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Alissa Warren Kimmell
Embodied connections:
Engaging the body in group
psychotherapy

ABSTRACT

An increasing number of therapists are turning to body-oriented practices in response to the perceived shortcomings of talk therapy. Although the literature on individual approaches to body-oriented therapy is growing, we currently know very little about how clinicians are adapting these models to group psychotherapy. Using a grounded theory methodology, this study explores the experiences of fifteen clinicians who have integrated body-oriented practices into interpersonal group therapy. I analyzed data from 40-60 minute telephone interviews through an iterative process of open and focused coding using the constant comparative method. This process revealed participants' common theory of body-oriented practice in group psychotherapy.

Major findings included describing the way body-oriented practices extend and innovate upon traditional talk therapy models by using the body as the central vehicle for accomplishing key therapeutic tasks. Study participants described drawing on body-oriented practices to access affect, uncover unconscious material, increase self-awareness, build emotional tolerance, deepen the capacity for connection, and strengthen resources for change. Participants encountered a range of challenges in pioneering this new approach, but found that body-oriented practice also facilitated professional renewal. Because this is an emerging area of practice, numerous debates remain and participants identified key concerns that may spur future research. In particular, findings highlighted

the lack of body-oriented group screening and practice guidelines, as well as insufficient training, as areas in pressing need of future research.

**EMBODIED CONNECTIONS: ENGAGING THE BODY
IN GROUP PSYCHOTHERAPY**

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

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2012

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CHAPTER I

Introduction

Over the past two decades, there has been a marked increase in the number of psychotherapists employing body-oriented practices in group psychotherapy. Clinicians are adapting individual body-oriented trauma treatment to help clients stay regulated and expand their capacity for relational intimacy in the group process (Langmuir, Kirsh, & Classen, 2012). Similarly, group psychotherapists are integrating grounding exercises and attention to physical sensation in order to deepen and expand healing opportunities in groups oriented toward interpersonal learning (Cohen 2011). Group analysts are encouraging physical expression and bodily adjustments in groups focused on uncovering the group unconscious in order to access repressed emotional experiences (Hadar, 2001). For the most part, clinicians practicing in this way have developed integrative models independently, because there is virtually no theoretical literature or training on the topic. Preliminary studies suggest that blending the group modality with body-oriented practices may offer added benefits for a wide variety of clients. Even as scholars have begun investigating the effects of such innovative methods, however, we remain largely in the dark when it comes to the theoretical and practical approaches of the clinicians who are integrating body-oriented practices and group psychotherapy.

In this study, for the first time, I will explore how theoretically diverse clinicians apply body-oriented practices in group settings. Before I continue, I will offer a working set of definitions that I will use throughout the paper. I define the phrases "body-oriented practices"

and "somatic practices", used interchangeably throughout this paper, as the utilization of a therapeutic method in which physical experiences and sensations are attended to and the body is viewed as a central “resource in the therapeutic process” (Fallon-Cyr, M. & Fallon-Cyr, M., 2002, p. 332). The field of body-oriented psychotherapy, or body psychotherapy, encompasses a wide variety of psychotherapeutic approaches and is united by a belief in the unity of mind and body and a focus on the body. Throughout this paper I will use the phrase “traditional talk therapy” to indicate approaches that do not include the body as a focus of attention. It should be noted, however, that the phrase is imperfect, since many approaches that include a focus on the body are primarily talk therapy based.

For ease and simplicity, I use the terms interpersonal group therapy, group psychotherapy, and group therapy interchangeably throughout this paper. The types of groups that I refer to in this study are verbally oriented and incorporate an element of Yalom and Leszcz's (2005) interpersonal process model where “interpersonal interaction within the here-and-now” is the focus of the therapy (p. xv). Many groups will have a more structured environment or therapeutic goals than this classic model, but will still utilize interpersonal processes as a therapeutic resource. This focus is especially appropriate given that the literature is largely silent about the integration of body-oriented practices into groups with an interpersonal component.

The research question that this study explores is: How do licensed mental health clinicians incorporate somatic practices into group psychotherapy? This research seeks to address the gap in the literature through a grounded theory analysis of interviews with 15 mental health clinicians who lead groups that integrate body-oriented practices with a focus on the interpersonal processes between group members. In 40-60 minute phone interviews, clinicians

across the country shared their views on the role of the body in therapeutic work and described their process of integrating body-oriented practices in group. In these interviews, therapists also explored why they began using the body in group therapy, what personal and professional challenges this type of work poses, as well as what benefits it provides.

The results of this study offer a picture of body-oriented group psychotherapy as currently practiced by 15 clinicians working in agencies, health clinics, and private practice settings across the country. The aim of this study is to shed light on the process of integrating body-oriented work into group settings as well as the challenges and benefits involved in this emerging practice from a clinician's perspective. I will discuss how this new model adds to the field of group psychotherapy and identify relevant debates within this emerging movement that raise concerns and point to areas for further theoretical and empirical research.

I argue that social work service should pay close attention to the developing phenomenon of body-oriented group practice. To begin with, body psychotherapy is a burgeoning field where new treatment approaches are being rapidly developed and gaining in popularity and empirical support. Secondly, interpersonal group therapy has been well established as an intervention that is as or more effective than individual therapy for a wide range of presenting issues (McRoberts, Burlingame, Hoag, 1998). In a managed care environment profoundly influenced by cost management pressures, group therapy is increasingly being utilized as the treatment of choice (Fried Ellen, 1999). Most importantly, an increasing number of practitioners are successfully integrating these two approaches and suggesting that body-oriented practices uniquely enhance the power of the group (Cohen, 2011; Hadar, 2001; Langmuir, Kirsh, & Classen, 2012; Segalla, 2003). Better understanding the process and the impacts of the application of body psychotherapy in the group format offers promising possibilities to the mental health field.

CHAPTER II

Literature Review

In recent years, there has been a proliferation of therapeutic approaches that incorporate the body as a fundamental concept in therapy. I will provide an overview of this new movement towards body-oriented psychotherapies, and outline the beginning evidence for these emerging approaches to therapy. Although this nascent movement has largely focused on individual psychotherapy, a growing number of practitioners have also started to experiment with body-oriented approaches in group therapy contexts. Groups integrating components of Yalom & Lecze's (2005) interpersonal process group model have long been recognized as an effective modality to harness the power of interpersonal interaction and social support to alleviate a wide range of psychological problems, including trauma and sexual abuse, addiction, depression, anxiety, and personality disorders. Advocates suggest that integrating body-oriented practices can enhance the effectiveness of group psychotherapy to heal and empower clients with a variety of disorders. However, the few researchers who have investigated the treatment efficacy of blending body-oriented practices and group psychotherapy have jumped ahead as there is little information available that describes these practices or explores how they are being used in group settings. Very little is known about the clinicians working in this way and their theoretical and practical approaches to integrating body-oriented treatment with group psychotherapy. I will outline the state of research in this expanding field and describe what is urgently needed to begin

to define and investigate the parameters and implications of body-oriented psychotherapy in group settings.

Bridging the Mind-Body Duality in Psychotherapy

Traditionally, psychotherapy has focused on the healing potential of talk, with many therapists paying little or no attention to the body: “the body, for a host of reasons, has been left out of the talking cure” (Ogden, Minton, & Pain, 2006, p.xxvii). However, early psychotherapy acknowledged the role of the body in the therapeutic process. In the 1890s, partly through the work of Jean-Marie Charcot and later Sigmund Freud, medically unexplainable physical symptoms among women were conceptualized as a psychological disorder called Hysteria. As these physical symptoms began to be understood as the sequelae of traumatic events or the symbolic representation of unacceptable wishes or urges (Alpert et al., 1998, as referenced in Steele, 2003), a connection was made between physical symptoms, past traumatic events or repressed desires, and one’s inner psychological and emotional life (Steele, 2003). In this way, the concept of Hysteria established a precedent for understanding unresolved events or thoughts from the past as stored in and manifested through the body.

Somatic or body-oriented psychotherapies represent a diverse family of emerging approaches that are united by the common assumption of a connection between the mind, body, and emotions, and a focus on physical sensations and movement, body language, and affect as key sources of information and as sites of psychotherapeutic intervention (Allison, 1999; Cohen, 2011; Young, 2005). Body-oriented practices form the core interventions of somatic psychotherapy, as the body becomes the vehicle for the integration of the cognitive, affective, and physical material that forms the content of the therapeutic process. Somatic or body-oriented practices involve a therapeutic method in which physical experiences and sensations are

overtly attended to and the body is viewed as a central “resource in the therapeutic process” (Fallon-Cyr, M. & Fallon-Cyr, M., 2002, p. 332). These interventions take different shapes within distinct approaches to body-oriented psychotherapy, but share a common focus on bringing attention and curiosity to physical sensations and bodily functions (such as tightness in the chest, quality of the breathe, type of eye contact, instances of physical pain and involuntary movements). All forms of body-oriented psychotherapy at times use either conscious body awareness and/or physical adjustments, such as deepening the breath, changing body posture, or exaggerating physical gestures as a means of creating therapeutic change.

There exist a variety of approaches to somatic psychotherapy, some of the best recognized models include: general interventions that draw on body awareness to promote health and wellbeing such as Mindfulness Based Stress Reduction (MBSR), body-oriented psychotherapies designed to address a range of presenting issues and use the body to identify and remove emotional blockages such as Focusing and Bioenergetic Analysis, and therapeutic approaches that were specifically developed to address issues of trauma through body awareness and regulation such as Somatic Experiencing (SE) and Sensorimotor Psychotherapy (SP). Despite the diversity of approaches and philosophies contained in these different schools, they have significant commonalities.

First, body-oriented approaches generally espouse a belief in the connection between mind and body. For instance, Mindfulness Based Stress Reduction (MBSR) directly confronts the traditional body-mind duality of standard talk therapy, encouraging a more direct focus on listening to the body as a way to create both physical and psychological wholeness and healing (Kabat-Zinn, 2005). Similarly, body-oriented approaches share an understanding that physical illnesses or imbalances are often related to emotional distress. Alice Miller (2005) describes

how “cruel parenting” is the cause of many adult illnesses, as repressed feelings of shame, anger, sadness, and unmet needs from childhood are stored within and become toxic to the physical body. Furthermore, modern trauma theorists are increasingly conceptualizing the emotional wounds related to violence as leaving a neuronal or cellular impression in the body that must be addressed for healing to take place (Levine, 1997, 2006, 2010; Ogden, Minton, & Pain, 2006; Rothschild 2003, 2006, 2010; Scaer 2005, 2007).

Different forms of body-oriented psychotherapy are also united in focusing on the body-itself as a primary site of psychological intervention. Body-oriented psychotherapies use somatic interventions to access stored psychological material such as traumatic or repressed memories, which may not be as readily accessible through verbal memory or talk therapy alone (Hadar, 2001). Additionally, the body is frequently used as a resource to restore the client to optimal functioning. Numerous theories contend that healing takes place through tracking, following, and opening to body sensations and in the process “mobilizing and developing [internal] resources” (Kabat-Zinn, 2005, p.9; Levine, 1997; Ogden, Minton, & Pain, 2006).

Still, the various traditions of somatic psychotherapy differ in the way they integrate the body into psychotherapy and the types of somatic interventions they use. Some schools have grafted body-awareness onto the process of traditional talk therapy. Sensorimotor Psychotherapy (SP), for instance, “blends cognitive and dynamic therapy” with “somatic awareness and movement interventions” as a means of treating the physical as well as the mental aspects of trauma (Ogden, Minton, & Pain, 2006, p. xxiv). Because of its origins in trauma theory, SP emphasizes the need to titrate physical and emotional experiences so that clients are not exposed to more information than they can process, therefore preventing re-traumatization. In contrast, Bioenergetic analysis, developed from the work of Alexander Lowen, who was a student of

Wilhelm Reich, suggests that emotional repression beginning in childhood is chronically sustained by physical mechanisms. Thus, Bioenergetic analysis endorses a more cathartic approach to healing, focusing on expanding clients' range of physical movement and breathing patterns in order to surface and release traumatic memories and repressed emotions through direct emotional expression (Hadar, 2001).

As I will demonstrate in the next section, body-oriented psychotherapy has been practiced with various populations. However, some commentators suggest that it is indicated only in cases that allow for long-term treatment with non-psychotic clients, and that it may not translate across cultures. For instance, Nancy Allison (1999), author of the definitive "Illustrated Encyclopedia of Body-mind Disciplines" and a champion of body-oriented psychotherapies, claims that effective treatment requires "a long-term commitment" (p. 381), thus excluding people who are not financially or otherwise able to commit to extended treatment. She adds that body-oriented psychotherapies are contraindicated for people with psychoses, or those "whose self esteem is so severely damaged that it cannot confront the truth of the body" (p. 381).

In contrast to this limiting view of the application of body-oriented psychotherapies, many researchers and body-oriented psychotherapists advocate its application across a broad spectrum of clients and presenting problems. A number of recent studies, including three randomized controlled trials, demonstrate the efficacy of somatic psychotherapy in reducing negative symptoms for clients with schizophrenia and psychotic spectrum disorders (Röhrich, 2009). Additionally, some body-oriented psychotherapies, such as Somatic Experiencing, are specifically geared towards short-term treatment (Levine, 1997). Furthermore, several articles have explored how to successfully integrate issues of culture and race into a body-oriented psychotherapy approach (Abalack, 2000; Ablack 2009). So called "bottom-up approaches", like

Somatic Experiencing or Sensorimotor Psychotherapy, have been promoted as more culturally sensitive as they "are less culture-specific because of their focus on biological responses that are common to all humans" (Leitch, 2007, p. 3). By providing a non-verbal means of conducting psychotherapy, body-oriented approaches may bypass many of the cultural assumptions rooted in the language and worldview of existing talk-oriented treatments. Thus, a review of the existing theoretical literature points to some of the uniting themes of body-oriented therapies and raises questions about how clinicians use the body to tailor their interventions to the unique needs of each client. This study seeks to further develop and map out the unifying theoretical conceptualizations across body-oriented psychotherapists from different treatment approaches. Additionally, this study will explore how body-oriented therapists respond to the unique needs and social contexts of client populations.

Empirical support for body-oriented psychotherapy. Not only is there a developing base of theoretical inquiry and justification for the use of somatic practices as a therapeutic healing agent, but there is also some empirical evidence as well. This accumulating evidence signals that body-oriented therapies are an approach that is worth taking seriously and investigating further. May (2005) reviewed all 33 empirical studies on the effectiveness of body-oriented psychotherapy interventions appearing in peer reviewed journals and found that "a body of literature is slowly developing that offers support for Body Psychotherapy under some conditions" (p. 98). The small number of existing outcome studies demonstrate that body-oriented psychotherapy has been effective in reducing symptoms and increasing functioning for clients with anxiety (Berg, Sandell, & Sandahl, 2009; May, 2005), reducing psychological distress in those with chronic medical concerns (Bohlmeijer et al., 2010), reducing pain and improving physical functioning in those with somatoform disorders (Röhrich, 2009), reducing

negative symptoms in clients with schizophrenia (Goertzel et al., 1965; May et al., 1963; Nitsun, Stapleton, & Bender, 1974; Röhricht, 2009; Röhricht & Priebe, 2006) and decreasing PTSD-related symptomology in those with trauma (Leitch, 2007; Leitch, Vanslyke, & Allen, 2009; Miller & Leitch, 2010; Parker, Doctor, & Selvam, 2009). In addition to reducing active symptomology, multiple studies have shown that body-oriented therapies led to an increased sense of well-being and life satisfaction for clients (Röhricht, 2009).

In addition to the developing body of empirical inquiry, there are a few extant mixed method studies that begin to describe clients' responses to this new form of psychotherapy. For instance, as part of a larger quantitative study measuring treatment effectiveness, Berg, Sandell, & Sandahl (2010) conducted in-depth interviews both immediately following treatment and one year afterwards to understand what participation in affect-focused body psychotherapy meant to patients. The findings indicated that successful completion of body-oriented psychotherapy was positively correlated to clients' ability to surrender to the uncertainty of the body's unfolding process. The authors suggested that clinicians be particularly sensitive to patient's individual experiences of body interventions and adapt their techniques in order to limit clients' anxiety.

