interlopers who envisioned the body-mind relationship in different ways, or conceptualized the human experience as a fluctuating intermixture of somatic and psychological experience. While the discussion has often been framed as one of strict dualism versus total mind-body integration,

most of the dominant schools of therapy in the 20<sup>th</sup> century practiced by social workers leave tremendous room for interpretation by the practitioner.

In an essay about the use of touch in psychotherapy—and by extension about the perceived relevance of the body in various schools of treatment, Smith (1998) divides the progress of body-oriented psychodynamic psychotherapy into three branches: the psychodynamic, the neo-Reichian, and the humanistic traditions. Theorists in each of these fields have explicitly declared the relevance of the body as a source of affective information or an avenue for connection between therapist and client (or both.) These traditions are distinct from the behavioral interventions that came about later in the 20<sup>th</sup> century, which will be discussed later on this section.

### **The body in the psychoanalytic tradition.**

Those theorists in the psychoanalytic tradition who have been open to the relevance of somatic information have tended to argue that the body can be a source of transferential information, and a way of reaching pre-Oedipal conditions that might be out of reach of talk therapy. As discussed above, Freud's understanding of the body-mind connection is far more complex—and more fluid—than his detractors in the body-psychotherapy camps often make out. Freud wrote in *The Ego and the Id* that “the ego is first and foremost a body-ego... ultimately derived from body sensations” (p. 16). As such, just as he is the author of a psychoanalytic methodology that has come to eschew the physical, relational experience, he is among the first to suggest an internal psychological structure that assumes the dimensions and sensitivities of the physical body. Throughout the evolution of the past century, psychoanalytic theorists have created space for the body in treatment without surrendering the basic commitment to eliciting and working through transference. (Spotnitz, 1972; Mintz, 1969); Winnicott, 1965). While these

views have by no means constituted the mainstream in psychoanalysis, their proliferation suggests a gradual loosening of the dualistic orthodoxy, even in this most language-oriented of therapeutic interventions.

### **The role of the body for Reich and his descendants.**

To understand the progress of the mind-body concept in Reichian theory, one must first consider Sandor Ferenczi, Freud's colleague and sometime pupil, who eventually became a teacher to Reich. In the early 20<sup>th</sup> century, Ferenczi took Freud's ideas about the relationship between affect and the body, and began to work in the opposite direction from Freud: rather than assuming that the retrieval of a memory can stimulate emotion, Ferenczi began with the body and attempted to summon memories through the physical expression of emotion (as noted in Lowen, 1971). This approach not only opened up the space for Reich's somatically-oriented treatments of "character armor" (discussed below), but also presaged the interventions that now comprise Somatic Experiencing, and other contemporary treatments.

Reich began as a student of Freud's, and the work that would eventually cause Reich's excommunication from the Psychoanalytical Association grew out of Freud's conceptualization of the body-ego. However, Reich's treatments were radical in that they ceased to treat the body as a source of ego stimulation or a model of ego structure, and began treating it, literally and directly, as the container of neurosis and the mechanism of its relief. Whereas Ferenczi had begun to dabble in treatments that would invite patients to gesture and enact emotion in order to elicit the repressed memories he still believed were the essence of the neurosis, Reich focused largely on embodiment. He developed the concept of "character armor" (Reich, 1945/1980) to describe this somatization of neurosis.

In the treatment room, patients would demonstrate their neuroses

...not in the content of the material, but in the formal aspects of the general behavior, the manner of talking, of the gait, facial expression and typical attitudes such as smiling, deriding, haughtiness, over-correctness, the *manner* of the politeness or of the aggression, etc. (Reich, 1945/1980, p. 238)

Reich's concept of character armor did not make use of the tripartite self. He made very little mention of the superego at all, but envisioned the conflict between ego and id taking place within the layers of resistance that constitute a patient's character. He also argued that few clients are developmentally far enough along to free associate, and therefore would not be able to generate sufficient energy for change simply through the process of Freudian analysis. As with many of the current body-centered orientations, Reich attempted to bypass the clouds of transference that arise from talk therapy, and targeted the neurosis at the point where body and mind were in conflict. However, his formulation of the orgasm as the wellspring and truest indicator of healthy energy in a person set him apart from all those before and after save his disciples. This concept (shocking and titillating as it was at the time) came to obscure his other ideas about the body in treatment, and Reich was forcibly separated from the mainstream. Young (2006) argues that a combination of old-fashioned dualism and a puritanical fear of the body alienated many of Reich's followers, and allowed body-oriented psychoanalytic treatments to be marginalized for decades after.

During those years, many of Reich's students and adherents developed systems that translated his ideas about character and the embodiment of neurosis into influential theories of their own. Fritz Perls, who was analyzed and trained by Reich, went on to be one of the founders of Gestalt therapy. Perls and Gestalt therapy took from Reich the idea of understanding the

patient as a whole person, and transferred the attention Reich gave to character armor to the shared experience of *being* in the treatment room. Though the goal of Gestalt therapy can generally be described as insight (Yontef, 2002), the means of reaching that goal frequently include an understanding of the client's physical being—in the treatment room and in the world—as part of the entirety of their experience. The concept of being in Gestalt therapy incorporates the constant traffic of emotion, information and stimulation between the body and the mind, all of comprising the present moment for therapist and client.

Gestalt therapy came to overlap with humanistic therapy in its phenomenological approach to the client encounter, and thus in its broad acceptance of the client as “organism in environment” (Rogers, 1961). In its determination to de-pathologize the clinical encounter and see the clients in terms of their potential for growth, humanistic psychology compelled the therapist to see and accept the totality of a client's experience. However, with its primary assumption that the organism is constantly striving to “actualize, maintain and enhance” itself (Rogers, 1961), some writers argued that humanistic psychology could not account for the interminable psychosomatic loops of a traumatized client (Gendlin, 1978). Eugene Gendlin, a student of Carl Rogers and a collaborator on many of Rogers' experiments, developed a method called Focusing. Focusing combined the clinical approach of Carl Rogers—unconditional positive regard, transparency, congruence—with an emphasis on the physical experience of emotion. This innovation formed a bridge between the humanistic therapies of the mid-20<sup>th</sup> century and the more deliberately somatically-oriented therapies of the 1990s and 2000s, which will be discussed below (Levine, 1997).

## **Factors Contributing to the Development of Somatically-Oriented Therapies**

Late in the 20<sup>th</sup> century, four factors converged to welcome in several mainstream psychotherapeutic methods that treated the body directly. First, as discussed above, parallel threads from the humanistic, psychodynamic and neo-Reichian theories had begun to come together in eclectic therapies that made more room for the body in psychotherapy. Second, the evolution of behavioral therapies cleared the way for embodiment and action in psychotherapy (Linehan, 1993; Beck, 1979; Skinner, 1976). Third, eastern concepts of the body-mind connection began to seep into the mainstream of American therapeutic thinking, through the popularity of meditation, yoga, Reiki, and other healing practices (Epstein, 1995; Ogden, Minton, & Pain, 2006). Finally, an explosion of neurobiological research gave credibility to the above-mentioned developments, and suggested that trauma in particular was a disruption of the mind-body connection. (van der Kolk, 1996; Siegel, 2003). Researchers argued that the experience of post-traumatic stress could be accessed and altered through the integration of brain functions, increased awareness of the body, and changes in movement and breathing. The relevance of these discoveries to trauma treatment will be discussed in the next section.