Additionally, Price (2011) conducted a mixed methods study in which participants responded to open-ended questions about their experience of body-oriented interventions. This study found that in contrast to the comparison group, which was assigned to massage therapy only, women in recovery from childhood sexual abuse who were assigned to body-oriented therapy reported an increased sense of the connection between their emotions and their bodies, as well as increased access to sensory and emotional experience. Contrary to clinical wisdom that sexual abuse survivors may have particular difficulty with body-oriented interventions, these clients reported entering the study in order to enhance connections to their bodies, suggesting

that recovering body-awareness may be a relevant goal for this population and that body-oriented approaches to psychotherapy may help at least a subset of these clients accomplish this goal.

Similarly, a mixed methods study conducted with female veterans diagnosed with PTSD and chronic pain utilized qualitative methods to provide clients' perspectives on a treatment that integrated massage therapy, body awareness exercises, self care skills, and talk therapy (Price, McBride, Hyerle, & Kivlahan, 2007). The study found that participants were generally satisfied with the intervention, attending almost all of the intervention sessions. Additionally, all participants experienced increased body awareness, which was soothing and helpful for managing their pain and PTSD, but noted that the body-oriented approach required a significant amount of trust both of themselves and the therapist (Berg, Sandell, & Sandahl, 2010; Price, McBride, Hyerle, & Kivlahan, 2007).

These studies, while limited in number, suggest the potential of body-oriented psychotherapy to create positive change, and identify some of the factors that may make clients more or less successful in treatment. In addition, they provide some recommendations for how clinicians can respond effectively to the unique clinical challenges of this work, particularly regarding how working with the body requires more capacity for trust and ability to surrender to uncertainty on the part of patients (Price, McBride, Hyerle, & Kivlahan, 2007). There is currently only one existing study that describes body-oriented psychotherapies from a clinician's perspective. Mehling et al. (2011) brought together a diverse range of practitioners, including yoga teachers, massage therapists, and body psychotherapists to form a focus group to begin to try to define the concept of body awareness. Mehling et. al (2011) also conducted an additional focus group with participants' patients for the same purpose. This research is an important beginning, because the focus on body awareness is viewed as a central mechanism of therapeutic

action within body-oriented paradigms. Mehling et al. (2011) found that practitioners and patients shared a belief in body awareness as "embodied self awareness," and saw it as necessary for a whole and organized sense of self. They also shared the belief that body-oriented practice resulted in clients developing a greater connection between the body and the self.

In addition to this information on clinicians' conceptualization of their work, a few recent case studies have begun to outline the "professional split" and "great loneliness" faced by therapists who are working to integrate somatic practices with a traditional psychodynamic psychotherapy paradigm, indicating that these trailblazers face some distinct challenges (Hadar, 2001; Shapiro 2003). These case studies also point to some of the reasons therapists begin to "build bridges between the mind and body" in psychotherapy, suggesting that existing methods of talk therapy were inadequate in fully understanding patient's psychosomatic symptoms and traumatic history as they lacked a mind-body approach (Hadar, 2001; Shapiro 2003).

Hearing clinicians' voices in the literature helps us begin to describe how body-oriented psychotherapies are being understood and practiced. Given the newness of the field, this is a knowledge base that is crucial to clinicians' ability to replicate and fully grasp the efficacy-focused findings. For instance, given the diversity of body-oriented and traditional talk therapy approaches that therapists are blending, it is important to understand which aspects of the different approaches therapists are selecting for their clinical use. In addition, there are even larger questions of why and how clinicians transition from using a talk therapy one to a body-oriented intervention. If these large gaps in qualitative research, especially glaring in regards to clinician practices, were filled, they would provide a deeper and complete understanding of these interventions.

In addition to this gap in qualitative research in the field, much of the body-oriented quantitative research available is limited by a lack of well-controlled designs, an absence of adequate comparison conditions, and bias in the application of the research protocol. For example, in one study supporting the effectiveness of SE in reducing PTSD symptoms (Leitch, Vanslyke, & Allen, 2008), all participants first participated in psychoeducation groups, after which the treatment group participated in two additional individual sessions. Symptom decline could potentially be explained by virtue of the additional therapeutic care as well as by the SE treatment. In addition, some approaches to body-oriented psychotherapy have not yet been studied (Fisher & Ogden, 2009), while others have been studied mainly in inpatient settings (May, 2005), or as short-term treatments (Leitch, 2007; Leitch, Vanslyke, & Allen, 2009; Parker, Doctor & Selvam, 2008). One notable exception to this involves a long-term evaluation of body-oriented psychotherapy interventions in an outpatient setting with a wide range of clients, which found “good efficacy of BOP [body-oriented psychotherapy] for a variety of problem areas” (Koemeda-Lutz et al. 2006 as referenced in Röhricht, 2009, p. 146- 147). Röhricht (2009) notes that despite a general statement of efficacy, the study did not “allow for more substantive statements or conclusions” since it was not conducted in a randomized controlled trial fashion (p.147).

Overall, research in this area is clearly in its beginning stages. Given this state, where we know very little about what body-oriented interventions actually entail and have little understanding of how clinicians use body-oriented practices in psychotherapy, it is difficult to adequately research the efficacy of these interventions. Having a clearer idea of how therapists actually practice would be helpful in understanding the implications of these models for clients in the field, and in identifying what aspects of the models are most distinctive and best suited to

testing. This study seeks to fill this gap in current research by using qualitative methods to describe and explore psychotherapists' process of integrating body-oriented practices into group psychotherapy in their clinical practice.

Interpersonal Group Psychotherapy

Groups are a key therapeutic modality in social work practice, yet group work encompasses many different approaches, ranging from psycho-educational and peer support groups to psychotherapy groups. Yalom (1985) has been recognized for his seminal contribution to the development of an interpersonal model of group psychotherapy, which draws on the interactions between clients themselves as key ingredients in the healing process. Although many groups are structured around a particular theme or diagnosis, in contrast to Yalom's more open process model, his legacy is evident in group psychotherapy that utilizes the interpersonal interactions among group members as a primary means of accomplishing therapeutic tasks. This study explores the experiences of clinicians who work within this tradition of group psychotherapy and harness the dynamics of the group process itself in order to create change.

The interpersonal approach to therapy was originally introduced by Alfred Adler, a founding father of psychotherapy who saw the potential for a group context to create healing by directly addressing the "social nature of human problems," and to make psychotherapy financially accessible to working class people (Aveline, 1990; Yalom & Leszcz, 2005, p.503). This idea of the interpersonal context offering unique healing capacities was developed by Harry Stack Sullivan, who believed that "psychopathology is invariably an interpersonal matter" and that the "interpersonal context" was needed to heal and disrupt psychological symptoms and distress in personal relationships and other areas of life (Brabender, 2002, p. 280-281). Although Sullivan was a psychiatrist rather than a group therapist, his ideas about the importance

of interpersonal interactions in the healing process were influential in the development of the field of group therapy.

Irvin Yalom is one of the most influential North American interpersonal group theorists (Aveline, 1990). Yalom's approach emphasized creating an environment where "clients can interact freely with others" (Yalom & Leszcz, 2005, p.xv) and receive "useful feedback" from the therapist and other group members about their interactions with other group members "in the context of the patient's relationships outside the group" (Brabender, 2002; Piper, 2011, p. 32). An interpersonal group therapist modeled after Yalom uses self-disclosure about here-and-now feelings in the group and makes use of "lateral transference" between group members (Brabender, 2002; Piper, 2011) to promote interpersonal learning that provides members insight about their lives and relationships outside the group. The interpersonal facilitator emphasizes each group member's impact on all group interactions and fosters an environment where members accept an identity as both an individual and as part of something larger than themselves, specifically the group (Piper, 2011). Yalom (1985) highlighted the unique "curative factors" resulting from the therapist skillfully running groups following guidelines described above, including fostering a sense of universality and hope, enhanced social skills and altruism, as well as interpersonal learning and a "corrective recapitulation of the primary family group" (p.3-4).

Empirical support for interpersonal group psychotherapy. There is substantial evidence for the effectiveness of group therapy. Multiple meta-analyses have demonstrated that group therapy is as effective as individual therapy, across different theoretical approaches, patient populations, and time frames (Fuhrman & Burlingame, 1994; McRoberts, Burlingame, & Hoag, 1998). Even more notably, a meta-analysis of 23 outcome studies found that when the

treatment targeted a specific symptom and problem, such as substance abuse, physical pain, or vocational problems, group therapy was more effective than individual therapy (McRoberts, Burlingame, & Hoag, 1998).

Although the empirical research on interpersonal process groups is smaller than the research on other group modalities (Brabender, Fallon, & Smolar, 2004), there are numerous outcome studies supporting the effectiveness of interpersonal group therapy in reducing symptoms and increasing functioning for clients with depression (Mulcahy, Reay, Wilkinson, & Owen, 2009; Soleimani, Mohammadkhani, & Dolatshahi, 2008; Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001), childhood sexual abuse (Callahan, Price, & Hilsenroth, 2004) and personality disorders (Budman, Demby, Soldz, & Merry, 1996). Furthermore, a meta-analysis published in 1998 included 6 outcome studies that compared interpersonal group psychotherapy to individual therapy and concluded that interpersonal process groups were as effective as individual therapy and other modalities of group therapy (McRoberts, Burlingame, & Hoag, 1998). Similarly, a randomized controlled trial and five outcome studies show that interpersonal group psychotherapy produced better outcomes than either treatment as usual or than a waiting list control condition (Callahan, Price, & Hilsenroth, 2004; Mulcahy, Reay, Wilkinson, & Owen, 2009). Highlighting the particular strengths of interpersonal process groups, a number of researchers have found that interpersonal group therapy not only resulted in symptom reduction, but also significantly improved relationship satisfaction and/or functioning (Budman, Demby, Soldz, & Merry, 1996; Callahan, Price, & Hilsenroth, 2004; Mulcahy, Reay, Wilkinson, & Owen, 2009). Thus, the effectiveness of both group psychotherapy and interpersonal group psychotherapy has been well established with a broad range of populations.

However, existing studies of group psychotherapy have overwhelmingly been conducted in correctional facilities or university counseling centers with doctoral level psychologists (Burlingame, Fuhriman, & Mosier, 2003). These findings thus may not be generalizable to the majority of therapy groups, and in particular to social work practice with groups, which is primarily conducted by master's level practitioners in community settings. Thus, there is a need for more studies examining group practice with a wider range of client populations, settings, and mental health clinicians.

Integration of Interpersonal Group Psychotherapy and Body-Oriented Psychotherapy

Most existing models of somatic psychotherapy have been developed and are increasingly being tested in individual therapy; however, clinicians are rapidly adapting existing models to integrate somatic practices in group psychotherapy settings (Segalla, 2006). Although group psychotherapy is a well-established treatment, the integration of body-oriented practices into group psychotherapy has only just begun to be researched. To begin with, several case examples describe the authors' personal process of integrating either Bioenergetic Analysis or mindful attention to and active engagement with body sensations into more traditional process groups. These authors suggest that integrating body-oriented and group psychotherapy has a powerful impact on the group process itself and may foster a closer connection among participants, spur group cohesion, and facilitate the process of healing (Cohen, 2011; Hadar, 2001; Segalla, 2003). Of note, all three authors found that the two seemingly disparate fields of group psychotherapy and their own approaches to body-oriented psychotherapy "have more in common and can contribute to each other and to psychoanalysis [or psychotherapy in general] more than is realized in both fields" (Cohen, 2011; Hadar, 2001, p.178; Segalla, 2003).

Additionally, several studies combining group psychotherapy and somatic psychotherapy included qualitative methods to begin to explore the client's experience of change in the group setting. Almost all of this literature involves the use of dance movement therapy in a group format, rather than the integration of body-oriented practices in a more traditionally seated process group (Brauninger, 2006; Erfer & Ziv, 2006; Payne, 2009; Payne 2010; Rohricht, Papadopoulos, Suzuki, & Priebe, 2009). For instance, a mixed method study exploring the impacts of a body-oriented group psychotherapy intervention with people with schizophrenia utilized some qualitative analysis of patients' experiences before and after a session. The authors designed and tested a structured, manualized group integrating dance movement psychotherapy, Neo-Reichan body awareness, and sensory awareness. The qualitative analysis found that participants experienced increased engagement and ability to verbalize emotional states and body sensations following an intervention (Rohricht, Papadopoulos, Suzuki, & Priebe, 2009). Additionally, Brauninger's (2006) mixed method study of a dance movement therapy (DMT) group process included a qualitative analysis of therapist impressions of 12 different short-term DMT groups and their group process, noting that similar themes evolved across different groups using this intervention.

There are few studies that use qualitative analysis to explore client experiences of participation in a non-dance therapy body-oriented group. For instance, Liu et al. (2008) conducted a mixed method study examining the efficacy of a body-mind-spirit group for women with breast cancer that included a post-treatment focus group interview exploring experiences of the intervention. The body-mind-spirit group format used in this study integrates Eastern philosophies and Chinese medicine with Western concepts of mutual support and positive psychology. Qualitative methods were included to contribute to a more complex understanding

of the mechanisms of change in this new group format. The study found that the integrated approach allowed patients to not only find symptom relief for anxiety and depression but feel that all of their domains of suffering were being attended to in this intervention (Liu et al., 2008).

In addition to this qualitative finding, there are some quantitative outcome studies that strengthen the case for paying close attention to this new integration. These outcome studies have taken place in Europe, Asia, Kosovo, Gaza, Canada, and the U.S. with a wide range of treating conditions, treatment settings, treatment durations, and racial and ethnic client populations. A number of these studies are randomized clinical trials (Gordon, Staples, Blyta, Bytyqi, & Wilson, 2008; Nickel et. al, 2006) or have used control groups (Leirvåg, Pedersen & Karterud, 2010; Liu et al., 2008; Payne, 2009). These studies have indicated that integrating somatic practices in a wide variety of group settings has provided symptom relief to clients with anxiety, depression (Liu et al., 2008; Payne, 2009), medically unexplained symptoms, somatoform disorders (Nickel et al., 2006; Payne 2009) PTSD, trauma (Gordon, Staples, Blyta, & Bytyqi, 2004; Gordon, Staples, Blyta, Bytyqi, & Wilson, 2008; Langmuir, Kirsh, & Classen, 2012; Staples, Abdel, & Gordon, 2011) and personality disorders (Leirvåg, Pedersen & Karterud, 2010). Furthermore, these body-oriented groups simultaneously created a more positive and empathetic group environment (Leirvåg, Pedersen & Karterud, 2010), strengthened group cohesion (Erfer & Ziv 2006) and facilitated direct emotional expression for clients (Nickel et al., 2006). This research points to the variety of client populations and treatment settings where the integration of somatic practices and group psychotherapy may be a useful practice.

Additionally, the therapists in these studies drew upon various body-oriented group interventions mainly in combination with standard talk therapies (Langmuir, Kirsh, & Classen, 2012; Leirvåg, Pedersen & Karterud, 2010; Liu et al., 2008; Payne, 2009). While many of the

groups involved imparting some type of body-oriented skill set to clients (Langmuir, Kirsh, & Classen, 2012; Liu et. al, 2008), several groups were primarily focused on using mind-body skills, such as meditation, guided imagery, and breathing techniques to reduce PTSD symptoms (Gordon, Staples, Blyta, & Bytyqi, 2004; Gordon, Staples, Blyta, Bytyqi, & Wilson, 2008; Staples, Abdel, and Gordon, 2011). Several of the skill-based groups were conducted in Kosovo by schoolteachers who consulted with mental health professionals (Gordon, Staples, Blyta, & Bytyqi, 2004; Gordon, Staples, Blyta, Bytyqi, & Wilson, 2008). Of particular note, one study conducted in Canada used a group design integrating both mind-body skills, body-oriented psychotherapy interventions, and some traditional interpersonal process components (what the researchers referred to as a "relational group"). Langmuir, Kirsh, and Classen (2012) adapted Sensorimotor psychotherapy to the group treatment of trauma, using a "body-oriented, psycho-education, and relational group" format. The authors encouraged patients to use the body as a resource in developing coping skills as well as fostered intimacy and interpersonal learning through encouraging members to provide feedback about what allowed them to feel connected to others in the group. Thus, researchers across this field have crafted unique treatment approaches by blending body-oriented practices with aspects of interpersonal process, psychoeducational and/or mutual support group formats.

With the exception of a few case studies (Cohen, 2011, Hadar, 2001, Segalla, 2003) and a recent research study (Langmuir, Kirsh, & Classen, 2012), there is little to no available quantitative or qualitative studies that investigate the use of body-oriented practices in more traditional interpersonal process groups. However, the existing research does serve to raise awareness about the increasing utilization of body-oriented practices in group psychotherapy. Similarly, qualitative analysis of client experiences in body-oriented psychotherapies sheds light

on some of the special treatment considerations for work with the body, especially around anxiety related to using the body and the importance of establishing trust in the therapist and one's own body (Berg, Sandell, & Sandahl, 2010; Price, McBride, Hyerle, & Kivlahan, 2007). Similarly, the research concerning body-oriented groups points to some of the potential gains around group cohesion and client engagement in the group process which may be achieved in this new modality (Cohen, 2011; Hadar, 2001; Rohricht, Papadopoulos, Suzuki, & Priebe, 2009; Segalla, 2003). These case studies, combined with the literature as a whole, suggest that somatic practices themselves may uniquely enhance the power of group psychotherapy for a wide variety of clients and practice settings.

While the existing literature is useful in indicating both the rich potential and some of the special considerations for group psychotherapy which includes the body, it also calls attention to the fact we currently understand very little about this emerging form of group psychotherapy and what the implications may be for clients and therapists alike. We have limited knowledge about the clinicians who are adopting these practices in group, and about how they integrate somatic practices effectively in group settings. A richer picture of how this work is being done is urgently needed in order to understand the interventions that people are beginning to test, and to develop a theory about the mechanisms of somatic psychotherapy. Additionally, more information is needed in order to uncover the significance and limitations of, as well as potential problems involved, in this type of work. This study responds to these gaps in the literature in both group and somatic psychotherapy by exploring the question: How do licensed mental health clinicians, particularly those working in community settings, incorporate somatic practices into group psychotherapy and how do they experience and conceptualize their work?

Summary

Therapeutic interventions that include the body as a major focus of treatment are rapidly expanding. Despite the limited amount of research, there is tentative evidence suggesting that various approaches to body psychotherapy have been effective in reducing distress with a wide range of populations and disorders (May 2005; Röhrich, 2009). There are also a growing number of group psychotherapists who regularly utilize the body in their groups. Both the small number of anecdotal reports and outcome studies suggest that this integration offers something unique and promising to the field. However, there are currently few studies that describe the therapist's process of and perspective about using body-oriented practices in either the individual or group modality. As of yet, little is known about how therapists conceptualize and integrate body-oriented psychotherapy into group settings. This study addresses these gaps in the literature and seeks to provide a picture of how group therapists understand and utilize the body in interpersonal group psychotherapy.

CHAPTER III

Methodology

The research question that this study explores is: How do licensed mental health clinicians incorporate somatic practices into group psychotherapy? This study was designed to achieve the following objectives: 1) explore how clinicians develop an interest in somatic practices and incorporate them into group psychotherapy; 2) investigate how clinicians conceptualize and utilize somatic practices in group psychotherapy; 3) identify relevant considerations in the process of integrating somatic practices into group psychotherapy; and 4) explore the impact of integrating somatic practices on the individual and group process from a clinician's perspective.

This study was conducted using qualitative methods. The research was structured in this way because there is little information about clinicians who are integrating body-oriented practices into group psychotherapy and their therapeutic process and conceptualization. Qualitative research is especially appropriate as a way to study phenomena when there is a largely un-researched field and it is unclear exactly what needs to be studied (Rich & Ginsburgh, 1999). Because this study aims to begin mapping out a new field—somatic group therapy—through an exploration of both meaning and process, the qualitative method is a good fit.

This research was conducted using a constructivist grounded theory methodology as described by Charmaz (2006), which advocates a more flexible approach to Glaser and Strauss' (1967) method of grounded theory. She argues that research offers an "interpretive portrayal of

the studied world, not an exact picture of it" (Charmaz, 2006, p. 10). In particular, constructivist grounded theory is used to "study how and why participants construct meaning and actions in specific situations" (Charmaz, 2006, p.130). This approach allows for an in-depth exploration of how participants understand their work and structure the group process. Furthermore, this methodology highlights how interviewee and interviewer mutually influence and interpret the world based on their unique locations in a particular time, place and context. The fact that this is a newly emerging field developing within a sometimes skeptical mental health system is an important aspect of this research and shapes how both the interviewer and the participants make meaning and take interest in this integration of body-oriented practices in group psychotherapy. Being self reflexive and transparent about the interpretative nature of the research process, as well as considering how all participants' views are informed by their particular context, helps shed light on the phenomenon of body-oriented group psychotherapy and contextualize the knowledge gained through this project. A constructivist grounded theory methodology is therefore uniquely suited to exploring both the process and the content of participants' work in an interpretive fashion.

Following the constructivist approach to grounded theory, this research draws on in-depth, semi-structured interviews guided by open-ended questions that were chosen to gather a comprehensive description of participants' experiences as a group therapist integrating body-oriented practices. The extended contact afforded by 15 in-depth interviews allows for developing a deeper understanding of the phenomenon since it provides the opportunity to explore participants' conceptualizations and experiences fully, giving each participant the opportunity to raise new considerations and influence the direction of the research process. In-depth interviews are the preferred method of qualitative research when "the goal is to collect

detailed, richly textured, person-centered” data which “investigate[s] what is meaningful” to the participant (Kaufman, 1994, p. 123). As I am trying to learn about how participants integrate body-oriented practices, my questions sought to draw out participants’ conceptualizations of their own work. Additionally, the research questions were both descriptive and process-oriented; as I was searching for a clear, "detailed, richly textured" picture of what integrating somatic practices in group entails and what implications it has for clinical work and the group process.

This qualitative, exploratory study was conducted using telephone interviews in order to reach a very specialized population of body-oriented therapists that are located across the country. Although telephone interviews can be viewed as less personal, potentially making it more difficult to build rapport and interpret participant responses without the benefit of eye contact and body language, there is some reason to believe that telephone interviews might in fact enhance participant disclosure because participants feel more relaxed and comfortable alone in private homes or offices (Novick, 2008). Participants were asked to agree to one telephone interview of 40-60 minutes, and were offered the opportunity to participate in a follow-up interview at their discretion to allow for further clarification and confirmation of the themes identified in the research process.

Major themes in the interviews were identified inductively through an iterative process of open and then focused coding, which involved reading and re-reading each interview and comparing data both within and across interview transcripts (Charmaz, 2006). Because somatic psychotherapy is a new field of practice with few established guidelines, particularly in group settings, this research seeks to highlight important considerations for training and practice in this developing field.

Sample Selection and recruitment

In order to answer the identified research questions, I spoke with licensed mental health clinicians, who had experience in integrating somatic practices in interpersonal group psychotherapy, and who were comfortable being interviewed in English. To ensure that participants' knowledge of integrating body-oriented practices in group psychotherapy was current, I required each participant to either currently be leading, or have in the last year led, one therapy group with both an interpersonal and a body-oriented component.

Because my target population was both very specific and relatively small, a purposive methodology was used to identify potential participants. I solicited participants by sending letters of introduction (see Recruitment Letter to Individuals, Appendix B and Recruitment Letter to Organizations, Appendix C) and flyers (see Recruitment Flyer, Appendix D) announcing the study to clinicians and professional associations for group psychotherapy and somatic psychotherapy. I also distributed the call for participants through internet and email listservs connected to these associations and to others associations serving mental health clinicians who might engage in these practices, such as listservs connected to local chapters of group psychotherapy or somatic psychotherapy associations. In addition, I invited individual therapists who advertised on professional bulletin boards and appeared to meet the study criteria to contact me if they were interested in participating. I targeted people who were affiliated with either group, somatic psychotherapy, or mental health professional organizations, because I was interested in reaching people who were actively engaged in their professional development and thus who were more likely to be thoughtful informants about this developing paradigm, as well as more likely to be interested in supporting research in their field.

Additionally, many participants themselves were rich resources for identifying colleagues who would also fit the study criteria. In order to take advantage of this information and reach as many participants as possible, some of whom were unaffiliated with any of the larger professional organizations or email listservs, I also used snowball sampling. I offered participants an opportunity to nominate colleagues who might be interested in the study at the conclusion of their interviews. I also asked my own professional contacts who were group psychotherapists and integrated body-oriented practices into their work to identify potential participants within their professional networks who I might contact for the study. Participants who read the flyer had the option of contacting me by email or by phone. Once contact was made, I provided additional information about the study and screened each participant by phone to ensure she/he met the inclusion criteria (see Screening Questionnaire, Appendix E).

Throughout the research process I utilized theoretical sampling, which is a core part of grounded theory methodology. Charmaz (2006) explains theoretical sampling as a process of searching for relevant data in order to “elaborate,” “refine,” and “develop” categories of understanding about one’s phenomenon and “emerging theory” (p. 96). Thus, I purposively chose participants based on a desire to elaborate, refine, and seek variation in categories developed through the analysis of past interviews. For example, in the process of data collection, it became clear that most of my respondents were clinicians in private practice. Many of these participants stated that private practice permitted them the freedom to develop a body-oriented approach to psychotherapy. In an effort to further understand the importance of the work context to the topic at hand, I employed theoretical sampling to recruit participants who worked in community settings to explore their ability to combine somatic psychotherapy and group work. In order to target this sub-population, I distributed flyers to special interest groups, focusing on

clinicians in public agencies within the larger professional organizations for Somatic Psychotherapy and Group Psychotherapy. Perhaps in response to these efforts, six clinicians who worked in community service agencies participated in this study.

In addition, given that most prior research on group therapists has been conducted with psychologists (Burlingame, Fuhrman, & Mosier, 2003), I made a special effort to recruit social workers as participants in this study. I relied on my own network of professional contacts, as well as distributing the call for participants to national and local chapters of professional social work organizations, such as the National Association of Social Workers and The Association for the Advancement of Social Work with Groups. I chose these organizations because of their large professional networks. I also made efforts to recruit for diversity in terms of race and gender by distributing flyers to special interest groups focused on racial and ethnic diversity and gay, lesbian, bisexual or transgendered issues within the Somatic Psychotherapy and Group Psychotherapy associations. Similarly, I sent recruitment information to social work associations dedicated to racial and ethnic minority issues. Unfortunately, these efforts did not appreciably broaden the diversity of voices represented in this study. No participants of color participated in this project. This research does not claim to be representative of a larger population, but instead seeks to explore the experiences of the particular clinicians I interviewed about the process of integrating somatic practices in group psychotherapy. This is in line with the aim of qualitative research, which serves primarily to develop a richer understanding of a particular phenomenon, rather than gathering information that is generalizable to a larger population (Charmaz, 2006).

Description of the Sample

I received over 50 inquires for this study. I started by interviewing each person who met the criteria, than as I transcribed and coded the data, I began to solicit and qualify participants

based on theoretical sampling in order to fill in analytic gaps. Thus, fifteen clinicians who met the inclusion criteria and were willing to participate came to constitute my data pool.

Researchers drawing on a grounded theory paradigm generally continue sampling until they reach the point of theoretical saturation, “when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of . . . core theoretical categories” (Charmaz, 2006, p.113). However, my research process was truncated by the time constraints of the thesis and, although I had not reached true theoretical saturation, I limited my sample to fifteen participants.

All participants were running groups at the time of their interviews. They all identified as white and two thirds were female (ten female, five male). The majority of participants were either Licensed Clinical Social Workers (seven) or Psychologists (four), with two licensed counselors, one MFT, and one psychiatrist. As a group, participants were highly experienced clinicians who had practiced for an average of 19.6 years, with a range from 2-40 years; the majority of participants (eight) had been in practice for less than 20 years. The average age of participants was 51 years old, with a range from 29-70, with the majority of participants (eight) in their 40s or 50s. The majority of practitioners worked only in private practice (nine), while six participants worked in agency settings alone (three), or in combination with private practice (three). A small percentage of participants saw clients in situations where there were very minimal or no fees for service (four), with most participants either accepting only private pay clients (six), private pay with the option of a sliding fee scale (four), or clients with insurance (five). Most participants reported working with a client pool that was at least somewhat racially diverse (12), with only three participants saying they worked with almost all white clients. There was a wide range of primary diagnoses among participants’ clients, although anxiety and depression (five), addictions (four), PTSD (three), and eating disorders (two) were the most

common. Interestingly enough, all participants who responded to a question about the type of group training they received (12), indicated that they were trained in the interpersonal process group format, and an overwhelming majority (10) also indicated they were trained in psychodynamic/analytic group format and/or humanistic/experiential group format (seven), with a few participants (two) reporting CBT or other (five) group training. Thirteen out of 15 participants received training in one or more models of body-oriented psychotherapy. The types of body-oriented psychotherapy models varied widely, with the most common approach being Somatic Experiencing (four). One participant reported having no body-oriented training, and one participant reported body work training (yoga teacher training) but no body-oriented psychotherapy training. Please see Table 1 (Appendix I) for a detailed summary of participant demographics and Table 2 (Appendix J) for participants' clients' demographics.

Data Collection

After receiving HSR approval (see Appendix H), I recruited participants and conducted interviews from mid-November 2011 until mid-February 2012. Once a potential participant made contact, I screened her/him for eligibility by telephone (see Screening Questionnaire, Appendix E), and began the process of securing informed consent by verbally describing what participation would entail, discussing the risks and benefits involved, and answering any questions he/she may have had. Based on the participant's preference, I then emailed or sent a hard copy of the consent form, which had been discussed, the interview guide, and a brief demographic questionnaire to allow the participant to have all the information necessary to make an informed decision about participating. Once the potential participant decided to commit to the study, I asked her/him to print, sign, and send me a copy of the consent form and the

demographic form by email or using a pre-paid envelope, and I called to schedule an appointment for the telephone interview once I received this documentation.

When scheduling the interview, I reminded participants of the procedure for the interview and we discussed how they could use the question guide to prepare for some of the topics that might be raised. I called participants during a mutually agreed upon time using a Google Voice number so that my personal cell phone number remained confidential. I used an Olympus recorder with a telephone connection microphone that I put in my ear to record the conversation. I started by thanking participants and recapping the purpose of the interview, and then gave each participant an opportunity to ask any final questions before we began. If there were no new questions, I then posed my first question (see Interview Guide in Appendix F).

In order to capture the richest possible picture of each participant's experience, I used a minimally structured interview guide with open-ended questions designed to elicit reflection in some general areas of interest. Although I maintained consistency by exploring the same general topic areas with each participant, I also adapted my questions from interview to interview to pursue new themes that emerged from the interviews themselves, as well as working to "answer analytic questions and fill in conceptual gaps" that emerged through the process of data analysis, which proceeded in tandem with the interviews (Charmaz, 2006, p.29). This format is intended to provide a consistent direction for inquiry while allowing for a meaningful exploration of the "participant's interpretation of his or her experience" (Charmaz, 2006, p.25). Throughout the research process, I tried to maintain the self-reflexive and inductive stance suggested by Charmaz (2006) where researchers acknowledge where they are starting, but are also "open and ready to change as the early stages of research may guide us elsewhere" (p. 17).

Instruments. I constructed a brief questionnaire (see Demographic Questionnaire, Appendix G) to gather basic information to describe the sample in terms of age, gender, race, ethnicity, and number of years in practice. It also included questions about the work settings and client populations that best described each participant's current practice, as well as his or her theoretical orientation, and any formal group psychotherapy or body-oriented training he or she may have received since graduate school. I asked participants to fill out this survey prior to the interview to avoid using interview time to gather basic information, and to help me learn a little about each participant's practice context before the interview.