### **Integration and “complexity” in brain function.**

The majority of the neurology-driven discoveries about trauma treatment involve the concept of integration in some form. The body-oriented interventions developed in the past two decades focus in varying degrees on the goal of integration. The experiences of flashbacks, numbness or dissociation, exaggerated startle response, nightmares, and disordered memories, are all considered to be symptoms of mis-allocated psychic energy (Rothschild, 2000). The research suggests that these experiences correspond to the dis-integration of various parts of the

brain. Van der Kolk (1996) divides brain function into three categories: the brain stem and hypothalamus, responsible for internal homeostasis; the limbic system, which monitors the relationship with the outside world; and the neocortex, which analyzes and processes responses to the outside world. He notes that though the neocortex is the least stable, and therefore the part of the brain most likely to accept lasting alterations based on external stimuli, it appears that traumatic experiences find their way deeper into the brain. PTSD is not only disruptive to more fundamental functions of the brain and body, but the disruption lies out of reach of such neocortex-driven therapies as talk therapy.

In addition to the distortion among these three functionally collaborative sections of the brain, many studies (van der Kolk, 1996; Schore, 2009, among others) have noted an increase in right hemisphere activity during exposure to traumatic memories, simultaneous with a decrease in left hemisphere activity. This failure of integration between hemispheres may contribute to discontinuousness in narrative memory among PTSD sufferers, an inability to integrate new stimuli, and difficulty prioritizing current challenges (Briere & Scott, 2006).

Siegel (2003) uses “complexity theory” to conceptualize the experience of trauma and the goal of trauma treatment. The theory suggests that healthy systems tend toward a chaotic, fluid dispersion of different elements, and that this self-regulating diversity adds up to a whole that draws energy from the chaos.

The complex web of interconnected neurons in the brain and the rest of the body become functionally linked through neural integration, which enables the differentiated circuits of the brain to become part of a coherent information processing system. Complex mental processes thus depend upon widely distributed regions of the brain to be linked together into a functional whole (p. 5).



### **The brain's map of the body.**

In addition to studies on integration, there is some evidence that the brain retains a “map” of the body, and that physical sensations (from the surface and interior of the body) can provide templates for feeling states. These discoveries have led to the idea that some aspects of trauma can be addressed and alleviated through targeted awareness of the right body parts (Levine, 1997; Ogden et al., 1996). In a study of the connection between cortical dynamics and touch healing, researchers led by Catherine Kerr (Kerr, Wasserman, & Moore, 2007) argue that the brain contains layered “maps” of the body, and that these maps can be engaged, and some types of pain alleviated, by directing the patient’s attention to particular parts of the body. They suggest that bringing the patient’s attention to a particular area while the patient is in a relaxed state can activate and reorganize the brain-body connection. They draw from the collective results of neurological studies on chronic pain, behavior change, animal behavior and sensorimotor disorders. The authors synthesize various ethnographic and anthropological studies of touch healing in Western and non-Western cultures with current research about the “cortical plasticity”--or the ability of the brain to make permanent changes in structure in order to adapt to new circumstances (Kerr, 2007). Though the findings did not address the mind-body connection in relation to psychotherapy, they established the connection between a patient’s body-awareness and the alleviation of psychosomatic symptoms.

Other researchers have discovered evidence that the awareness of the body’s internal sensations (known as “interoception”) provides data that ultimately inform what we experience as feelings. Damasio (1994) devised the concept of “somatic markers” to suggest this dynamic, arguing that “brain regions involved in mapping and regulation ...provide a basis for awareness of feelings states” (as paraphrased in Gerbarg, 2008). In a survey of functional magnetic

resonance images (fMRIs), Critchley (2005) discovered a “feedback” response between changing states of bodily arousal and the cultivation and comprehension of feeling states.

### **Breathing and the brain.**

Many of the contemporary body-oriented therapies involve some component that focuses on changes in the breath. While a lot of the faith in breathing is attributable to traditional or anecdotal experience with the healing effect of breath regulation, neurological research now supports some of these basic assumptions. Slow, deliberate breathing alters the functioning of receptors in the lungs that send signals throughout the nervous system. (Gerbarg, 2008). Gerbarg also argues that “yoga breathing” can solicit changes in the signals from the larynx, chest wall, and diaphragm that will translate into the experience of greater calm. However, a more comprehensive study (Ansgar et al., 2007) found little evidence that altered breathing patterns reduced the measurable experience of chronic stress.

### **A Survey of Current Body-Centered Therapies**

The complete range of body-oriented therapies is too broad for the current study. A complete survey would cover yoga, Reiki, cranio-sacral therapy, various forms of massage, biofeedback, the Alexander technique, Feldenkrais, the Rosen method, Rolfing, and many others, including the work of therapists who combine elements of the above. As this study concentrated on social workers treating trauma, the following sections will survey a few of those therapies most accessible to, and most commonly practiced by, social workers in the United States.

### **Eye-movement desensitization and reprocessing (EMDR) and brain integration.**

EMDR is now among the most widely-practiced treatments for PTSD and traumatic memories, yet no one can say authoritatively how it works (Gunter & Bodner, 2009). The essential component of EMDR is the bilateral stimulation of clients’ bodies (or perceptions)

during the processing of traumatic material. Among the most prominent of many theories about how EMDR works is the idea that the stimulation engages both hemispheres of the brain, thereby correcting some of the imbalance in activity between right and left hemispheres mentioned above. Other theories point to the value of relaxation and orientation in space. (Gunter, & Bodner, 2009). A 2009 meta-analysis by Ponniah & Holton assessed fifty-seven studies on the efficacy of CBT and EMDR interventions for acute stress disorder and post-traumatic stress disorder, all published in 2008. The researchers found both interventions to be effective in terms of symptom reduction, but conceded that the research on EMDR has thus far focused on PTSD in particular.

### **The body in dialectical behavior therapy (DBT).**

Originally devised as a treatment for borderline personality disorder (BPD), Dialectical Behavior Therapy (DBT) is not primarily a body-oriented therapy. However, the study and practice of mindfulness is one of the four modules of DBT, and body awareness provides a foundation for two of the main goals of the therapy, distress tolerance and emotion regulation. (Linehan, 1993). Research by Soler et al. (2012) suggests that the mindfulness curriculum alone can bring about significant change for clients diagnosed with BPD. Soler and his colleagues studied 60 patients in a hospital setting, 40 of whom were given general psychiatric treatment in conjunction with the mindfulness module, while 20 were given the psychiatric treatment alone. The mindfulness patients demonstrated improvements over the control group on all measures. Researchers also observed greater degrees of improvement in those patients within the mindfulness group who practiced for a longer duration. DBT clients complete daily exercises of mindful observation, description and participation (Linehan, 1993). In terms of neurological integration, the priority of non-judgmental awareness may engage the holistic tendencies of the

right hemisphere, while the tasks of observation and description engage the more linear, descriptive left hemisphere. DBT has been widely studied for efficacy with many populations (Kliem, Kröger, & Kosfelder, 2010). A 2010 meta-analysis, using a mixed-effect hierarchical model to consider sixteen studies, found DBT effective for treatment of borderline personality disorder (Kliem et al., 2010). Though DBT is not currently indicated as a treatment for PTSD alone, many studies (Sansone, Hahn, Dittoe, & Wiederman, 2011) have indicated a significant correlation between childhood trauma and adult BPD.

**Beginning with the body: Somatic experiencing and sensorimotor psychotherapy.**

Several new methods have developed in the past decade that take clients' sense of their own bodies as the primary field for therapy, and use that sense as a primary gateway to trauma and intrapsychic conflict. Among the most widely practiced are Somatic Experiencing, developed by Peter Levine, a psychologist and medical biophysicist, and Sensorimotor Psychotherapy, developed by psychologist Pat Ogden. Both methods encourage therapists to be constantly reading a client's body, to monitor and take note of bodily shifts in the client, and to teach the client to notice and make room for those sensations. Ogden and Levine both advocate their treatments as a supplement to talk therapy, rather than a comprehensive, monolithic theoretical framework. (Ogden et al., 2006; Levine, 1997) Each author acknowledges the significance of language, memory and narrative in synthesizing traumatic material. Ogden et al. propose a three-stage treatment derived from the work of Judith Herman (Herman, 1992), beginning with the establishment of a sense of physical safety, and proceeding through an experience of memories and a stage of integration. While it proceeds from a very similar orientation, Somatic Experiencing is more experientially-based, prescribing a range of body-

oriented interventions and exercises designed to uncouple negative ideas from physical postures and to “complete” aborted or distorted movements associated with the trauma.