I constructed the interview guide in dialogue with my research advisor in order to get a clear picture of how, when, and why participants utilized body-oriented practices in their groups. I asked participants to describe a typical group session, paying particular attention to how and when somatic practices are utilized. I also asked participants how they felt the use of the body changed their work in group, with particular attention to any impact on boundaries, group cohesion and conflict. In order to get a sense of their conceptualization of their work, I asked participants what led them to begin using the body in group and how they understood the role of the body in their therapeutic work. Additionally, I inquired about the challenges as well as the supports for working in this way, and I asked them about what they believed clinicians entering this emerging field might need to know. I also made sure I left ample time in each interview to explore topics that the participants themselves raised, to clarify my understanding of their responses and to reflect on the interview process itself.

Data Management

My research assistant—who signed a confidentiality agreement—and I transcribed each interview verbatim. We were the only people who had access to the data. All identifying

information was removed at the time of transcription and each de-identified transcript was assigned a number as a method of identification. A code sheet was developed to link each interview numbers to the names and contact information of the individuals so that I could contact them in the future to clarify or provide feedback on the findings. Transcripts and audio files are stored on my computer, which is password protected, and kept in a locked house. Printed consent forms and the code sheet with names and contact information are kept in a separate locked drawer in my desk inside my home. In compliance with federal regulations, these data will be maintained under lock and key in my home for a period of three years after which I will destroy the data, unless I am still using it for professional publication, in which case I will keep it secure and destroy it once it is no longer needed.

Procedures to protect participants. All participants signed an informed consent form and were given the opportunity to discuss any concerns or questions before participating in the interview. The consent form explained that participation in this study was voluntary, there were no inducements for participation and that minimal risk to participants was anticipated. Participants were informed that they could withdraw from the study at anytime or choose to waive any particular question. Although the methodology didn't allow for anonymity, participants were assured that steps would be taken to protect their confidentiality, including disguising or removing all identifying information from any illustrative quotations or case examples that might form part of the results of the study. Participants themselves were asked to disguise the identity of any clients they might discuss during the interview to protect their clients' confidentiality. No participant chose to withdraw from the study or reported experiencing any adverse consequences from recalling their experiences in practice during the interview.

Data Analysis

In keeping with the tenets of grounded theory, I used the constant comparative method to “make analytic sense of the material” at each step in the process (Charmaz, 2006, p. 54). I began by employing open coding to inductively identify relevant segments of meaning in all interviews, preserving participants’ language and conceptualization through in-vivo codes containing participants’ actual words (Charmaz, 2006). Open codes were then compared within and across interviews, involving an iterative process of reading and re-reading to develop selective or focused codes, which synthesized and represented larger amounts of data. I then developed a master list of codes and identified the relationships between codes, separating major and minor themes, and describing the relationships between major themes using a concept map. The concept map served as a tool to help me review and refine the existing themes and to further clarify their relationships to one another. Once a final set of codes was identified through this process, I checked my work by re-coding all of the interviews with these codes to ensure proper fit, choose illustrative quotations, and identify the number of participants who fit a certain code. Each step in the analytic process involved another reading of the original interview transcript to ensure that each level of conceptualization could be clearly and accurately grounded in participants’ experiences themselves.

Similarly, the data analysis itself formed an iterative process with the data collection. I transcribed and coded the interviews as soon as possible after conducting them. Through this process, new themes, directions, and questions emerged as I moved from interview to interview. I capitalized on preliminary findings in subsequent interviews, structuring my questions to further develop my understanding of emerging themes. Thus, each step in the research process

from data collection to analysis was continuously informed by contact with informants, ongoing review of the data, and new information as it surfaced.

I will represent the results of this data analysis by describing the major themes identified from participant interviews and the sub-themes that support them. I will use participants' quotations to elaborate on the themes and demonstrate that they are well grounded in the data. I also provide a diagram that will visually represent the relationship between the major themes (see Figure 1, Appendix K) and describe the mid-level theory that emerged from the analysis regarding how participants integrated body-oriented practices in group psychotherapy. The results of this study can hopefully serve to direct and inform further research, as well as to provoke an ongoing dialogue about the possibilities and challenges involved in this emerging approach to group therapy.

Criteria for Assessing the Trustworthiness and Significance of the Findings

Constructivist grounded theory assumes that knowledge and meaning is co-created between researcher and participant in concert with the contemporary sociopolitical cultural context. Charmaz (2006) suggests that “researchers and research participants make assumptions about what is real, possess stocks of knowledge, occupy social statuses, and pursue purposes that influence their respective views and actions in the presence of each other” (p.15). While bias can never be eliminated within this conceptualization of the research process, the researcher's own reflexivity plays an important role in acknowledging some of the key elements affecting the research process, which helps to further contextualize the findings and increase the trustworthiness of the project (Charmaz, 2006).

I developed an interest in the area of body-oriented psychotherapy through my own personal exposure to the benefits of meditation and yoga, and therefore have a personal belief in

the efficacy of these practices that motivated my desire to better understand how body-oriented modalities worked in group therapy settings. Thus, there is a risk that I interpreted the data to be consistent with my pre-existing beliefs. Similarly, the participants I interviewed qualified for the study by their active interest and engagement in integrating body-oriented practices in group therapy and were similarly enthusiastic about this form of practice. Although I combated my own bias by asking for specific information about the potential challenges of this practice and the potential limitations involved, in terms of who might benefit from this approach to group therapy, it was rare for participants to offer negative case examples. A researcher with an inherently skeptical view towards body-oriented practices may have collected a different type of data and/or interpreted the current data through a disparate lens. In addition, it should be noted that although I took steps to recruit a diverse population of practitioners in terms of professional affiliation, gender, race, and work context, my population was dominated by white middle to upper class professionals in private practice. This limits the types of experiences that are represented in terms of the ways in which body-oriented practices are conceptualized or integrated into the group therapy process.

The integrity of the research process itself is another important criterion in assessing the credibility and trustworthiness of the findings of this study. In addition to managing bias through reflexivity, I took a number of specific steps to ensure sufficient rigor in sampling, data collection and data analysis. I followed a systematic research process based on the tenets of constructivist grounded theory. I used different sampling methodologies to gather the most knowledgeable and diverse group of informants possible, while relying on theoretical sampling to allow the analytic process to guide the evolution of the sample. I qualified each participant according to the study criteria, asked questions about the same topic areas in each interview, and

used the same procedures for data collection. I conducted every interview, transcribed data, and coded each interview personally in order to remain immersed in the iterative cycle of data collection and analysis that is foundational to the grounded theory research process. I followed a systematic process of open, then focused or selective coding, and then developed themes and subthemes and made links between them (modified axial coding as described by Charmaz, 2006) that allowed me to clearly trace my conceptualization of participants' experiences directly to the data themselves. I also looked for contradictory data, exploring and describing rather than suppressing discrepancies among the themes emerging from participants' interviews.

Although I did not use member checking, a common practice to ensure the trustworthiness of the researcher's interpretation of the data in grounded theory, I did employ an external auditor as another form of quality control. My research advisor provided feedback on several of my fully coded transcripts to ensure that the coding accurately reflected the data and to bring attention to potential biases and explore alternate interpretations of the material as needed (Rubin & Babbie, 2010). My research advisor continued to audit the analysis at each step in the research process, ensuring that the coding and the themes that were being developed and elaborated were grounded in the data themselves and provided a coherent and comprehensive representation of participants' experiences as I understood them.

All in all, qualitative research is "more valuable as a source of insight than as a proof of truth" (Rubin & Babbie, 2010, p. 230). My aim in this study was to understand and describe an emerging form of practice that has broad implications for the field of social work as a whole. I supply enough information about the nature and the context of the study and the participants that readers can understand the research process, evaluate the relevance of the findings for their context, and reproduce the study (Rubin & Babbie, 2010). It is my hope that the findings

themselves will resonate with and be meaningful to therapists who engage in body-oriented practices, as well as shed light on these practices for therapists and clients new to these developments. The following section will describe the major themes that were identified in the study, as well as outlining the relationship between these themes. I will begin to address the implications of these findings for social work practice in the subsequent discussion.

CHAPTER IV

Findings

Through an analysis of interviews with 15 participants, I identified four major themes that described their experience of integrating body-oriented practices into group psychotherapy: Attend to the Whole Person, Body as Truth Teller, Body Provides Connection, and Body as a Resource. These major themes were supported and elaborated by more than 25 subthemes identified through participant interviews laid out in more than 120 pages of transcript. Although these themes overlap with one another to some extent, they each describe a unique and key aspect of the process, rationale, and experience of integrating body-oriented interventions in interpersonal process groups for this sample. Before I lay out these themes, however, I will provide some background information outlining how the participants came to body-oriented work and describe the context of their psychotherapy practice in group settings.

Participants' Journey to Integrating Body-Oriented Practices Into Group Psychotherapy

Participants consistently reported becoming interested in learning about body-oriented practices in response to discovering limits to what could be achieved through standard talk therapy treatments. They were often led to this conclusion because they felt that something was missing from their own experiences as psychotherapy clients, or conversely, that their own body-oriented practices, such as yoga, seemed to effectively augment their therapy or personal wellness, helping them to process their experiences in new ways. One participant who represented this common viewpoint explained:

I myself had been in psychodynamic talking therapy as a patient...and I realized that I was only getting so far with my therapy and needed to do something that included my body, because I felt I wasn't getting at my affect...even though I had an excellent therapist, I stayed too much in my head, too intellectualized.

Other participants reported that they began including the body in their professional psychotherapy practice because they were working with populations—clients with eating disorders, chronic illnesses, trauma, and addictions—whose physical experiences were intimately related to the presenting problem. They identified an obstacle in being able to acknowledge and work with this aspect of their clients' experiences through talk therapy alone. A participant who specialized in addiction treatment represented this view when he stated:

There is a fairly strong physical component to most addictive processes, whether it's drugs or alcohol or food or sex. Those things are pretty intimately tied up with the body. So in order to work with people recovering from addictions, one pays attention to the body in a way that might not be as pronounced if one were focusing on things like anxiety or depression.

Many participants shared the view that integrating the body in psychotherapy was also particularly important for working with trauma. One such participant said:

Often times with dissociation that is common with PTSD...there is a split between the mind and body processing...So the body is one of the ways to be present in the moment...and to deal with dissociation... If there is not awareness in the body, one may use the best insight and cognitive techniques but they will not last or be transformed into the body.

Participants were divided between three groups: two participants were initially educated as massage therapists and then later identified a need for psychotherapy training, seven participants were initially educated as non body-oriented psychotherapists and later identified a need to attend to the body clinically, and six participants had meaningful personal experiences of using the body therapeutically in their own lives and then entered the psychotherapy field with a desire to integrate the body into their work. For participants who were initially educated as massage therapists, or participants who already had a personal body-oriented wellness practice, the move to psychotherapy training evolved naturally from their work or personal experience as they linked their clients' or their own physical pain to mental and emotional distress. One such participant noted:

Massage therapy brought me there because when I was working with people on the table...people would be emoting all over the place, and that was coming out because history and emotions are embedded in the body and the cells and tissues. So...that led me to train more therapeutically, more in the psychological, emotional end, because I wanted to know how to work with these people.

Regardless of their background, 9 out of 15 participants reported, at least initially, struggling with the process of integrating body-oriented practices in the group format. The six participants who did not report any struggles in the integration process included all three people who had received body-oriented group training and someone who worked as a massage therapist before becoming a therapist. Thus, almost all participants who came to body-oriented practices after a career as a talk therapist described some challenges in incorporating the body into their group work. Although standard group therapy protocols offered few guidelines for addressing the role of the body, somatic psychotherapy protocols sometimes challenged traditional ideas about both

the content and process of individual and group psychotherapy or called for a renegotiation of client-therapist boundaries and group member boundaries. Therapists had to consider and resolve these dilemmas as they worked to acquire skills in body-oriented psychotherapy. For instance, four participants discussed how leading body-based interventions required them to take on slightly different roles than they would usually as a group therapist. One such participant explained this challenge:

[Facilitating a body practice] pulls the group leader into a much more active role which in my opinion is going to interfere with any sort of transference reactions that people have. So the group leader is less of a blank slate for people to project onto and they start to see more of who the person is, who is being more directive. So I do think that it pulls the group leader into a different role and that actually could disrupt some of the transferences that are in play.

Additionally, participants spoke about how much they struggled to adapt individually-based methods of body psychotherapy treatment to the group format:

Yes, the SE [Somatic Experiencing] model is individually based...[but in group] I am not able to reprocess the traumatic events of each person in the group. This has been the most challenging because each individual needs unique interventions designed for them that only their body can guide. I attempt to be attuned to each person's nervous system in the room, but often what one person needs can be too activating or stimulating to another. This has been a challenge...I'm struggling with this integration of group purpose, length of group, and number of sessions.

Another participant who was trained in the same Somatic Experiencing format as the participant above spoke about this same challenge and how it related to her relative inexperience:

It's hard for me [to do these groups] because there's a lot to track. As we're paying attention to each person talking I am also paying attention to the activation in the room as a whole...I feel new in this work and as my skill develops I'll be better and I probably would not answer that question the same way.

Even if the group modality presented unique challenges, for the 14 out of 15 participants who received body-oriented training, their particular body-oriented approach was an anchor point that grounded and guided their work. Participants characterized the discovery of a body-oriented modality which resonated with their interest and which they would later utilize in their groups as a relief. One participant exemplifies this moment of beginning training in a body psychotherapy modality: "I started training in that model, and I was like 'Oh, thank you! Finally, a theory that fits!'"

Regardless of the starting point, at the time of the interview, each participant actively integrated body-oriented interventions into their psychotherapeutic work with groups as a routine practice. Only three participants received group training that was specifically body-oriented. The rest of the participants drew upon a variety of models of body-oriented psychotherapy, body work, and group psychotherapy in developing their own unique styles over time. For instance, six participants reported incorporating training from more than one and up to eight different body-oriented modalities in crafting their group leader style. Similarly, of the participants who reported group therapy training, all indicated more than one, and on average 3.4 different types of group training. I make a distinction between body work and body-oriented psychotherapy for the purpose of this paper. This is an imperfect distinction, but I will use the term body work to refer to activities such as yoga, massage therapy, or NIA dance that involve the body as a primary source of attention, but do not include psychotherapy. Body-oriented psychotherapy or

body-oriented practices refer to psychotherapeutic interventions that include the body as a site of intervention such as Bioenergetic Analysis or Somatic Experiencing. Although most participants had formal body-oriented psychotherapy and/or body work training (with one exception) as well as training in group psychotherapy (with two exceptions), they often regarded themselves as trailblazers in integrating the two, and frequently encountered prejudice or misunderstanding in introducing their work to other professionals. One facilitator reported: "When I first started out there was a good deal of prejudice and anxiety about doing this kind of work." Another participant elaborated on the experience of prejudice in the mental health field towards body-oriented work:

I think there's been a lot of resistance...in the therapeutic community generally to using these sorts of activities...that has kept me from using them in my regular process groups as much as I would like...and so I'm wanting to push myself [to use them more]. But I do think sometimes people are resistant to something that's unknown or unfamiliar. It may seem dangerous at times.

Similarly, participants reported that colleagues might express concerns about the potential violation of client boundaries in drawing on the body in psychotherapy, particularly in groups involving touch. More frequently, they were simply puzzled or bewildered about how one could draw on the body in ways that might be helpful or appropriate to psychotherapy practice. Since the integration of body psychotherapy and group work is an emerging area of practice, all of the participants were not only active clinicians, but 12 out of 15 were also engaged in teaching about body-oriented practices to other clinicians in some respect. In order to combat the prejudice they encountered, some participants deliberately offered demonstrations of their work

to colleagues to clarify concerns and misconceptions and to help them better understand the unique benefits of body-oriented models of practice. One such clinician reported:

And what I ended up doing was quarterly, free [body practice] for therapist workshops, so people could come have an experience of it. And after that they would usually be more interested in referring clients. They'd have familiarity with me and they would know I wasn't a crook, and they would feel comfortable referring people. So that was the way that I networked professionally.

These workshops were at least partly in response to the common view that "the body is often neglected in psychotherapy" and in society in general. In particular, there was a general perception that agency guidelines made it difficult to develop innovative practices in public settings. Consequently, 9 out of 15 participants took shelter in the relative freedom of private practice to conduct their body-oriented groups. One group leader explained:

I don't know if there are agencies that actually support the kind of work I'm doing. Certainly being in private practice has given me a lot of freedom that I wouldn't have otherwise had. There is nobody telling me what kind of treatments I cannot do.

The minority of participants (6 out of 15) who did this work in agency or medical settings either relied on the support of specific supervisors or on the "open door" culture of an agency that supported creativity and autonomy to afford them relative freedom in structuring their groups. In some circumstances, clinicians in these settings were required to circumvent agency guidelines and fly under the radar to avoid running afoul of supervisors who were unfamiliar with body-oriented approaches to psychotherapy. One group leader reported:

A lot of the things that I've done I have done because I haven't asked somebody I've just done them. I'm not being a maverick or being cavalier about it. But in the clinic I

worked at I did lots of things I didn't have to ask other people to agree with. People would say, 'your group is doing so well' and I would say 'thank you'. And I wouldn't get into why they might be doing 'so well.'

Even in situations where agency-based clinicians felt they had support from supervisors or administrators, they still were negatively impacted by a lack of familiarity with and skepticism about body psychotherapy models. One participant offers an example:

Fortunately I've had very supportive administrators...but they're very into evidence-based practices. The [SE] model is not yet evidenced-based, so I have had to completely fund my own training and supervision in this model. In the past, I had to use my vacation time to get the training. So it's expensive.

By contrast, another participant was experiencing a growing sense of support for and a belief in the credibility of body-oriented approaches at her agency. She explains:

I work in an agency that really encourages you to do innovation and encourages people to explore what makes sense to them....[but still] in the beginning my group was controversial...then it was the group that no one really knows what's happening. Now there's more interest, I've had other therapists ask to sit in recently and there are probably five therapists that are doing other body-focus training now. So I think in general its kind of gaining some presence and interest.

Although participants were excited by the therapeutic gains they reported witnessing their clients achieve through their integration of body-oriented practices in group, they sometimes found the pioneering aspect of their work to be "lonely" or "a burden," and often longed for the professional supports that come with the widespread acceptance and dissemination of a particular psychotherapeutic model. One participant commented: "the truth is...there are not a lot of other

people who are doing it the way that I am.” Additionally, several participants, who were early in their career, described the process of integrating body-oriented practice and group work as particularly challenging as they had to find their own way with few guidelines and role models. As one participant stated: “I’m just winging it.”

All participants embraced the viewpoint that integrating body-oriented practices augmented the effectiveness of the therapeutic process. They reported that many clients, like their colleagues, were initially unfamiliar with and wary about the prospect of attending a group that integrated body-oriented practices. Most participants addressed this issue by conducting screening interviews where they introduced prospective participants to body-oriented psychotherapy by demonstrating the work and inviting a discussion of their questions and concerns. One participant explained: “When I do the intake I do a little – I give them a taste of what the experience will be because they need to be able to go to their body without getting overwhelmed.” The screening interview helped each participant to assess the client’s readiness for body-oriented interventions, while enabling the client to make an informed decision about pursuing this form of group work.

Few participants set many exclusion criteria for their groups. All participants agreed that as long as clients were able to tolerate experiencing their physical sensations and interacting with others they could benefit from the group. However, potential group members would often decide not to pursue the group if they were uncomfortable with the approach. One participant explains this common view by saying, “I don’t have to exclude anybody. If they don’t like what I have to offer then they don’t come in.” Thus, participants accepted clients with issues that covered the full range of potential diagnostic categories. The exception to this was three participants who mentioned that they would not accept clients who were highly symptomatic with eating

disorders, were actively violent or suicidal, or had substance abuse disorders. All participants, except one, stated that they explicitly established an agreement regarding how the body would be integrated into the group process so that clients would know what to expect. More than two thirds of participants also discussed the importance of matching the types of body-oriented interventions they used to the readiness of the individual client and the group as a whole. For example, one participant stated: “With some people I would want to be very gradual and really invite a little attention to the body and then invite them to move back out of that.” Another participant elaborated on the way he would scaffold his interventions to ensure that they were both safe and meaningful for the client. He commented:

[With some clients] I am noticing their body posture, I am noticing the way they are breathing, I might say 'when you are talking about that you stopped breathing completely.' But I won't go the next step and say 'if you want to do something to expand your breathing right now I know some ways to do that, do you want to try it?'. I won't do that until I am pretty sure that the person is going to find that at least comprehensible, that it is going to make sense to them, that it is not coming from out in left field.

In addition to utilizing the body more frequently or integrating more complex interventions as clients gained comfort and familiarity with body-oriented interventions, participants reported that group members took a more active role in initiating body-oriented work themselves as the group matured. Nine out of 15 participants found that group members might begin to comment directly on their own, the leader's, or each other's gestures or facial expressions, or inquire about each others' physical experiences as they gained expertise in drawing on the body to explore individual or collective concerns. Several participants noted that body-oriented psychotherapy worked particularly well when group members were relatively

sophisticated in their ability to attend to their physical sensations. One such participant commented:

I have one group that is a group of psychotherapists...Psychotherapists tend to be quite expressive with their bodies. And I realized that patients are not as expressive physically as these particular group therapists. They were very particularly expressive and they were also able to report on their physical sensations very well.

By contrast, one participant noted that in her experience, body-oriented approaches also tended to be particularly effective for clients who struggled to identify and articulate their feelings. Prior to starting her body-oriented training, she had not considered these particular clients to be a particularly good fit for an interpersonal psychotherapy group. She said:

[Using the body in group is] much more inclusive and it doesn't limit the group experience to only those who have fine verbal capacity. So it's a way of involving maybe more silent group members, or maybe more regressed group members, or...those with a poor history of attachment. They would be less capable of accessing their words, but more available would be the body information and if you ask that of them they may be able to report that more readily.

Although modest in number, the 15 participants in this sample therefore represent a very broad range of experiences in applying body-oriented interventions in groups with an interpersonal process component with clients at various levels of sophistication with diverse presenting issues. I will now turn to a consideration of the major themes and sub-themes I identified, which describe how participants integrated body-oriented practices into interpersonal group psychotherapy.

Attend to the Whole Self

A major finding that emerged from an analysis of the participants' interviews was the belief that including the body in group psychotherapy served as a way to attend to the whole self. In many respects, the concept of working holistically—approaching a human in all of his or her complexity—is the philosophical basis for the study participants' desire to attend to the body. All participants valued the body as an important aspect of the self, and thus felt it was necessary to include it in the therapeutic process in order to attend to the whole self of their clients. All participants reported that they included their group members' and/or their own bodies in the work as a way of inclusively attending to a person's entire experience. One group leader explains:

How could we be practicing any sort of holistic treatment, by holistic I mean treatment in which all aspects of the person are present in every thing they do and say and feel in every cell of their bodies. How could we be practicing that without reference to whole experiences? Whole body, whole body mind.

Body and mind are not separate. Participants believed that it was essential to attend to the body as part of the whole self, because they were united in believing in the interconnection of body and mind. One participant explained the basis for her belief in the importance of including the body by saying, “we talk about mind-body-spirit, but really it is all one, there is no mind without the body.” Clinicians viewed people as holistic beings, and understood the body and the mind as being in a constant state of mutual influence. Two participants included the person's spirit or spirituality in this sense of attending to a whole person. Another participant represented this belief in the mind-body-spirit unity by commenting:

I don't make a distinction between body and other processes, psychic processes and interpersonal processes and...spiritual processes. They are all different aspects of the same underlying energetic process. So I get at it in any way that I can.

Given this belief in the unity of mind and body (and for some participants, spirit) participants all held a view that intervening at a body level inevitably impacted the rest of the self, namely the mind and emotions. For example, one group leader stated:

Emotions are bound up in the physiology. And usually if [clients] are having emotional reactions in the group the first thing that happens is that their breathing becomes shallow. And by encouraging them to breathe a little more deeply you are opening them to an experience that they were otherwise trying to block by breathing shallowly. And usually an emotion begins to seep through into consciousness when they start to breath.

Thus, participants believed that the emotional awareness fostered through attending to the body generated both a release of energy in the physical organism and emotional insights that also ultimately supported clients' health and wellbeing by helping them to address issues that may otherwise have lingered until physical symptoms developed. Another clinician addressed this link between emotions and body by saying:

And the high medical needs are maybe the outcome of aggression not being put into words but going instead towards the self. So the idea is that if we can help [clients] talk and put their feelings into words, eventually, now this is a long process, they won't have as many medical issues... [if clients can] speak their anger, their rage directly in the moment they may have more vitality physically.

Given this strong belief in the interconnection of mind and body, all clinicians reported that they could not imagine excluding the body from their therapeutic work at this point in their careers.

Participants said that attending and intervening at a body level was fundamental to their way of understanding clients and groups, as well as approaching the therapeutic process. One participant succinctly summarized the common sentiment in saying: "If I'm ever failing to pay attention to the body...then I'm not doing therapy."

Everything is in the body. A natural extension of this mind-body-emotion connection was the view expressed by 11 out of 15 of clinicians that "all experience is physical" and "everything is in the body," meaning that the body is a primary site for contact with the world around us and is the first point at which we are affected by and begin to process our experiences. The remaining four participants all endorsed a view of the body, if not as the site at which we process all experience, then at least as the receptacle for a wide array of experiences, including repressed emotion, traumatic and preverbal memories. Thus, all participants believed that experiences are stored in the body. As one participant explained: "I believe that our memories are stored in our muscles and body." Another participant offered his view on the paramount influence the body has on all experience:

90% of the information [we receive] is coming from the body rather than [from the mind]. So everything is stored in the body or is manifested in the body or is generated in the body or is informed by the body.

Similarly, one third of participants conceptualized the body as the first frontier for making sense of experience. Another participant described this concept:

In my understanding, the body has the first contact with our environment...We draw through the body our emotions. Our experiences come into the body first, and only then can we...process these feelings...[and reach] understanding by the mind. Everything that we experience is recorded [first] in the body.

Thus, there was a shared belief that all experiences are processed, felt, and/or stored in the body.

Following from the idea that all experiences are stored in the body, 14 out of 15 clinicians believed that emotions and experiences had a “somatic marker.” Participants explained that all past and present experiences and emotions were not only stored or experienced through the body, but were simultaneously expressed through an array of inner physical sensations or outer physical presentations. By looking for, attending to, and drawing out these sensory markers of experience in the body, participants believed that they were able to attend to all the dimensions of a particular experience. Consistent with this belief, 14 out of 15 participants felt that more complex interpersonal dynamics such as transference and countertransference were first and foremost experienced at a somatic level. For example, one group leader noted:

Transference occurs at every level of experience. If you are having a reaction to me in group, you are having a reaction at every level of experience, from the cellular to the spiritual. And some of those are identifiable to you in what I would call somatic psychic patterns.

Without the body we miss so much. Because the body was viewed as the primary site of experience, all participants reported that without the body they would miss so much that was occurring in the therapeutic process at an individual and/or collective level. Illustrating this idea, one participant stated: “If I don’t pay attention to the body...I’m missing the richness of what the group could offer.” All participants introduced the idea that there are certain experiences, emotions, and memories that cannot be accessed solely through standard talk therapy interventions that do not explore and utilize the experiences of the body. While six participants used interventions that asked participants to move while standing, the remaining nine participants drew clients’ attention to physical sensations or encouraged them to make physical

gestures while seated. One participant explained his view about the importance of physical movement in group treatment, saying: “A way we can incorporate more of the whole person into treatment is when we access parts of them that they wouldn’t get through just sitting.”

Across body-based interventions, all participants viewed body-oriented practices as laying a foundation for interventions at the affective and cognitive level, and maintained that the body facilitated access to material that would not be readily available through talk therapy alone. One participant described the constant interaction and flow between verbal and body-oriented expression and intervention:

I realized there was stuff going on in the body which might not be accessible through words but might be accessible through physical intervention...having access to those feelings through the physical actually made it possible [eventually] to have more verbal access to those feelings, so they’re not 'either-or.' It’s 'both and.'

Another participant built on this idea explaining how physical experiences could lead to insights that were then cognitively integrated and applied:

Sometimes people have really powerful epiphanies, they think of themselves in a certain way, [and while doing a physical exercise] all of a sudden their horizon opens up and they start to feel like they can go on to tackle other goals they’ve had in mind for themselves.

Practitioners in this sample all articulated in various ways the belief that by including the body clinicians can attend to the whole self of each client. There was a sense that not only are the body-mind-emotions (and in some cases spirit) inextricably interconnected, but that the body is impacted by, interprets, and influences our past and present emotional states and experiences. Thus, for participants it was impossible to extricate the body from the therapeutic endeavor, and

exploring the body as it impacts group members and the group process formed a crucial component of their theoretical stances. In many ways this theme embodies the philosophical foundation that guided participants' process of integrating verbal and body-oriented modalities in group. Furthermore, the idea that experience and emotions are manifested physically sets the stage for the exploration of the next theme, which explores in greater depth participants' use of somatic markers of experience.

Body as Truth Teller

All participants viewed the body as providing privileged information about the here and now experience of the group and the individual. Clinicians saw the body as telling the truth about the depth and breadth of a client's experiences. 14 out of 15 participants believed that the body told the truth about relationships in the room, including about the intricate dynamics of transference and countertransference reactions. As one participant stated: "It adds to the range of information available to the person and to me as to what really constitutes this transference experience." The body was viewed as providing both a greater range of information than would otherwise be available for therapy, as participants used the body to help clients access information that they believed might not otherwise surface or be as readily identified. They also viewed it as providing access to information that was truer, less filtered, and more authentic, thereby deepening the therapy process and improving the quality of the insights resulting from their work. One participant affirms this concept of body as truth teller, facilitating deep uncovering work in this quote:

Including the body is...how we get at the truth...[because] with unconscious motivations or drives that exist in someone, they can feel that somatically as attention or conflict in

their bodies, and when we can tease that out we can get more to the truth of what is really going on that may be blocked consciously.

The body communicates. Central to the concept of body as truth teller, participants all articulated a belief that their clients' bodies communicated important information about their experiences. Moreover, part of their development as therapists who include the body was learning to become aware of clients' physical communication and learning to help clients listen to and interpret their bodies' messages. One participant described her transition towards body-oriented group therapy by saying: "Now I'm even tracking respiration and tracking movement, and tracking all sorts of things that I just was never aware of [in the past]." Participants identified a wide range of ways that the body communicates: through sensations, gestures, breathing, facial expressions, body postures, somatic symptoms, and physical ease or tension. Participants actively observed, responded to, and engaged with their clients' somatic experiences to advance the therapeutic process. A participant describes her technique and its impacts on the group process by providing this example:

I will...see people's legs start shaking or tapping up and down or I will notice their chest gets tight...sometimes they're impacted by something in the group, if you start watching people's bodies it's very clear. And then they think 'how did you know?' 'oh my goodness can you read my mind?' And I say 'No, I'm just watching your body.' It is amazing, once you're in tune to the body you can really pick it up and that's really good awareness for your clients because then you're their mirror. And then they start wanting to do it for themselves. Because before you noticed, they didn't even know they were getting anxious.

In addition to listening to and engaging with clients' somatic experiences, two thirds of participants indicated that they drew on their own somatic experiences to guide groups. For example, participants reported looking to or questioning what was going on in their own bodies when they became confused or unsure, or when the group felt stuck. Tuning into their own physical sensations was seen as a method of bringing deeper insight or greater clarity to a situation and providing direction for moving forward. Thus, paying attention to and engaging with all the bodies in the room gave clinicians a deeper understanding of individual group members, as well as helping them to better understand and guide the group process as a whole.