Neither Sensorimotor Psychotherapy nor Somatic Experiencing has been widely tested for efficacy. A 2012 study (Langmuir, Kirsh, & Classen, 2012) assessed the effects of a 20-week, closed therapy group for women with a history of interpersonal trauma. Sensorimotor psychotherapy was the guiding methodology for the group. Each session began with a mindfulness exercise and moved through discussions of bodily sensation, a body-oriented exercise, and further discussion of the effects of the exercise. The study found significant improvement in body awareness, reduced dissociation and receptivity to soothing. At the time of my writing, this was the only study of sensorimotor psychotherapy available through an online database of scholarly articles. A 2009 study (Leitch, Vanslyke, & Allen, 2009) examined a group of social service workers who were given SE treatments to relieve the effects of secondary trauma after treating victims of Hurricane Katrina. SE treated the symptoms of trauma with a “bottom-up” approach, examining body sensations as the gateway to psychodynamic work. The study interviewed 142 non-randomly-selected social service workers in the New Orleans area, some of whom had graduate training as therapists and some of whom did not. The researchers administered the therapy and psychoeducation to 91 respondents, against a matched comparison group of 51. The researchers reported statistically significant reduction in PTSD symptoms and improvements in resiliency (Leitch et al, 2009). While the study suggests that SE may be effective in addressing the body origins of PTSD and preventing its onset, a population of social service workers (already familiar with at least some theories of trauma and recovery) is not representative of the general population of trauma survivors.

### **Mindfulness-based practices.**

Apart from their widespread incorporation into many therapeutic settings (see above for references) mindfulness practices alone have received broad attention in western therapeutic circles in the past decade. Mindfulness-Based Stress Reduction (MBSR) is a direct, largely patient-practiced method for addressing stress of all kinds. Developed by Jon Kabat-Zinn, a biologist with an education in yoga and meditation, MBSR has been widely tested for clients with a variety of symptoms. In the most recent and thorough meta-analysis, Teleki (2010) sorted results from seventeen different studies, involving more than 800 subjects who had received the full initial training in MBSR and were practicing on a regular basis. The meta-analysis suggested that, when used according to the established method, MBSR is significantly effective in reducing stress. However, while all these studies were randomized controlled studies, the population of trained MBSR practitioners is a self-selecting group, possibly more privileged than the majority of traumatized social work clients. Many of the studies considered drew respondents from retreats, conferences and classes on MBSR, and seemed to suggest a bias in favor of MBSR's fundamental validity. Some of the studies examined were designed specifically for clients diagnosed with PTSD. Kimbrough (Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010) administered a program of MBSR, combined with home-based meditation, to twenty-seven adult survivors of childhood sexual abuse. The study provided follow-up courses through 24 weeks, and assessed participants for depressive symptoms, anxiety symptoms, flashbacks and other PTSD symptoms. The survey found that depressive symptoms were reduced by 65 percent at eight weeks, and statistically significant improvements in all categories persisted through 24 weeks post-treatment.

## **Recent Related Work by Smith Students**

Several recent theses from the Smith School of Social Work have examined aspects of body-oriented treatments. A 2010 thesis by Sunshine Elizabeth Finneran focused on the use of touch in psychotherapy. Finneran's thesis was based on a survey of clients, and focused primarily on their responses to treatment. Anastasia McRae's 2008 thesis focused on the effects of formal training in body-oriented therapies on clinicians' outlook. Lastly, a 2005 study by Anne Fine examined clinicians' thoughts about the efficacy sensorimotor psychotherapy, one specific body-oriented intervention. None of these studies had as their primary subject the state of clinicians' ideas about the body's role in trauma, and none considered the full range of new treatments now gaining popularity among clinicians.

## **Summary of the Literature Review**

Psychotherapists and theorists have always recognized the body in treatment as a source of data about the client's psychological experience. However, as theories were developed and systematized over the past century, the body-mind connection has most often been overlooked or taken for granted. The task of constructing a comprehensive map and catalog of mental functioning consumed the majority of the attention and debate after Freud, and clinicians were left to interpret the client's somatic experience on their own terms.

Several factors converged to bring the mind-body connection to the forefront of clinical research and theory in the past two decades. First, a popular interest in eastern health practices provided a new vocabulary, a new set of metaphors, for the dynamics of the mind-body relationship. Second, the refinement of neuroimaging techniques put hard data behind some of those mind-body theories that had long been considered speculative or "New Age." This research

has been particularly revealing in studies of trauma and PTSD, whose symptoms seem to have a particular neurological and neurochemical manifestation. A series of new theories interventions (and some that had been around for a long time, but without the blessing of the establishment) now seem to be clearly indicated for the treatment of trauma.

The question thus arises whether these interventions are being adopted in the field. Are social workers, who do the majority of the therapy with traumatized people in the United States, implementing these new interventions? Are they conceptualizing trauma according to the most current research about the nervous system? No research was found as to what kind of interventions for trauma are most commonly used by social workers in the United States. Some studies (Gockel, 2010, e.g.) have observed that mindfulness education is on the rise, but that represents only one component of mind-body training. This study aimed to take the measure of social workers' conception of the body, and to suggest new directions for clinical practice and social work education.



## **CHAPTER 3**

### **Methodology**

#### **Purpose**

The purpose of this experimental study was to examine how social workers think about the role of the body in trauma treatment. The survey discussed below was designed to assess social workers' attitudes not only about particular treatment methodologies and interpretations of trauma, but also their more general outlook on the connection between mind and body. The questions were designed to answer a larger question: Have recent discoveries about the neurobiology of trauma and the proliferation of eastern mind-body practices led to an increase in body-oriented trauma treatment by social workers? Implicit in this research question are two hypotheses: social workers currently treating clients in therapy would be more inclined to treat the symptoms of trauma and PTSD through mind and body together than through traditional psychodynamic methods; and younger clinicians, whose formal education would have incorporated more recent ideas about the mind-body connection in trauma, would be more likely to embrace mind-body therapies of all kinds, and more likely to incorporate the concept of mind-body connection into their treatment of traumatized clients.

#### **Study Design**

Because the study was intended to reach and gauge the attitudes of a broad sample of social workers currently practicing therapy with traumatized clients, an online survey was devised that could be conveyed to clinicians in a variety of settings. This method would enable the researcher to collect a range of data about clinicians' attitudes, while providing enough

structure to enable the quantification of responses. Because the purpose of this study is to gauge attitudes and approaches, rather than results, the majority of the questions presented a stated position and invited respondents to agree or disagree, or to choose among the options one that most closely matched their attitudes. Several short-answer questions were also provided, to enable respondents to describe some facet of their experience with trauma treatment and the body-mind relationship in areas that could not be ascertained through the multiple choice format. The Likert Scale questions would encourage respondents to place themselves along a continuum of attitudes in the ongoing debate over various approaches to trauma treatment and the conceptualization of the body in psychotherapy.

The survey was created using SurveyMonkey.com, an online survey-creation program, after approval of the study by the Smith College School for Social Work Human Subjects Review Committee. (A copy of the approval letter is contained in Appendix A), The link to the survey was then forwarded to an informal list of clinicians and non-clinicians known to the researcher in an email announcement. (A copy of the announcement is included in Appendix B). The initial round of emails was sent to thirty recipients, with encouragements in each to forward the link to the survey to any potential respondents known to each recipient. Those recipients personally acquainted with the researcher were excluded from responding. Several recipients wrote back to say that they had posted the survey on listservs, or forwarded it to their departments in a clinic or hospital.