Physical symptoms have meaning. Almost half (7 out of 15) of the participants made reference to attending not only to clients' sensations, gestures, and posture, but also to their physical pain or illnesses. There was a sense that a client's physical pain can carry valuable information about unmet psychological or spiritual needs. One group leader explained her position on the importance of attending to physical illness:

I really view the body as a truth teller and it may tell truths that the person doesn't consciously know yet and I find that that is really true with clients who actually have illnesses. There usually is a message that the body has that is part of the learning that is being created by the illness.

Similarly, these participants spoke about how they would use physical pain as a metaphor for helping the client explore and interpret the messages that the body was sending through their pain. One such facilitator reported:

More often than not, I find that people use their bodies to express their emotions. When people say 'I have low back pain,' really if you look at what might be going on, your back is your support, that's what holds your body up, that's your core, and your core is the

most important part of your body. So I'm not saying this is true for everybody, but I would use it as an exploration point. 'I wonder, are you feeling support in your life right now?' And then, 'is that [physical pain] a metaphor for holding onto what you're experiencing emotionally?'

One third of all participants deliberately attended to the client's medical condition and inquired about how he or she was seeking/or not seeking treatment as part of bringing the body into the therapeutic process. One group leader offered the following example of her stance on inviting group members to regularly share about their medical conditions:

If people are ill or are have some kind of a medical problem, they're invited to talk about it in group, and I've learned to be very curious about what kind of treatment is being sought. I get more involved in their treatment and their treatment process, trying to help them be as proactive as possible to use both the language of feeling about what's going on in the body but simultaneously to attend medically as is indicated, and to help people think about their healthcare in a way that's going to be most useful to them. People can be quite passive about their healthcare, and need some help taking care of themselves.

These participants viewed their close attention to clients' medical conditions and physical self-care as both a symbolic means of extending psychological care and as a practical means of providing concrete therapeutic support to the whole person. Speaking of her experience with a specific client, another facilitator commented:

My willingness to join and actively support her concern about her medical worries with her heart gave her another kind of heart. The way I would think about that, it's not about the heart organ, it's about the quality of being willing to go to any lengths, of being willing to put it all out there, that's heart.

Thus, participants regarded bringing attention to clients' physical challenges as an integral part of helping clients address those challenges.

Body moves defenses. In addition to listening and responding to a wide range of physical communications, clinicians also actively used the body to help their clients work with well-defended therapeutic material. Thus, one of the reasons participants saw the body as an effective truth teller is because they (9 out of 15) believed that bodily expression bypasses most intellectual defenses. One group leader summarized this idea as follows:

I do think that using the body moves defenses more efficiently. Because there is a sense that the use of the body will mean that you are transparent even when you don't mean to be. And so after a while the defenses...aren't able to be effective in the same way.

Eleven out of 15 participants noted that clients often became lost in the content of an issue when working at an intellectual level, while working from the body provided a more raw and unadulterated sense of their experience in the here and now. Although clinicians were sensitive to the importance of not overwhelming the client, they saw commenting on a group member's physical experience as a powerful intervention to spur greater insight or emotional awareness about the topic at hand, since group members could not deny what their body was showing.

Participants' perspective on how the body's ability to move defenses furthers the group process will be explored in greater detail under the theme "body provides authenticity."

Body as gateway. Not only did participants view the body as communicating, but they also saw those communications as offering access to client experiences that might otherwise be inaccessible. The majority of participants consistently reported that one of the ways they saw the body as telling the truth was by serving as a gateway to help them clients access experiences that

were previously “unconscious,” “out of awareness,” or “invisible.” The following quote from a participant explains the view on the body as a way to reach the unconscious:

The body makes speakable that which would otherwise be covert. So, experiences in the body could be described as unconscious because they’re not speakable. But if one of the things we do in therapy is to make the unconscious conscious, one way to do that is to pay attention to what the body does and how the body gives information that might not have been accessible if we weren't including the body.

The body was seen as providing access to areas that were previously deadened, areas that one would not be able to reach without using the body. For instance, one third of participants saw the body as a way to access preverbal experiences and traumatic memories that might be stored in the body. Similarly, 6 out of 15 clinicians used the body to help clients connect current experiences of being triggered by a disturbing feeling or sensation with the historical anchors for these experiences by asking: “When did you feel that way in the past?” Almost all participants (13 out of 15) also used the body as a gateway to help clients approach and express unwanted, repressed, or unconscious feelings of shame, hate, or jealousy. For instance, by helping a client to turn a static feeling into a physical expression, the body could be used as a vehicle to begin to access and work with repressed emotions. One group leader provided this example:

So frequently people have trouble owning their hatred and then verbalizing it. But they might have an easier time saying 'I want to hit you right now,' which would be a bodily expression, right? So we would then say 'well, what part of my body do you want to hit?' and ask them to describe that. This would be a way of beginning to access their rage, hatred, anger, by going first through the bodily experience.

Another participant offered the following description of another commonly shared view of the importance of the body in accessing emotions:

The body is the access to the emotional world. The body helps access emotions that you may not be aware of, that you may not have a label for and that you may not have insight about because you're so used to them being there...The mind is unhelpful, what we have to help us is our body...We feel emotion and every emotion has a physical sensation associated with it, even if it's really slight, it has a physical response in your body. So if we're going to be able to accurately identify our emotions, we have to be in touch with our bodies.

Participants viewed the body as a crucial gateway that could help clients access and process heretofore unacknowledged emotions, which they regarded as essential to the therapeutic process.

Similarly, participants reported that helping clients access unconscious issues and split-off emotions deepened and enlivened the therapeutic process for the group as a whole. Thirteen out of 15 participants drew on the body to bring attention to unacknowledged relational dynamics in the group. One facilitator gives an example of how using the body can open up both individual and group exploration of relationships in the room and of how she connected body information to verbal processing:

Including the body creates more clarity, it opens things up. Also it deepens the experience that the person is having. The experience might be more superficial, but when the body is brought in it deepens the experience. So an example is a woman who was expressing some disappointment in another group member who she thought was not being genuine...While she was saying it she was not just tapping her foot, but actually hitting

her foot against the floor, it was quite noticeable and aggressive. And so what I often do is ask the group first if they notice anything, and the group's members are instructed that they will gain from listening to one another. So in this particular group no one noticed it, people said they didn't notice anything. And I said you notice Jane, that while she was talking to Tom, she was tapping her foot. And then everyone kind of perked up at that point. Yeah it is true she has been doing that, and she also realized that she has been doing that. And then she and the man that she was talking with started to process what was going on between them based on the information that he and she were getting based on this nonverbal behavior they were getting and what is meant to her and what it meant to him. And then of course there were feelings and responses from the whole group.

Thus, facilitators in this study regularly drew on the body as a gateway to help clients surface, connect to, and process unacknowledged, unconscious, or unarticulated individual and group concerns as they arose in the moment.

Healing through the body alone. While participants acknowledged the importance of using the body as a gateway to access a depth of client experiences, all participants also believed that helping clients to translate their sensory experience into words, at least some of the time, was an important part of the therapeutic process because it helped clients to better understand, organize, and learn from significant experiences. However, they differed in their emphasis on the importance of verbalization. For instance, two clinicians saw body-oriented interventions primarily as a way to translate physical experiences into words and aimed to have clients verbalize all of their physical experiences. One participant explained this view as: “We just use the body to give us more ways to talk.”

The remaining 13 participants felt that although verbalization was important and helpful, it wasn't always necessary to have a therapeutic impact. They believed that, at times, simply helping the client to deliberately attend to their physical sensations and experience their body's signals had a therapeutic effect. For instance, seven participants led an exercise to help the clients enter the group and connect with their physical experience in the current moment as a means of "grounding" them or preparing them for the therapeutic work of the day. Often these "grounding" exercises were seen as being orienting and helpful in and of themselves without requiring clients to put words to their private experiences. Thus, participants believed that conscious use of the body itself could also serve as a gateway to help clients metabolize experiences directly, without cognitive mediation. One participant summarized this view in saying "healing can also occur through body practices that don't actually have to always go through a verbalization." Another participant gave the following example of how non-verbal physical exercises created a way for group members to engage more fully with the material they were each working on for that session:

So I will start with an activity that has people personify or imbue a ball or an object with their goal for the work. And then I'll have them throw that the distance they feel they are from attaining the goal and then with the help of the group everyone has to retrieve their objects together.

In addition to utilizing physical exercises, facilitators would sometimes invite clients to use or exaggerate physical gestures to express the emotion they are experiencing as a means of helping them surface and learn about the issue or concern connected to the emotion. In this way, participants relied on the body as a gateway to help clients explore aspects of their experience or issues that others could see being played out in group or in their lives, but which remained

largely outside of their conscious awareness. Facilitators also used this technique of acting out feelings as another way to help clients bypass ingrained taboos about expressing threatening emotions, especially in relationship to the therapist. One participant provides an example:

So somebody who is feeling hatred toward me may have a hard time verbalizing it, usually the non-verbal method of communication, whether it be screaming or hitting on cushions may be much more effective in communicating their wish to kill me.

The majority of participants discussed how once a difficult-to-verbalize experience was expressed through physical action, such as in the above example, the underlying meaning for the client became increasingly evident to both the client and everyone else in the group. These clinicians concurred that in their experience simply beginning to have clients act out their emotions in a safe setting facilitated the process of insight, helping the client better understand and ultimately articulate his or her underlying feelings or concerns. One participant summarized the common view, saying: “If the therapist is willing to pay attention to people’s bodies it brings an entirely fresh perspective to stuff that would not otherwise be visible to the group.”

Body provides authenticity. Stemming from the idea that the body serves as a gateway to the unconscious, participants shared the view that the body lent authenticity to the therapeutic process for both the individual and the group. Twelve participants saw the body as providing access to privileged information that was somehow more authentic, real, or true than what was accessible through the mind via traditional talk therapy alone. One participant encapsulated this view, saying: “Your mind can fool you, but your body knows. Your mind can make up all kinds of things that are not true, rationalize, etc.” These participants suggested that the body represented a more integrated, holistic, or honest perspective on experience. One participant emphasized this view in declaring: “I mean, one can talk cerebrally or one can talk from one’s

whole body.” Thus, communications from the body were prized as offering more meaningful information about the needs and the process of the individual and the group as a whole.

Consequently, these 12 participants believed that involving the body in group therapy helped clients to become more authentic and less defended in their communication with others, which in turn, deepened the work that could take place in the group. One facilitator talked about how using the body opened up communication in group by saying:

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

Another participant noted that bringing sensory awareness into the group also created a greater degree of intimacy and supported a group norm of truth telling:

They are hearing about and identifying with one another at that level of the body, not just feelings, but also physical sensations. There is more authenticity with that. So people feel closer to each other or more comfortable or safe right away.

One third of participants endorsed the idea that involving the body in group therapy, as one participant put it, “begets a whole other quality of truth telling in the group for everyone.” A little less than half (7 out of 15) of the participants believed that the increased authenticity and sense of intimacy created by body-based interventions accelerated group development. Another seven participants were either not sure or did not believe using the body impacted group development either way. One group leader who served as an exception to both trends shared a difficult experience of running a somatic practice-oriented group where the consensus was that the session limit imposed by the medical setting she worked in prevented the group members

from being able to open up on a sensation level, which felt particularly revealing and vulnerable for group members. She said: “They shared with me...it was hard for them to trust knowing that we were only going to be together for a short period of time.” Another group leader’s experience sheds some light on the above participant's experience, while still supporting the idea that the body provides authenticity. She commented:

[When] including the body, people feel a heightened sense of vulnerability at times, especially with the kind of trauma I am working with [sexual trauma], there is going to be a heightened sensitivity to that. I think that the group members can just feel very vulnerable opening up at a sensation level. People are used to negotiating opening up from a cognitive place and the emotional place takes more guts or risk and then adding the body level is new for people and can just feel very vulnerable. And the other side is, once there is that trust, it is a beautiful process because it is almost like people are developing a trust in their own sensing experience while they are developing a trust in each other and trust in the group.

Thus while the body's communications were seen to be more vulnerable and authentic by almost all participants, group structure, population, and the setting within which the group took place mediated how the group was able to receive this aspect of the work. The next three sub-themes will further elaborate on the concept of “body provides authenticity” paying particular attention to how this impacted therapists’ experience and methods of leading the group.

Permission to follow body experience. Not only did drawing on the body increase group members’ authenticity, but the majority of participants also reported that basing their therapeutic work in the body liberated them to be more authentic as group leaders. Over time and with practice they learned to trust and rely on the sensory cues they were experiencing to inform their

decisions as a group leader. One participant described how integrating the body into her work freed her to be more genuine and helped her to see how she can use her personal experience in the group in the service of her role as a group leader:

As a leader, I love [my body-oriented group] it is my favorite part of the whole week. I think it is because...the work with the body...gives me permission to feel more authentic. My experience with learning and then integrating [body based practice] as a therapist has been a lot about...an increase in authenticity. Because [working with the body] encourages being in touch with what is happening to your body, as well as understanding that you can get behind whatever you are feeling because whatever is happening for you is the authentic feeling in the moment and that is useful. [Working with the body] there is so much more permission to just be with whatever you are feeling. There is some space in that...knowing however I am feeling is useful in the moment has opened up permission to be more authentically present.

One third of participants concurred with this idea of body-oriented practice increasing their ability to be authentic in group and noted that in stark contrast to the traditional talk therapy groups they led in the past, they also felt more able to let the therapeutic process unfold in the current body-oriented groups. Because they relied on their own sensory experiences as primary cues for their decisions as facilitators within this model, prior planning and goals for each group had to be dropped to some extent in favor of simply staying connected to their own sensory experiences in the moment. As the result of this discipline, facilitators reported that they felt considerably less anxious and more able to be present in the body-oriented model, as well as developing a greater trust in their ability to discern what was happening in the group and to

respond effectively by tuning into their sensory experiences. Another participant explained her experience of feeling more present and relaxed while running a body-oriented group as follows:

It also helps me to relax and to let go of trying to control all of the dynamics of the group, to kind of surrender to the process, letting go of expectations and so it helps be more in the flow. And to be more open to just being in the present moment with whatever comes up, [knowing that] is what's supposed to be worked on that day. So the performance anxiety that you can get into as a therapist is definitely lessened.

Additionally, three participants noted that their increased ability to be present to the therapeutic process in the body-focused model opened up space for more dynamic interaction in the group as a whole and enabled them to be more effective as facilitators. One such participant explained how the effects of shifting his way of being as a facilitator through adopting a body-focused model of practice were palpable:

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

One notable exception to this trend was two participants who reported that the body-based portion of their groups revolved around structured physical activity and was therefore more focused than the free flowing process period that followed.

All participants encouraged their clients to develop the same attitude of curiosity, interest, and trust towards whatever was arising in their bodies in turn. When clients experienced something in their bodies, participants affirmed that experience as containing information that

was potentially valuable for both the individual and the group. A participant provides this example of how following a client's feeling created a group exercise that led to insight for all:

I was leading a workshop for group therapists entitled 'Your Body is your Supervisor.' People were going around the room introducing themselves. A young woman (I'll call her Kate) who was attending the conference for the first time talked about her anxiety because she was so new at being a group therapist. She wasn't sure she should be taking this workshop, maybe she wasn't qualified and should leave. I asked her to close her eyes and become aware of her body and see if there was a movement or a way she could show us how she was experiencing her anxiety. She followed the suggestion, stood up, and put her arms up on each side of her head, making what looked like big ears. "I feel like a monkey with big monkey ears. I want to be able to be myself here and that is what I feel like." I asked if it would be all right if all of us did that, put our arms up on each side of our heads to make big ears, to see how it felt. She said yes. We all did that and then people shared with her what it felt like to them. Everyone was laughing, including the workshop participants who were senior group leaders with many years of experience. Kate looked at all of us and we looked at one another and everyone started to laugh at how silly we all looked. Kate felt she had to be a grown up even when she didn't feel like one, and she wanted the monkey to come out. Seeing everyone being the monkey helped her feel that she could, that that could happen, and of course everyone else loved it too. Others felt they had to act in a serious and reserved manner, as if they had to have all the answers because they were so experienced. Everyone could relax and now it was okay not to have all the answers.