Participants were screened with a series of four questions. In order to qualify for the survey, they must have claimed to have a master's degree in social work; to be currently treating at least some clients with a significant history of trauma, and to be practicing in the United States. Because the goal of the survey was to gauge themes and commonalities in the attitudes of

all social workers treating traumatized clients in the U.S., no further screening (for race, gender, geographic location, age) was necessary. Some of these data were collected in a series of demographic questions at the end of the survey. Respondents' demographic information will be addressed in the Findings chapter.

The survey consisted of thirty questions: five screening questions, five demographic questions, and twenty questions on the research subject (see Appendix C for a copy of the survey questions). Eighteen of these twenty questions were multiple choice; two were short answer. While some questions were designed to address directly the clinician's approach to trauma treatment (e.g., "PTSD requires a different type of intervention from other psychological complaints") others were designed to elicit more general statements about the mind-body connection (e.g., "The value of meditation in psychotherapy has been exaggerated in recent years"). The responses were recorded anonymously in an online database.

### **Data Analysis**

Data were analyzed according to several research objectives. In order to assess the relationship between experience and attitudes toward the mind-body connection in trauma, all Likert Scale questions were examined against variables of age and years of experience in the field using Spearman correlations. The short-answer question asking clinicians which interventions they use for traumatized clients was also analyzed for a possible relationship to the respondents' age and years of experience in the field. Lastly, a series of related questions were scaled together as an indication of a more general disposition for or against the conceptualization of a mind-body connection in trauma. This cluster of responses was also analyzed for correlations with age and experience, and was assessed as an indicator of general attitudes.

## **Discussion**

While this study design was the most appropriate for this particular research question and these circumstances, it did have some limitations. First among these is the likelihood of the respondents to share demographic and ideological traits with the researcher. But choosing a snowball method of data-gathering, the researcher cast the study out in widening circles beginning with his own acquaintances in the field. Though efforts were made to reach respondents in a variety of settings, many with no connection to the researcher, his current internship site, or the school where he is studying, still the likelihood of responses is higher among those who know the researcher well. Therefore it seems likely that the majority of the responses come from clinicians from similar educational backgrounds, and those who have received similar training. As such, the data may present a bias toward psychodynamic interventions, and an openness to somatically-oriented interventions (in which the researcher has had some training). Some of this may be accounted for in the demographic information, which asks respondents where they got their master's degrees and what training, if any, they have had in interventions specifically designed to treat trauma. Lastly, of course, some possibility exists that the researcher's own biases regarding the efficacy of mind-body treatments for trauma may have influenced the structure or language of the survey

## CHAPTER 4

### Findings

This study was designed to investigate the state of trauma treatment among social workers—specifically the ways in which social workers conceptualize the role of the body in the experience of post-traumatic symptomology. In light of the proliferating neuropsychological evidence of an essential, dynamic connection between mind and body in the experience of trauma; and also in light of the widespread acceptance of Eastern mindfulness practices (discussed above), the hypothesis was derived that social workers treating traumatized clients would be increasingly invested in body-oriented therapies. The survey’s most striking and consistent finding was that respondents are overwhelmingly disposed to think of the mind and body as inextricably connected in both the experience of trauma and the process of recovery. This supported the first hypothesis behind the research. Some correlations were found to support the second hypothesis, that younger clinicians would be more invested in somatically-oriented therapies than older and more experienced clinicians; however, these correlations hovered near the cutoff for statistical significance. Furthermore, despite those correlations, even the oldest quartile of clinicians demonstrated a marked disposition toward somatically-oriented therapies.

Because of the nature of the survey mechanism (an anonymous online survey) it was not possible to obtain the percentage of respondents who completed to the survey against those who received it. However, among the total population of 46 who began the survey, 39 passed beyond the screening questions; thus, the (*n*) for this survey was 39.

## **Demographic Information**

### **Age and experience.**

Thirty respondents gave their age. The average age was 45, with respondents ranging from 26 to 71. Twenty-three percent were between the ages of 26 and 30, while 26% were between 60 and 71. Age responses were spread fairly evenly among the intervening years. Years of experience were similarly distributed, with an average of 13 years in practice, and 17 respondents reporting ten or fewer years in practice. Eight respondents reported having been in practice for more than 20 years.

### **Education.**

Thirty-one respondents listed the schools from which they received their master's degrees. Among these, a disproportionate number (9 respondents, or 29 %) graduated from Smith College School for Social Work, likely due to the limitations of the researcher's professional network. The remaining respondents had graduated from 12 different programs, all located in New York and Pennsylvania.

### **Current work settings.**

Respondents were asked to report what interventions, if any, were officially encouraged in their work settings. Among the 29 respondents, 13 listed interventions encouraged by their workplace. (Seven reported being in private practice, and the remainder said no particular interventions were encouraged.) Among the officially-sanctioned interventions, Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) were most common, with four reports for each.

### **Outside training.**

Perhaps most significant among the demographic data were reports of additional education clinicians had received in trauma treatment. Twenty-four respondents reported some training. Among these, the most common response by far was Eye Movement Desensitization and Reprocessing (EMDR), which was listed by 13 respondents. Eight clinicians had had training in Somatic Experiencing (SE), but the prevalence of this answer is likely attributable to an anomaly in the selection process. Many other modalities were listed one or two times, including Reiki, hypnosis, narrative therapy, family systems therapy, biofeedback, motivational interviewing, DBT, meditation, and guided imagery.

### **Survey Response Data**

Respondents to the main questions in the survey consistently demonstrated a tendency to think of trauma treatment in terms of mind-body integration. Among the themes demonstrated in their answers were: a focus on sensation over cognition when assessing traumatization and recovery; recommendation of body-oriented supplementary therapies, such as yoga and meditation; and distinguishing trauma from other symptoms in choosing a method of treatment.

Respondents demonstrated a basic inclination to address the body in therapy with their responses to question 14, which posited that, “Every kind of effective psychotherapy engages the client’s body in some way.” Twenty-two respondents (65%) agreed or strongly agreed with the statement, while eight (24%) disagreed. Two other questions designed to address the basic definition of trauma elicited a near consensus in the favor of a conception that integrates mind and body. No respondents disagreed with the statement that, “The experience of trauma directly interferes with the connection between the mind and the body,” and only 3 (9%) had no opinion. In response to the suggestion that “trauma blocks the flow of energy in the body,” 28

respondents (82%) agreed, with 5 (14 %) having no opinion and one respondent (2.9%) disagreeing somewhat.

The survey began with a question designed to assess how clinicians think about the essence of recovery. Asked “Which of the following is a stronger indicator of a client's recovery from trauma?” only one respondent (2.9 %) answered “The client is able to think and talk about the traumatic event without distress.” Twenty respondents (57%) answered, “The client reports feeling more connected to him/herself”; and 14 respondents (40%) answered, “Neither: the two are equally important indicators of recovery.” In assessing clinicians’ general attitudes on the structure of trauma, these responses can be linked to questions 17 and 18, both of which inquire about the relative value of cognitions and sensations. The first question asks, “Trauma will be more effectively treated by focusing entirely on the body, or entirely on the mind,” in an attempt to solicit respondents’ attitudes to the therapeutic dualism described in the Literature Review chapter. Twenty-seven responses (82%) either disagreed or strongly disagreed with the statement. In the following question, clinicians were asked to respond to the statement, “The essential component of trauma is a person’s inability to comprehend an experience. The therapist’s task is to help the client reach some understanding.” Sixteen respondents (50%) disagreed with the statement, with another three (9%) declaring “no opinion.” Thus, a minority of respondents agreed with this statement advocating a cognitively-focused definition of trauma recovery.

Another set of questions sought to gauge respondents’ perception of traditionally eastern practices like yoga and meditation as components of trauma treatment. Twenty-seven respondents (79%) agreed with the statement that “Yoga can be an effective treatment for PTSD,” with 11 respondents (32%) strongly agreeing. Three respondents (10%) disagreed with



the statement. When presented with the statement “The value of meditation to psychotherapy has been exaggerated in recent years,” 25 respondents (79%) disagreed, 14 of them (41%) strongly. Four respondents (12%) agreed. Approaching the same ideas in a slightly different format, clinicians were also given the statement “Practicing yoga is unlikely to have any effect on a client's recovery from a traumatic experience.” Two respondents (6%) agreed, nine (27%) had no opinion, and 22 (67 %) disagreed.

Respondents demonstrated a near consensus on one question about the types of encounter most likely to lead to trauma. Asked whether the flight, fight or freeze response was most likely to lead to post-traumatic stress, 29 (90%) respondents answered, “freeze.”

Despite relatively consistent findings that demonstrated a disposition toward mind-body theories of trauma, several questions did elicit mixed responses. A question based on the statement, “Traumatic experiences hold their power primarily through the false ideas that people develop about themselves in the aftermath,” was designed to divide the more cognitively-focused thinkers from those with an interest in mind-body treatments. However, the majority of respondents agreed with this statement (22, or 65%) with only 9 respondents (32%) disagreeing. The following question had a similar focus, stating that, “Treating trauma is primarily a process of confronting painful memories and putting them into context.” Seventeen respondents (51 %) agreed, with 13 (30%) disagreeing.

### **Short-answer questions.**

The survey also included two short-answer questions regarding clinicians' interventions with their own clients. The first question asked, “What types of interventions do you find most effective in treating trauma?” The answers here were similar to those in the demographic question about what training clinicians had received (mentioned above): CBT, SE, and

mindfulness-based strategies were most common. The majority of clinicians also mentioned some form of talk therapy, however, and described strategies for modulating clients' distress through talk. As one clinician wrote,

PACING the treatment so that the patient is not overwhelmed; making sure the patient has time at the end of each session to consolidate if the patient is dissociated, and to feel ready to leave the room. NO intervention such as EMDR, SE, sensori-motor, etc. is as important as the above.

The responses suggested collectively that these clinicians are using talk therapy as the primary frame with traumatized clients, and implementing EMDR, SE, and CBT as supplements. Another clinician noted that

When the client is disclosing a trauma for the first time, I will zoom in and out with the client to check in 1) about how X made them think or feel and 2) how the client thinks or feels about talking about X.

Neither of the clinicians quoted here mentioned body-oriented interventions in their answers, despite both having listed them among interventions in which they had some training. This was the case for four other clinicians as well, who focused entirely on strategies for talk therapy when describing their own practice, despite having been trained in body-oriented therapies for trauma.

## **Correlations**

This study was initiated with two main hypotheses: First, that social workers would be inclined to embrace body-oriented therapies and to practice them with their traumatized clients; and second, that younger clinicians would be particularly disposed to think about mind-body connections. The second hypothesis arose from the idea that recent neuropsychological research about the experience and treatment of trauma has strongly indicated that the nervous system as a

whole is altered, and younger clinicians with more recent training might have had exposure to this rather than older ones. To test this second hypothesis, a Spearman correlation was run between the clinicians' reported years of experience and several of the responses addressing their general attitude toward the mind-body relationship in trauma. The instrument found a minor, significant correlation ( $\rho=.347$ ,  $p=.048$ , two-tailed) between age and the tendency to disagree with the statement, "Psychological trauma registers in the mind and body equally." Thus, older clinicians were more likely to disagree with the statement. However, this correlation was only slightly above the cutoff for significance, and no other significant correlations were observed with age or experience.

### **Summary**

As a whole, the data represent a significant majority of clinicians endorsing body-oriented therapies, envisioning a consistent mind-body connection in trauma, and recommending mindfulness and yoga for traumatized clients. However, a smaller but distinct portion of the data suggests that while these interventions and attitudes are popular among this population of clinicians in the abstract, the actual interventions being practiced fall more commonly under the structure of talk therapy. Hypothesized correlations between age and disposition toward mind-body practices were largely disproved, with one minor exception in which a borderline significant correlation was observed. Demographic information on clinicians suggested a relatively narrow survey population in terms of race and educational background, perhaps limiting the broader applicability of the survey data. The discussion chapter will consider the themes that emerged in the survey responses, the implications of the data, and suggestions for further study in this area.

## **CHAPTER 5**

### **Discussion**

The purpose of this research study was to assess the attitudes and practices of social workers treating trauma in the United States. Graduates of master's degree programs in social work were sent an online survey anonymously in which they were asked a series of multiple-choice and short-answer questions on the subject of the mind-body relationship in the experience and treatment of trauma, as well as questions meant to gauge clinicians' general disposition toward mindfulness practices and yoga as supplements to psychotherapy. The aggregated data indicate that the social workers surveyed strongly endorse a dynamic, fluid relationship between body and mind in trauma. Respondents consistently chose definitions of trauma that focus on a total experience, or on sensation, rather than on cognitive distortions or disruptions in memory.

As discussed above, several factors have conspired in the past two decades to alter the understanding of trauma within the medical establishment. First, discoveries in neurobiology and neuropsychology have isolated sections of the brain that are specifically disrupted by traumatic experience, chemical changes associated with PTSD, and neurological responses that suggest a "map" of the body impressed upon the structure of the brain. Furthermore, the increasing popularity of yoga, meditation and other traditionally eastern mind-body practices has cleared some space in the mainstream for psychotherapeutic interventions that incorporate similarly integrated approaches to the mind-body relationship.

While a considerable body of research exists about the efficacy of various body-oriented interventions, little is known as to how these changes in theory and discoveries in

neuropsychology have trickled down into the care of traumatized clients by social workers, who often constitute the first line of treatment in the United States. This study was designed to give a preliminary indication of social workers' outlook on the mind-body connection in trauma, and a sketch of how trauma treatment is being conducted in this population in 2012.

The history of the body in psychotherapy, as discussed in the Literature Review, is a story of fluctuating enthusiasms and orthodoxies. While psychoanalysis began with an acute interest in (and explicit clinical attention to) the body itself, the theoretical structures that developed around the practice seemed for a while to obviate this interest. At almost the same time, Wilhelm Reich was developing a conceptualization of the body in psychotherapy that continues to influence theoreticians and clinicians today. In the intervening generations, the language of the body, and the dynamism of the body-brain connection, have surged and receded from view over and over again in psychotherapy curricula. In this most recent wave of interest, some interventions have gained not only popularity but considerable empirical support. EMDR and DBT, each of which have significant somatically-oriented components, have become standard practices for trauma treatment in many clinics. Another question, then, arises out of this popularity: Have the clinicians who practice these interventions—or who are encouraged to practice them—adapted their conceptualization of the client's experience in response to the efficacy of such interventions? Is the clinical experience matching the research on efficacy?

The results of this study suggest that social workers of all ages are embracing the concept of a "body-mind," a conceptualization that understands trauma as a breakdown of the natural equilibrium between sensations, cognitions and emotions. Some of the respondents received their degrees before the emergence of any significant neurological research on the effects of trauma, before the research of Bessel van der Kolk and the theories of Judith Herman (Herman,

1992). Yet these clinicians demonstrate no more consistent adherence to earlier definitions of trauma than those who graduated within the last five years.