Several participants built on this idea of giving clients permission to follow the body. One third of group leaders stated that they often encouraged clients to take care of themselves in whatever way they needed to in group rather than requiring that they adhere to more rigid group guidelines in order to create a sense of safety. One leader explained:

So I feel like it makes it safer for clients to talk about what is actually going on for them, because we're not judging. It's not bad if you're anxious or your legs are going, nothing's wrong with you. It's not bad if you have to shut your eyes during group, or it's not bad if you fall asleep. It's interesting that your nervous system did these things or it's interesting that you kind of fell asleep here, it's less like—I've been in groups where it's like, no sunglasses allowed—versus something must be going on that you need to not have so much light. In my groups, people are not being judged and criticized for things that have helped them.

By using the body as a foundation for group work, participants believed that clients' needs could be more effectively validated and their defenses acknowledged and explored. However, all participants reported that they explicitly asked permission of the group member(s) before beginning a body-based intervention to ensure that the client was prepared to engage in the work, especially if it involved the use of touch in any way.

Body resonance/attunement as a way of knowing. Another reason that participants gave themselves and their clients permission to follow the body's experiences was the idea that the body served as a vehicle for truth telling in the therapy process through what 8 out of 15 participants referred to as “body resonance” or “body attunement” or “felt empathy.” Participants described body resonance or attunement as an intuitive feeling of empathetic connection that occurs when people sense in their own body something about another person.

This could mean spontaneously experiencing or mirroring another's emotions, body sensations or physical posture, or just feeling a sense of “knowing” about someone else that is not cognitive but rather is experienced on a physical level. Body resonance was seen as occurring when the leader of a group intuitively picked up on unspoken feelings in the group. It was also seen as occurring when one group member would feel in his own body what another group member was describing for him/herself, or alternatively, a feeling that the group member was unaware of, or disowning. Participants actively used incidents of body resonance to spur insight among group members. For example, one participant commented:

How do we understand that one member of the group is talking about the death of a parent and another member of the group is crying? It is as if the thought has to be separated from the feeling. So I might say to the person who is talking, are you aware that you have elected someone in the group to express your feelings?

Clinicians talked not only about responding to instances of body resonance in the group, but six clinicians reported that they actually worked to foment it by asking members to mirror each other’s movements, or to attend to the feelings in their own bodies when another group member was talking. One participant offered this example of how he explicitly elicits and builds upon body resonance in group:

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

This participant articulated his sense that the empathy that occurred when group members were helped to experience body resonance was somehow more deeply felt and conveyed a more complete understanding of the experience. This is a concept to which I'll return in discussing the theme "the body provides connection."

Given their belief about the body providing authenticity, the majority of clinicians felt that they could trust the information gained through body resonance. One third of participants actively used their own experience of body resonance to guide their interventions. They viewed body knowledge as authentic and useful, and tended to privilege this information, even when it was surprising, or when it conflicted with what they understood intellectually. One clinician provides an example of just such an intervention:

I think there is another aspect which is the therapist's sensitivity to the body experiences of the group members and how that [works]... I have a member in one of my groups whose mother was really very cruel, sadistic to him and he is very mistrustful of me. He thinks I am really shoving things down people's throats or controlling people or manipulating people. And he presents as very anxious. He has a tremor. He looks anxious. And yet, there's something about his body, the way he appears in the group and how he holds himself that makes me feel very comfortable with him. I just feel very comfortable with him. I just feel like we have a nice relationship, and we can work together. So I generally say to him in the group, 'If you feel I'm manipulating and I'm controlling and I'm being too directive, chances are you're right.' It just feels like he's right, you know, like he's picking up on something. I think that response of mine is completely different from how his mother might have reacted. His mother probably would have been defensive, angry, and attacking.

This participant was able to create a corrective experience for her client by following her sense of body resonance with him and validating his intuitive read on her interventions in group. Furthermore, where there was a conflict between her training or beliefs and her “body knowing,” this participant followed her body.

Although 13 out of 15 clinicians reported, at least occasionally, asking group members to pay attention to how they felt in their bodies in relation to others in the room, body resonance was not a topic mentioned by seven clinicians. Instead almost all of these clinicians (5 out of 7), asked participants to feel their body in relation to others as a way to help clients connect more profoundly with their own experience instead. One participant who worked with clients with eating disorders and did not endorse the goal of body resonance spoke about why she wanted to help people stay focused on deepening their connection to themselves rather than fostering connection as follows:

I’m pretty intentional, particularly with this population, when there can be such focus on another’s experience and providing empathy...and when you're really focusing on empathy with someone? else, [there is a] pattern of disconnecting from one’s body and not tracking what’s going on with oneself. I specifically didn’t want that to happen in this group. I wanted the focus to be on staying with one’s own experience. It was very intentional to not get into that too much because it takes folks out of their own experience. I don’t know if it was a different population if that would be different, but with this population it seems very important.

Similarly, three out of these seven participants indicated that for the group and the population they worked with most members needed to learn to stay present with themselves before working with empathy or connection with others would become a realistic goal. The majority of all

participants shared a belief that different populations might have different capacities for integrating body-oriented practices in group and that each group's capacity would expand as the group matured over time and individual members became increasingly skilled in staying connected to both their own and each others' bodies.

Body as a barometer for group dynamics. The participants who did identify with the concept of body resonance extended this concept not only to individuals within the group, but also to the group as a whole. One third of participants saw their own body resonance with the group as a key tool for understanding, exploring and intervening in the group dynamic. One such participant commented:

I might not know anything with my mind about what is going on, but I will get a feeling, like an uncomfortable feeling around my heart or in my stomach, or I may notice my breathing change. And so I can make self-observation comments if I don't see [those same processes going on] in anyone else, that facilitate an awareness of countertransference and transference. I can say things like, 'I am feeling really uncomfortable in this silence right now, I feel tension, is anyone else experiencing that?' And often, there is something there. So I use my body awareness as a barometer for group dynamics...One of the hardest things as a facilitator is figuring out when it might be countertransference I need to process on my own or something that might be useful to introduce into the group dynamic, but the searching for what is going on in my body is always a part of that. I think it is really helpful in the group dynamics because the body is making conscious impressions that are often ignored by the mind...So the body's impressions can be one of those ways of realizing that something is going on.

This participant speaks to several themes that were common in other interviews. Four participants reported using comments about their own sensory experiences to acknowledge and explore unspoken group dynamics and to increase the group's awareness of unconscious processes. Similarly, one third of participants suggested that "the body's impressions" are a reliable indicator of unconscious processes in the group. Additionally, the participant quoted above, like many others, described sensing her own body as a means of separating observations that might be useful to introduce in the group from personal countertransference that needed to be processed outside of the group. A subsequent section on the theme "body as a resource" will explore what participants felt was needed for them to be able to use their bodies effectively as tools that were open, clear, and receptive to body resonance.

Body Provides Connection

Further developing this concept of how including the body can deepen intimacy and empathy both between group members and between group leaders and their clients, another major theme throughout the interviews, endorsed by all participants, was the body's role as a source of connection. Participants used the body to deepen the client's awareness of and connection to the self by introducing them to more aspects of the self and by helping them to engage with and process their experiences in the moment. As these interventions helped clients open up to their own experiences, they also created a foundation for helping clients become more aware of and available to others in the moment. Twelve facilitators also used body-based interventions to help clients see, know and connect with one another through the group process.

Deepening connection to oneself. One of the most essential interventions mentioned by 13 out of 15 participants was to invite group members to tune into their internal sensory experiences. In many ways this awareness of bodily sensations formed the basis for subsequent

interventions and was the most universally endorsed treatment technique. Participants reported that increased internal awareness fostered greater self-understanding as clients began to become aware of experiences they had attempted to overcome or had effectively disowned in some way. As clients gained a greater facility with drawing on their physical sensations over time, they were able to more effectively identify and work with both their immediate experience in the group, as well as learning about larger patterns and themes that emerged from attending to that experience. One participant commented on this process for her clients in saying:

By tracking their sensations, they have learned that they are anxious, they have learned that they are depressed. But if they actually pay attention to what they are feeling [they realize] it may be symptoms, it may be ever changing.

Thus, participants reported that helping clients to tune into their body sensations increased their ability to understand and respond to their experiences.

Increased capacity for intimacy/empathy/connection. Four fifths of participants reported that using the body increased the group's capacity for connection and intimacy. These participants explained that as clients began to feel more regulated and/or connected to their own experience, they were increasingly able to connect with the experience of other group members as well. One participant shared his observations of how inner connection facilitated group connections, saying:

And what I am beginning to discover in using that attention and awareness in group is that people are better able to meet one another, to recognize what the other is feeling, to recognize the 'two personness' of the interaction, if they actually know what is going on with themselves first...People can really track the complexity of what is happening amongst several different players when they first get in touch with where they are inside.

In this way, eight participants came to believe that guiding clients in attuning to their own sensory experiences was a pre-requisite for helping group members fully attend to one other. One participant described how she began each group by guiding members in establishing their sensory connection to themselves and only then would she ask them “to take that and connect to others at the same time,” maintaining a “dual attention” of self and other, and effectively expanding their presence with and connection to themselves and to other group members as well. Another participant definitively echoed the common belief in working to facilitate connection from the inside out, saying: “Until you know what is going on inside of you it is almost irrelevant what is going on between you because you are not fully there.”

Although the majority of participants focused on facilitating the client’s self-awareness as a primary means of fostering empathy in the group, other participants used this foundation as a jumping off point for creating or surfacing a more profound connection between group members. For instance, four participants used shared body-oriented exercises to create a connection between group members. There was a sense that bonding occurred through engaging in the shared, often emotional or otherwise impactful, body-oriented practices. One such participant offers the following example of the impact of her group's beginning body-oriented practice:

Just on a surface level...going through an experience like that creates cohesion. Because everyone is getting together and moving their bodies, and even though everyone has some self-consciousness, they’re all doing it together...So they start to feel really safe with one another, because they’ve been through this experience together and they have this experience of one another energetically...Also their surface defenses after doing the [body-oriented] practice are lowered, and they’re feeling more open to connection.

Deepening the interpersonal process. Participants reported that increasing clients' connection to their bodies and actively using body-oriented interventions to create intimacy further heightened the natural expression of empathy in group, because these interventions provided clients with a whole new realm of information about themselves, each other, and their interconnection. Thus, the majority of participants saw their work with the body as adding another dimension and, in the process, deepening and enlivening the interpersonal exploration of what people were thinking and feeling in group in the moment. Consequently, participants described their body-oriented groups as enjoying a greater degree of intimacy than they had previously been able to foster in groups using talk therapy alone. When asked how using the body impacted the group process, one participant encapsulated the common viewpoint by noting: "It has deepened the quality of human contact between two people." Speaking to the here and now focus of interpersonal process groups, another participant commented that using somatic practices "intensified the group process" because it "requires people to be present." Almost all participants (13 out of 15), regardless of whether they used the body to foster group connection or intimacy, stated that they relied on the body to help people stay focused on their here and now experience in the group.

Faster group cohesion. A little less than half (7 out of 15) participants reported that their body-oriented groups developed a sense of group cohesion more quickly than the talk therapy groups they had previously led. They linked this to the effectiveness of a body-oriented approach in fostering greater authenticity and a greater focus on group members' here and now experiences. One participant provided the following example:

Intimacy is achieved more quickly [when emphasizing the body] because we are cutting through all layers of verbal bullshit, including rationalizations and intellectualizations...

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

Additionally, four participants identified the simple repetition of body-oriented practices such as a group meditation, yoga practice, or a physical team-building exercise as fostering a sense of cohesion through shared activity, as did the novel project of exploring their sensory experiences, which helped create a "shared identity" as "explorers of our organic intelligence" among group members.

As noted earlier, eight participants did not feel that the use of the body created faster group cohesion. One of these participants stated that while she used body-oriented interventions to foster a sense of universality and insight into core issues, which in turn led to group cohesion, she didn't think the effects created by body-oriented practices were notably different from than the results gained in their non body-oriented groups. As she explained: "It's probably similar to what you're doing in other groups, it's just a different way of doing it." Thus, participants' views diverged on the role of body-oriented practices in fostering group cohesion.

Body as equalizer. While empowerment-oriented, client-directed approaches to therapy exist across therapeutic modalities, nine participants in this sample described a non-hierarchical approach as a key aspect of their body-oriented psychotherapy practice. Almost all of these participants articulated a view that body-oriented group practice as inherently equalizing. In these participants' clinical practices, including the body necessitated a shift towards viewing clients as experts on their own experiences. Similarly, some of these participants felt that using

the body inherently resulted in the therapist being more transparent and seen as more similar to the clients. The following quote illustrates one participant's view on how using the body supports egalitarian leadership:

My style generally is not wanting to have any hierarchy...But particularly in this [body-oriented] group, clients are the experts in their own experience and...it's also this idea we're all human and we all get activated and it's not good, bad, or indifferent...so I will include my own body in that.

By drawing much of their therapeutic direction from their own sensory experiences, the group process was democratized because all group members have bodies to refer to and from which to learn. The universality of the experience of being embodied fostered an increased sense of equality and connection between the group leader and group members. Another participant commented on how using the body as a vehicle for psychotherapy equalized the power dynamic:

[When including the body] there is more of a feeling of openness, we are all in this together trying to get to our truths, and our body is the way of doing that. It creates less of a feeling of me being the expert therapist and more of a feeling of me being a facilitator who shares the same vessel as you do. I would say that is true even...where I may not share the same body issue with my groups, but I share a concept of a relationship with my body and that really breaks down the barrier because I can say I have struggles with the way I relate to my body and you are struggling with that too. We are all looking for a way to relate to our bodies that is healthier and better.

Aside from whether they felt the body was inherently equalizing or not, nine out of 15 participants worked to translate therapeutic interventions used to equalize the balance of power into the realm of body-oriented therapy. Techniques included following the client's lead in the

group, fostering a sense of universality in the group, being transparent as a group leader, and acknowledging the clients' expertise on their own experience. It is important to note that not all participants commented on this theme of body as equalizer, with three participants preferring instead to maintain a more traditional hierarchy that separated them as the group leader from the group members as clients. The next two sub-themes will further elaborate on the views of participants who resonated with the concept of body as equalizer.

Therapist transparency. Participants saw transparency as a key tool for equalizing the therapist-client relationship, as well as an inherent consequence of working in a body-oriented way. Different participants conceptualized the transparency involved in body-oriented group therapy in different ways. Four participants in the sample would disclose their own body sensations in the group as a therapeutic intervention, including interpersonal countertransference, nervous system activation, and simple physical sensations. One such participant describes being transparent about her somatic experience as an effective method of commenting on the group process and moving the group forward:

I shared that with the group, I said I just am feeling in my body this huge arousal that's coming in and I'm just wondering if this might be related to the lack of movement and people in here not being able to process their own sadness. I'm just curious about that. And so then members were able to respond and actually start to get a little unstuck because...we were able to...talk about the big blockers in them opening...and address it a little more.

Additionally, clinicians would self disclose about their physical experience as a means of modeling body awareness for their clients. One participant provided an example of this type of transparency:

[I would use] the same vocabulary of sensation. And I'm going to talk about what we [my co-therapist and I] notice in our bodies too...I can use myself, if say my shoulders are up to my ears and I'm leaning forward and it's such a great defensive response so I can use that as an illustration...Here it is, let's learn from it.

Thus, these therapists felt that part of how they practiced effectively in a body-oriented way was acknowledging a shared sense of vulnerability in their human experience, rather than positioning themselves as blank screened experts, far from the struggles of their clients.

Three other participants described transparency as an added dimension of visibility that occurred almost as an unintended consequence of drawing on the body in group psychotherapy. One of the reasons that including the body equalized the relationship was that clinicians couldn't hide their physical responses from clients in the same way that they could conceal their thoughts or feelings. Once attending to the body became a norm in the group, the therapist's own body was subject to being read and interpreted by group members. One group leader elaborated on the implications of this in saying:

If sometimes I'm becoming defensive, I may without any awareness cross my legs or withdraw my eye contact and if the group is functioning well then at least one member of the group may point that out, with a certain amount of glee. 'Oh look at Doctor [name]', 'Oh, he's being defensive.'