The questions that elicited the greatest differences of opinion were those that assessed traumatization or recovery in terms of cognitions (rather than sensations or states of being.) In those cases, respondents were often split between agreement and disagreement, with few respondents at the extremes. In two of the three questions (# 20 and # 21), the majority of respondents identified sorting through memories and correcting false beliefs as the central elements of trauma recovery. One implication seems to be that while the vast majority of the respondents endorsed ideas about mind-body connectedness in trauma, they did not abandon ideas about the importance of beliefs about the self, cognitive tendencies, and coherent narratives of the trauma experience. In those questions that received the most varied responses, no correlation existed between more skeptical responses and age or years of experience. In future studies, researchers might explore the ways in which clinicians reconcile their investment in mind-body treatments with these more traditionally cognitive elements of treatment.

### **Suggestions for Further Research**

The relative unanimity in responses to many of the questions in this survey suggests a clear direction for further research in the area of mind-body therapies for trauma. However, it should be noted first that the relatively low number of respondents, and the (presumed) demographic narrowness of the sample, may limit the generalizability of these results. Though efforts were made to solicit respondents from settings where body-oriented therapies are less likely to be practiced or discussed, this may not have been sufficient to offset the likely prevalence of those practices among many others. On the other hand, the near absence of

forcefully negative responses to the idea of mind-body connection in trauma suggests that even in the broader population of social workers, the idea is taking hold.

The data from this survey provide a general, self-reported picture of which interventions are being practiced by social workers dealing with trauma. They also suggest a tendency to embrace the idea of mind-body mutuality in trauma recovery. However, it remains to be seen how these ideas translate into interventions with actual clients, within particular settings. The everyday realities of clinical practice in an institutional setting have been known to complicate the practice of a new, untested type of treatment; the priorities of the institution can obstruct the therapists' clear perception of their clients' experience, and hamper their responsiveness to the clients' particular needs. A qualitative study involving interviews and observations of clinicians would be well-suited to assessing just how these ideas play out in practice. The questions for discussion could be designed to elicit actual case material, and to explore the ambiguities and frustrations of bringing theory into practice. The current study also gives no indication of how clients are experiencing the current interventions. Looking at the wide support for mind-body connection in trauma among therapists, the question arises whether clients ever feel that their bodies are being left out of traditional psychotherapy or cognitively oriented therapies? Do they feel the same urgency to include the entire nervous system? Does the focus on memories and exposure in contemporary trauma treatment leave clients feeling as if a part of their experience has been kept in shadow? A survey of client responses to treatment—body-oriented and not—would give some indication of whether these new body-oriented treatments are on the right track.

Another study could address how clinicians were bringing ideas about mind-body treatment into practice *within* the framework of given institutions. Many respondents to my

survey reported being trained in interventions not supported by the clinics and hospitals where they practiced. Many insurers require that diagnoses, case notes, and billings be oriented toward certain types of treatment; does this lead clinicians to practice body-oriented treatments furtively? Or do they only try these interventions out in private practice settings? Another study could focus on clinic directors or insurers, to assess whether these influential parties believe in the efficacy of body-oriented treatments, whether they are inclined to sanction them, and whether they believe in the validity of yoga or mindfulness as complements to psychotherapy. The future of trauma treatment will be determined largely by insurers' willingness to fund interventions; if the majority of social workers support the expansion of body-oriented treatments, as this study seems to indicate, then it would behoove the profession to gauge the receptivity of the government agencies and private companies that will be paying them for their work.

### **Implications for Practice**

If the agreements that show up in this survey are at all generalizable to social workers out in the field, then our treatments for trauma seem to be at odds with the outlook of those expected to carry them out. While the vast majority of respondents indicated an interest in body-oriented therapies, a relatively small minority reported working in a setting where body-oriented therapies were encouraged. So most clinicians, if these respondents are typical, are going beyond the treatments prescribed by their settings when treating trauma. If we assume that some then feel compelled to underreport their use of body-oriented interventions, it follows that these therapists are not receiving supervision that addresses the whole range of work they do. If, on the other hand, supervisors as well as line therapists share the views expressed in this survey, then a certain complicity may arise between the two, in which the concepts and vocabulary of mind-body connection are implicitly worked into the supervision process. In either case, body



awareness is still considered a peripheral concern, a hovering, amorphous X-factor that cannot be directly addressed. These institutional settings might benefit from some formal, in-house trainings in the nervous system response to trauma and, at the very least, a survey of the most contemporary research supporting body-oriented therapies.

Certainly there are potential dangers associated with an increased focus on somatic experience as well. This shift in attention can be disorienting for clients who have been taught to defend themselves cognitively. A new focus on the body may circumvent their defenses and leave them suddenly overwhelmed, disoriented, or in direct confrontation with the unmediated experience of a past trauma. While clinicians may point to the limitations of a purely psychodynamic focus, those limitations also afford many clients a form of control over their introspection, their associations, and their interaction with the unconscious. They can use language and cognition to negotiate with their nervous system. A somatic orientation can bypass that language. Clinicians must learn how to prepare clients for a new type of discovery, a new type of experience in session, and they must learn how to monitor signs of dissociation, overwhelmed states, and psychosis when working in this new modality.

An increased focus on the body may also be more unsettling to some cultural groups than others. As the proliferation of yoga and Eastern mindfulness practices in the West has shown us, different cultures learn the body differently. This education is largely unconscious; it begins well before the acquisition of language, and it is enacted and reinforced in daily life on a level even deeper than culturally-based ideas or traditions. While clients from some cultures may arrive in therapy with a body-orientation more attuned than that of the therapist, others may be affronted by the suggestion that their mental illness is somehow physical. Clinicians should prepare to read this awareness in their clients, and gauge their willingness and ability to work through the body.

## **Theoretical Implications**

The widespread support for yoga (in the therapy culture and the culture at large) offers another entrée to deeper consideration of mind-body connection in therapy. Millions of Americans practice yoga on a daily or weekly basis without demanding any concrete, physiological explanation for why it makes them feel good. The same is true, in a way, about exercise itself. Apart from our vanity, exercise is taken on faith by most people as a mood-improver, a contributor to mental as well as physical health. At least part of the reason for this lies in the connection between the mind and the body, in the exhilaration that comes from unifying elements of our experience that daily life in this culture forces into separation. While the neurobiological research behind mind-body therapies may be complex, the everyday logic is entirely accessible, and therapists can use this simple body-mind idea to bring clients, supervisors, insurers and administrators around to the value of body-oriented therapies for trauma: mental health is the naturally-occurring balance between mind and body, cognition and action, physical presence and governing consciousness. Our goal in treating trauma should be to restore that balance.

Nearly all respondents believed that PTSD calls for a different type of intervention from other diagnoses. In order to build interventions based upon this belief, perhaps education and practice in trauma treatment should do more to emphasize the distinct etiology and symptomatology of PTSD. This distinction is the foundation of such treatments as Sensorimotor Psychotherapy and Somatic Experiencing, and provides a basic conceptualization for the treatment of PTSD that draws attention to clients' difficulties compiling a coherent self-narrative, reflecting on their traumas, and conducting other cognitive tasks often central to the practice of talk therapy.

Indeed, the practice of talk therapy seems most susceptible to reassessment in light of the biases displayed in this survey. Talk therapists might take the role of the nervous system into account in their approach to traumatized clients, particularly in terms of body posture, positioning, the circumstances of the treatment room, and their general physical bearing and approach to the client. In this survey, those clinicians who described themselves as psychoanalytically-oriented were no less likely (in fact, slightly more likely) to espouse ideas of mind-body connectedness. This suggests to me that these ideas are registering and coming into play largely as less than fully conscious adjustments in approach, that therapists practice along a continuum of body awareness without much regard for the psychodynamic methodologies they embrace.

However, the field would benefit from a set of formalized principles, a method that would allow therapists to approach traumatized people as “one nervous system approaching another” (Levine, 1997). If this survey is any indication, perhaps the idea of psychotherapy as one mind in conversation with another is on its way out, to be replaced by a general awareness, across theories and methodologies, that the body is always present, always responding, susceptible to the same fluctuations of tension and fluidity as the dualist mind.

## References

- Aron, L. (1996). From hypnotic suggestion to free association: Freud as a psychotherapist, circa 1892-1893. Retrieved on April 11, 2012 from Psychoanalytic Electronic Publishing.
- Beck, A. (1979) *Cognitive therapy and the emotional disorders*. New York: Plume.
- Briere, J. & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA US: Sage Publications, Inc.
- Cornell, W. (2008). Self in action: The bodily basis of self-organization. In F.S. Anderson, *Bodies in treatment* (pp. 29-49). New York: The Analytic Press.
- Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, 48(4), 451-459. doi:10.1093/sw/48.4.451
- Critchley, H.D. (2005). Neural mechanisms of autonomic, affective and cognitive integration. *J. of Comp. Neurology*, 93 (1), 154-166.
- Damasio, A. (1994). *Descartes' error: Emotion, reason and the human brain*. New York: Putnam Books.

- Epstein, M. (1995). *Thoughts without a thinker: Psychotherapy from a Buddhist perspective*. New York, NY US: Basic Books.
- Fast, I. (2006). A body-centered mind. *Contemporary Psychoanalysis*, 42(2), 273-295. Retrieved from <http://search.ebscohost.com.libproxy.smith.edu:2048/login.aspx?direct=true&db=psyh&AN=2006-08960-010&site=ehost-live>
- Freud, S., & Breuer, J. (2000) *Studies in hysteria*. New York, NY: Basic Books. (Original work published 1895.)
- Freud, S. (1962). *The ego and the id*. New York, NY US: W. W. Norton & Co.
- Goodman, M., Weiss, D. S., Koenigsberg, H., Kotlyarevsky, V., New, A. S., Mitropoulou, V., & ... Siever, L. J. (2003). The role of childhood trauma in differences in affective instability in those with personality disorders. *CNS Spectrums*, 8(10), 763-770.
- Gendlin, E. (1979) *Focusing*. New York, NY: Bantam Dell.
- Gerbarg, P. L. (2008). Yoga and neuro-psychoanalysis. In F. Anderson (Ed.) , *Bodies in treatment: The unspoken dimension* (pp. 127-150). New York, NY US: The Analytic Press/Taylor & Francis Group.

Gockel, A. (2010). The promise of mindfulness for clinical practice education. *Smith College Studies In Social Work*, 80(2-3), 248-268. doi:10.1080/00377311003784184

Gunter, R. W., & Bodner, G. E. (2009). EMDR works...But how? Recent progress in the search for treatment mechanisms. *Journal of EMDR Practice and Research*, 3(3), 161-168. doi:10.1891/1933-3196.3.3.161

Herman, J.L. (1992). *Trauma and recovery*. New York: BasicBooks.

Janet, P. (1825). *Psychological healing -- A historical and clinical study. Vol. I*. New York, NY: The Macmillan Company.

Kerr, C. E., Wasserman, R. H., & Moore, C. I. (2007). Cortical dynamics as a therapeutic mechanism for touch healing. *The Journal of Alternative and Complementary Medicine*, 13(1), 59-66. doi:10.1089/acm.2006.5245

Kimbrough, E., Magyari, T., Langenberg, P., Chesney, M., & Berman, B. (2010). Mindfulness intervention for child abuse survivors. *Journal of Clinical Psychology*, 66(1), 17-33.

Kliem, S., Kröger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting and Clinical Psychology*, 78(6), 936-951. doi:10.1037/a0021015

Langmuir, J. I., Kirsh, S. G., & Classen, C. C. (2012). A pilot study of body-oriented group psychotherapy: Adapting sensorimotor psychotherapy for the group treatment of trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(2), 214-220.  
doi:10.1037/a0025588

Leitch, M. L., Vanslyke, J., & Allen, M. (2009). Somatic experiencing treatment with social service workers following hurricanes Katrina and Rita. *Social Work*, 54(1), 9-12.  
Retrieved from  
<http://search.ebscohost.com.libproxy.smith.edu:2048/login.aspx?direct=true&db=psyh&AN=2008-19245-002&site=ehost-live>

Levine, P. (1997). *Waking the tiger*. Berkeley, CA: North Atlantic Books.

Linehan, M. (1993). *Skills training for treating borderline personality disorder*. New York, NY: Guilford Press.

Mintz, E. E. (1969). On the rationale of touch in psychotherapy. *Psychotherapy: Theory, Research & Practice*, 6(4), 232-234. doi:10.1037/h0088759

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York, NY: W W Norton & Co.

- Ponniah, K., & Hollon, S. D. (2009). Empirically supported psychological treatments for adult acute stress disorder and posttraumatic stress disorder: A review. *Depression and Anxiety*, 26(12), 1086-1109. doi:10.1002/da.20635
- Reich, W. (1980) *Character analysis*. New York: Farrar Straus and Giroux. (Originally published in 1945)
- Rogers, C. R. (1961). *On becoming a person*. Oxford England: Houghton Mifflin.
- Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: W. W. Norton & Co.
- Sansone, R. A., Hahn, H. S., Dittoe, N., & Wiederman, M. W. (2011). The relationship between childhood trauma and borderline personality symptomatology in a consecutive sample of cardiac stress test patients. *International Journal of Psychiatry in Clinical Practice*, 15(4), 275-279. doi:10.3109/13651501.2011.593263
- Schore, A. N. (2009). Attachment trauma and the developing right brain: Origins of pathological dissociation. In P. F. Dell, J. A. O'Neil (Eds.) , *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 107-141). New York, NY: Routledge/Taylor & Francis Group.



Siegel, D. (2003) An interpersonal neurobiology of psychotherapy: The developing mind and the resolution of trauma. In D. Siegel and M. Solomon (Eds.), *Healing trauma: Attachment, mind, body, and brain* (pp. 1-56). New York, NY: Norton & Company.

Skinner, B.F. (1976) *About behaviorism*. New York: Vintage.

Smith, E. (1998). Traditions of touch in psychotherapy. In E.W.L. Smith, P.R. Clance & S. Imes, *Touch in psychotherapy: Theory, research and practice*, (pp.3-15). New York: Guilford Press.

Soler, J., Valdepérez, A., Feliu-Soler, A., Pascual, J. C., Portella, M. J., Martín-Blanco, A., & ... Pérez, V. (2012). Effects of the dialectical behavioral therapy-mindfulness module on attention in patients with borderline personality disorder. *Behaviour Research and Therapy*, 50(2), 150-157. doi:10.1016/j.brat.2011.12.002

Spotnitz, H. (1972). Touch countertransference in group psychotherapy. *International Journal of Group Psychotherapy*, 22(4), 455-463.

Teleki, J. (2010). Mindfulness-based stress reduction: A meta-analysis of psychological outcomes. *Dissertation Abstracts International*, 71, Vol 71(3-B), 2010. pp. 2063.

van der Kolk, B. (1996). The body keeps the score: Approaches to the psychobiology of posttraumatic stress disorder. In B. van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp.214- 241). New York: The Guilford Press.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. Oxford, England: International Universities Press.

Young, C. (2006). One hundred and fifty years on: The history, significance and scope of body psychotherapy today. *Body, Movement and Dance in Psychotherapy*, 1(1), 17-28.  
doi:10.1080/17432970500468299

Yontef, G. (2002). The relational attitude in gestalt therapy theory and practice. *International Gestalt Journal*, 25(1), 15-35.

Appendix A

Human Subjects Approval Letter



---

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

February 14, 2012

Samuel Douglas

Dear Sam,

Your project is now approved. Nice job and I am excited about your project as I work with trauma myself. I appreciate the professionalism and detailed responses.

*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.

Good luck with your research. I am looking forward to seeing your results.

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Burton', with a long horizontal flourish extending to the right.

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

CC: Gael McCarthy, Research Advisor

## Appendix B

### Email Announcement of Survey

Would you like to participate in a study on the role of the body in trauma treatment by social workers?

This study is seeking any social workers who currently see clients for therapy who have experienced significant trauma. Participants must have a master's degree in social work, and must be working primarily in a clinical setting in the United States.

The survey will be anonymous, will take place entirely online, and can be completed from any internet-connected computer. It should take no more than fifteen minutes to complete.

If you're interested, please click the link at the bottom of this email. This will take you directly to the survey.

Please forward this email on to any clinicians you know who meet the above criteria and might be willing and able to participate.

This survey is seeking participants from a variety of racial and ethnic backgrounds.

Thank you for your time,

Sam Douglas

## **Appendix C**

### Survey Questions

**Initial questions**

Thank you for your interest in this survey. Please answer the following three questions in order to determine your eligibility.

[Upgrade to Add More Questions](#)

Q1 [Edit Question](#) [Edit Question Logic \(1\)](#) [Move](#) [Delete](#)

**1. Have you graduated from an accredited master's degree program in social work?**

Yes  
 No

[Upgrade to Add More Questions](#)

+ Add Page

[Upgrade to Add More Questions](#)

Q2 [Edit Question](#) [Edit Question Logic \(1\)](#) [Move](#) [Delete](#)

**2. Does your clinical work take place primarily in the United States?**

Yes  
 No

[Upgrade to Add More Questions](#)

+ Add Page

[Upgrade to Add More Questions](#)

Q3 [Edit Question](#) [Edit Question Logic \(1\)](#) [Move](#) [Delete](#)

**3. Are you currently seeing any clients for therapy?**

Yes  
 No

[Upgrade to Add More Questions](#)

+ Add Page

[Upgrade to Add More Questions](#)

Q4 [Edit Question](#) [Edit Question Logic \(1\)](#) [Move](#) [Delete](#)

**4. Do any of the clients you are currently seeing for therapy have a history of trauma which, in your opinion, significantly disrupts their current functioning?**

Yes  
 No

[Upgrade to Add More Questions](#)

+ Add Page

Q5 [Edit Question](#) [Edit Question Logic \(1\)](#) [Move](#) [Delete](#)

**5. This is a letter of consent to participate in a brief survey about the role of the body in treating trauma.**

The survey is part of my research for a master's degree thesis at the Smith College School for Social Work. My name is Sam Douglas. The survey should take between five and ten minutes. As a participant, you will be asked to complete a series of multiple choice and short answer questions. I will compile the data from all the surveys using an online survey tool, and at no time will respondents' identifying information be attached to their responses. To be eligible, you must have a master's degree in social work, must be seeing at least some clients for therapy who have a significant trauma history, and you must be practicing in the United States.

The questions are focused on the respondent's experience of his or her clients, and will not ask for any information about the respondent's personal, non-work experiences. This research will contribute to the profession's understanding of how trauma is being conceptualized and treated. There will be no compensation for completing the survey.

The survey program will gather all data anonymously. The anonymous data will then be stored by the program and on my computer, and will be shared with a thesis adviser as part of the research project. No one else will see the data. Should the final thesis include any specific responses, the data will be carefully disguised. The data will be kept in a secure, password-protected place for a period of three years as required by federal guidelines. If it is kept any longer for any reason, the password protection will remain. Should you choose to participate in the study, please exclude any identifying information about clients.

Participation in the study is voluntary, and you can quit at any time or refuse to answer any question. Should you choose to withdraw, all of your responses will be immediately destroyed. Should you have any questions about the research, you can contact me at [sdouglas@smith.edu](mailto:sdouglas@smith.edu). Should you have any further questions about your rights or about any aspect of the study, you are encouraged to contact the chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY CHECKING "I AGREE" BELOW YOU INDICATE THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

- I agree  
 I do not agree

Q6 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**6. Which of the following is a stronger indicator of a client's recovery from trauma?**

- The client is able to think and talk about the traumatic event without distress  
 The client reports feeling more connected to him/herself  
 Neither: the two are equally important indicators of recovery

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q7 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**7. Psychological trauma registers in the body and the mind equally**

- Strongly agree  
 Agree somewhat  
 No opinion  
 Disagree somewhat  
 Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q8 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**8. Yoga can be an effective treatment for post-traumatic stress disorder**

- Strongly agree  
 Agree somewhat  
 No opinion  
 Disagree somewhat  
 Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q9 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)



Q9 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**9. The value of meditation to psychotherapy has been exaggerated in recent years.**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q10 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**10. One common result of psychological trauma is a sense of physical numbness.**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q11 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**11. Trauma blocks the flow of energy in the body**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q12 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**12. What types of interventions do you find most effective in treating trauma?**

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q13 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**13. PTSD requires a different kind of therapeutic intervention from other psychological complaints.**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q14 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**14. Every kind of effective psychotherapy engages the client's body in some way**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q15 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**15. Organisms under threat are thought to respond with three instinctive types of behavior: fight, flight, or freeze. Which response is more likely to leave the threatened person feeling traumatized after the fact?**

- Fight
- Flight
- Freeze

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q16 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**16. The value of meditation for people with PTSD symptoms is that it settles the mind and focuses the attention.**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q17 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**17. Trauma will be more effectively treated by focusing entirely on the body, or entirely on the mind**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q18 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**18. The essential component of trauma is a person's inability to comprehend an experience. The therapist's task is to help the client reach some understanding.**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q19 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**19. The experience of trauma directly interferes with the connection between the mind and the body.**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q20 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**20. Traumatic experiences hold their power primarily through the false beliefs that clients develop about themselves in the aftermath.**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q21 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**21. Treating trauma is primarily a process of confronting painful memories and putting them into context.**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q22 [Edit Question](#) [Move](#) [Delete](#)

**22. Have you recommended to clients with a history of trauma any activities to practice on their own as a supplement to therapy? If so, what were they?**

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q23 [Edit Question](#) [Add Question Logic](#) [Move](#) [Delete](#)

**23. Practicing yoga is unlikely to have any effect on a client's recovery from a traumatic experience.**

- Strongly agree
- Agree somewhat
- No opinion
- Disagree somewhat
- Strongly disagree

[Upgrade to Add More Questions](#)

#### Demographic information

Following are the last five questions in the survey. This demographic information will be recorded anonymously and will be linked to your survey responses.

[Upgrade to Add More Questions](#)

Q24 [Edit Question](#) [Move](#) [Delete](#)

**24. Please enter your age**

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q25 [Edit Question](#) [Move](#) [Delete](#)

**25. Please enter your self-identified race or ethnicity.**

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q26 [Edit Question](#) [Move](#) [Delete](#)

**26. For how many years have you been working as a social worker?**

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q27 [Edit Question](#) [Move](#) [Delete](#)

**27. From what institution did you receive your M.S.W.?**

[Upgrade to Add More Questions](#) [Split Page Here](#)

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q28 [Edit Question](#) [Move](#) [Delete](#)

**28. Does your current workplace encourage clinicians to practice particular types of therapy? If so, what are they?**

[Upgrade to Add More Questions](#) [Split Page Here](#)

Q29 [Edit Question](#) [Move](#) [Delete](#)

**29. Have you received training in any therapeutic methodologies designed specifically to treat trauma? If so, what are they?**

[Upgrade to Add More Questions](#)

[+ Add Page](#)

PAGE 8 [Edit Page Options](#) [Add Page Logic](#) [Move](#) [Delete](#)

[Show this page only](#)

### Thank you!

Your responses have been recorded, and will be stored anonymously. You can exit by clicking the "Exit the survey" tab, or by closing this window.

Thank you for participating in the survey!

If you have any additional comments about the survey, please include them in the box below.

[Upgrade to Add More Questions](#)