Thus, some participants felt that integrating the body automatically created a more level playing field by adding another dimension of communication that was both patently visible and largely involuntary. Although the first group of therapists actively created and used transparency through their interventions in group, this later group of therapists focused on responding to the additional transparency generated by introducing a body-focus in the group.

Clients interpret their own body experience. Another reason that the body was seen, at least by one third of clinicians, as an equalizer, is that while the therapist or other group members might comment on their observations of a client's nonverbal communication or help them make meaning, the client ultimately had the final word on their own physical experience. Although many participants didn't directly articulate the idea that the body was an equalizer, for almost three fourths of participants, their interventions were focused on bringing a gesture or experience to the client's attention, while asking the client to sense into and interpret that experience. Even though participants would use body resonance as a way to intuit what might be happening with a client, participants saw the client as the only person who could actually know what was happening inside their body. One participant highlighted how this style of intervention helped to equalize the relationship and empower the client:

There is no expert in the same way. It's like you are the only one that can read what is happening in your own body right now. I can observe, but you know what it is feeling like in there. So I think it can in a good way break down some of the hierarchy where you begin to realize that you actually have access to wisdom inside your self through the impressions that your body gives you.

Additionally, the majority of participants suggested that at times less interpretation might be required from the leader in a body-oriented group because the focus on sensory experience itself helped clients quickly crystallize and understand their experiences for themselves or with the help of one another rather than relying on the facilitator. One facilitator provided an example in speaking about a client:

And I offered him the experiment of expressing what I viewed as rage, in a more direct way. So the group created a space around him, I have a large foam bed, and he started to

hit the bed with a tennis racket (people can hit with their hands, sit on it, bounce on it, do all sorts of things) and he was screaming at the top of his lungs while he was hitting— “Love me! Love me!”—and I looked around at the group and everyone in the group was sitting with their jaws dropped open, because here was a man screaming at people to get them to love him. And I don’t really have to make an interpretation after that all you have to do is look at peoples' faces and see that people were astonished that he could believe he could cow and intimidate people into loving him.

In this instance, the group leader[s] and the group members were together reaching a shared insight as they watched a group member engage in a body-oriented exercise. Thus, by acting out or tuning into their physical experiences, group members were often able to experience insights into their issues without the need for the facilitator to mediate the experience.

Body as Resource

In this final major theme, all participants described the body as a primary resource for individual and group healing both within and outside of the therapy room. While many of the interventions described so far used the body to help clients or the group access information or experiences that were previously inaccessible, this theme introduces the body as a resource to help clients create new sustainable patterns in their lives. Participants saw the body as a resource for finding inner sources of wisdom and resilience that would help clients break old patterns, set healthier boundaries, practice self-care, and approach their relationships in more effective ways.

A central aim of 12 out of 15 facilitators was introducing the client to using the body as a resource in their everyday experiences. For instance, one group leader asked each of her group members to set an intention for the week by noticing how they felt in their bodies when they thought about or did activities that they were struggling with and then would introduce body-

oriented tools in group which would help clients build resiliency. This participant described her approach:

Part of the nature of an eating disorder is to be disembodied in some way. And my curiosity is in that sense of disassociation or disconnection from your body, what happens around eating, is there a high state of activation which triggers an eating pattern? ...So I really wanted to be able to slow that way down and be able to just track and teach people how to track their own activation, just by practice, we do a lot of just noticing and then getting more comfortable [in group and on their own during the week] with 'this is activation'...and also gaining some resources, so that clients feel 'when I'm activated that I can have more of a sense of grounding or resilience that I'm not so overwhelmed with activation, but can just observe it'...[For instance with one client] her intention would be to just be able to have freedom around choosing what she's going to have for dinner. She'd have this panic just standing at the refrigerator. We did a lot of imagery and...paying attention to the patterns of that.

In addition to the above example, participants used a wide range of body-oriented interventions to help clients use the body as a resource in regulating their experiences, breaking old patterns, and expanding their capacity to create and enjoy positive new experiences. These interventions included: helping clients to deepen their breathing or monitor their body sensations as they changed; helping clients use props for physical expression or to reduce physical tension; asking clients to change their physical position vis-à-vis others in the room, or using movement to shift their experience; inviting clients to use physical gesture to express themselves; using body-oriented mindfulness exercises to help clients change their level of awareness; asking clients to shift their posture in a chair or shift the type or intensity of eye contact; and having clients

engage in physical challenges that give them a new sense of themselves. The group split between the four participants who used physical touch, either their own touch or the touch of another client as an intervention, and the remaining 11 clinicians who did not use touch and would not consider using touch as an intervention. Almost all clinicians (12 out of 15) applied these interventions in an as-needed, unstructured way throughout the group.

Nine out of 15 participants provided their clients with some amount of body-oriented psychoeducation to create a framework for helping clients to understand and engage with body-oriented interventions, while others preferred to model how to engage with and learn from the body as the occasion arose in group. Even participants who provided psychoeducation tended to offer it in a relatively unstructured way. For example, one group leader commented:

We started to do [psychoeducation] at the beginning and it didn't seem all that helpful because it becomes more helpful matched with experience. So now we do it more as somebody... is experiencing something, then we're more likely to name it.

Thus, while participants differed somewhat in the techniques and structure they used, they all used the body as a resource in helping their clients create more effective ways of being.

This theme of "body as a resource" as introduced so far will be elaborated through four sub-themes. Firstly, "body as creating something new" will discuss how the participants used interventions to create an experience that accesses a new sense of resilience for clients. "Body awareness as self care" elaborates on how therapists help clients accomplish a new level of emotional, physical, and psychological self care in their daily lives through the use of body awareness. In "body as regulator," the concept of the body as a resource to create greater self and group regulation will be demonstrated. Finally, "body as a guide" discusses participants' relationships with their own bodies as important tools in their practice. Thus, the elaboration of

this theme will begin by describing how clinicians used the body as a resource for their clients' therapeutic work both inside and outside of the group, and conclude with how participants used it as a resource for themselves as group leaders.

Body as creating something new. This sub-theme elucidates how a central aim of all participants was to draw on the body to help their clients interrupt and replace destructive patterns of behavior with new and more effective ways of being. While many forms of therapy may traditionally emphasize simply recognizing and then understanding a pattern as a critical step in the process of change, 12 out of 15 participants advocated for the benefits of actively changing, rather than simply analyzing the pattern as it emerged. One therapist explained:

I am not so interested in having something play out, what other group therapists might call an enactment, a transference enactment...I am interested in what is happening in the nervous system that has become a pattern...and if we slow it down and if we pay close attention and we bring lots of curiosity and openness and space, what else might happen? What else could possibly happen? And rather than interpreting an enactment, I am interested in catching an old pattern early on and slowing it down and seeing if we can invite something else to happen.

Furthermore, while many non body-oriented therapeutic modalities would agree with this emphasis on creating new skills for clients, the way that these participants achieved the creation of a new pattern through the body was unique. Without drawing on the body, participants felt, these new therapeutic experiences might not be as readily accessible, or in some instances, might not even be possible. One participant who integrates team-building experiences into talk therapy process groups explained how physical interventions can help people try out new roles:

Say if someone who has been a quiet member of a group for a year all of the sudden is out on the [team-building] course and they find themselves a very powerful, physical support person for the other people in the group, all of a sudden that person is perceived differently. Maybe prior to that they've been perceived as shy or withholding...but all of a sudden that person is perceived as a leader. So it could be a powerful way to shift roles of people in groups.

Often these interventions also capitalized uniquely on the resources available in a group where physical expression was legitimized and bounded to create a sense of permission to acknowledge and process physical experiences balanced by a sense of safety. One clinician provided this example:

If somebody is feeling tremendously alone and isolated...part of the isolation is manifested literally not being touched by any other human being for days at a time. I might ask the person if they're willing to see what it feels like to touch somebody in the group. I may ask another member of the group to hold their hand... And then I'm interested in hearing, 'how do you feel with somebody holding your hand?' Sometimes that simple act will lead the person to cry, realize the human touch is something they've been terrified of or they feel a lot of grief about not having and maybe they grew up in a family where nobody was allowed to touch anybody else. They can experiment with the behaviors that they haven't allowed themselves to experiment with outside...Group offers them a laboratory to express feelings and to use their bodies in ways they wouldn't otherwise consider doing.

This example illustrates how the group leader was interested not only in accessing an emotional experience and an insight through a body-oriented intervention, themes discussed earlier, but in

encouraging clients to experiment with shifting a maladaptive painful pattern through new physical experiences.

In particular, seven out of 15 participants focused on using the body as a resource in helping clients to identify and interrupting patterns of anxiety and tension that they regarded as the physical sequelae of the issue or concern the client may be addressing at that moment. For instance, when participants noticed constricted breathing or a tense posture, they might invite the client to breathe in a fuller way or help them relax the target body part as a means of shifting their relationship to the issue itself. One participant discussed her body-oriented approach to helping clients discharge or move through their anger or anxiety, in order to help move the group process move into a more productive discussion as follows:

One of my favorite things is the yoga pose called the hammer. It's a moving pose [in which] you stand with your feet apart and your hands clasped over your head and then you just drop, you swing it down and you swing your hands in between your legs and you make a noise as you go down. And it is a wonderful anger release... if there's a lot of anger in the group that people are struggling with and it's not moving...I will do that with them. It can really dispel the anxiety, so people can stop sitting with every muscle clenched...it's like when the affect is overwhelming a person can't really deal with other things. They're full. So we need to purge some of that and then they're not full and they can regroup and refocus and function better group-wise. One of the things that [using the hammer pose] does...is the group discussion can stop being a discussion about [client's] anger and started being a discussion about a pattern, an issue, or a problem with much more perspective.

Similarly, participants who used body-oriented exercises to ground participants at the beginning of the session noted that these exercises tended to reduce client's anxiety, creating a more relaxed climate for the work of the group. Thus, participants used the body not only to access emotional experiences, as discussed earlier, but to release, reduce, and shift them, as clients tried out new ways of being. That being said, another participant, who also used yoga in her group, said she did not want to slip into using the body to "bypass feeling:"

Because there can be this tendency in yoga, like somebody's feeling anxious then do this stretch or try this position, as though that is some quick fix when maybe what we're needing to do is experience the discomfort or connect with other people.

However, participants did not just use the body as a way to at times dispel treatment-interfering anxiety. For instance, participants used physical expression to help clients develop a new sense of mastery and control in situations they traditionally feared and avoided. Not only did group leaders help clients access and express unwanted or taboo feelings through nonverbal communication or physical language, as discussed in "body as a gateway," but by inviting clients encountering conflict in the group to experiment with experiencing and expressing their feeling in this supportive environment, they were able to help clients develop new insights about their actions and reactions and to work through the fear of conflict itself. A group leader provided this example of using physical manipulation as a way of helping his clients create a new, more productive experience in conflict:

If two people in group are in an impasse, [for one person to] be able to stand up and literally stand their ground, feeling what happens when the other person literally comes at them, with whatever they are coming with, they yell or they criticize or they manipulate or they try to be seductive or whatever it is. And to feel them self standing their ground

and then to feel what that does to their body, do they feel them self leaning forward when the other person is being seductive or do they feel them self tightening inside when they are getting louder or do they find their back stiffening up...those are all very useful pieces of information. And if they want to, they can experiment with reversing that or increasing it, making it more dramatic even, so that they really get to see what it looks like. And meanwhile the other people in the group are either participating or sharing the experience.

This participant referenced an idea introduced by an earlier quote in this theme: the group is seen as a laboratory where clients can use physical expression, movement, or awareness to experiment with new responses or roles. Furthermore, once clients had a positive new experience in the group, participants reinforced the experience by having the client verbally articulate the physical sensations related to the experience or feel the new experience in their body as a means of helping the client further metabolize the experience and cement its memory in the body-mind.

Body awareness leads to self-care. Two thirds of participants helped clients use body awareness, connecting with and observing their internal sensations, as an essential resource for self-care both in and outside the group. This is distinct from the interventions promoting body awareness discussed under “deepening connection to oneself” that worked to foster greater self-knowledge and consciousness. In this sub-theme, “body awareness” is regarded as an internal compass that clients could develop to take charge of their own healing in their lives outside of group. One participant explains this common viewpoint:

I really have faith in this natural intelligence or body wisdom. It is essential to support peoples’ awareness of that and it is a huge resource that often times the body already

knows what we need to move through a piece of work or whatever the connection is for us. And a lot of people these days don't know how to listen.

Nine out of 15 participants viewed helping clients to monitor body sensations as primary means of equipping them to more effectively take care of their emotional, psychological, and physical needs on a day-to-day basis. For instance, clinicians encouraged clients to use their body signals as a kind of signpost to help them set healthy limits and boundaries with themselves and others. One participant provided an example of this idea when she said:

The body as a source of information helps clients create boundaries because they can start to feel in their bodies when they have pushed past the point of comfort because their bodies will tell the truth about that...I am working with a client where I am trying to help him feel in his body the difference between when his thoughts are helpful and curious versus when they become obsessive and stress producing. And his mind may keep going in the direction of obsessive and stress producing but his body begins to register a series of symptoms that tells him he is past a type of equilibrium...his heart is starting to race, and if he can realize that he can...work with the body to soften the response he is having, and then he no longer is obsessing over the thoughts. And so it really is profound boundary work in terms of letting your body set the boundaries for you that you may not be allowing yourself to set because of a false self concept or some sort of obsessive behavior that takes over.

The majority of clinicians noted that as a group progressed, members exhibited an increasing ability to utilize their bodies in the therapeutic process and in their lives. One facilitator reported:

They learn to gain some control over their physiological processes -- their breathing, their real life contact, not just manufactured contact. And they can feel the changes happening

to them physically. And they learn to appreciate this and acquire a skill set at managing [this] both in the group and in their relationships.

Thus, clinicians not only helped clients develop and integrate body awareness within the group context, but also assisted clients in generalizing this skill to life outside of group where monitoring their sensations could serve as a guide to more effectively responding to their needs.

Body as regulator. In line with this emphasis on using the body to create a new beneficial therapeutic experience, 9 out of 15 participants viewed the body as a way to create or restore balance or regulation in the person. For instance, six participants talked about the way that routine nervous system responses become dysregulated through experiences that are traumatic or overwhelming, causing people to over or under react to stimuli or alternatively to develop patterns of chronic physical tension. This physical dysregulation then serves as the anchor for self-defeating psychological and interpersonal patterns of functioning resulting from these difficult past experiences. A major goal of the group leaders in this study was to help clients restore, maintain and monitor a sense of regulation. Simply helping clients to explore and express their emotions directly through connecting with their physical sensations was seen as a primary intervention that in and of itself served to restore the body's regulation. For example, one participant reported: "Because in tracking with curiosity how the body experiences things it really detoxifies the feelings." Sometimes participants also drew on more active interventions such as having clients shift their physical posture to restore equilibrium. Another participant explains:

Another thing that happens is they will close their mouth or jaw or clench their teeth or look away. So we are trying to open these territories rather than have people close them.

And it becomes routine to have them raise the eyes, breath deeper or clear the throat. I will use it to help them open their emotional expression apparatus.

Thus, participants used the body to encourage physical self-regulation, which in turn was seen as the basis for creating emotional self-regulation within the client at the same time.

Facilitators also drew on the unique power of the group to encourage client's self-regulation. Three participants commented that they drew this aspect of their work from recent findings in neuroscience suggesting that each person's nervous system is influenced by nervous systems of others nearby. Thus, they believed that the regulation of the group leader or of other group members could increase and support the regulation of the whole group. Participants therefore actively took responsibility for supporting the regulation of each client by remaining regulated themselves, and by taking an active role in being the "arousal manager," encouraging the regulation of both the individual and the group at each step in the process. One facilitator noted:

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

One of the key methods that 9 out of 15 group leaders used to foster regulation in the group or cope with conflict was simply to slow down the group process. While this is a common tool in group therapy, these participants used the body as the primary method for slowing the group down, especially in times of conflict. Also in line with the concept of the body creating something new, participants were particularly interested in keeping the group regulated. These participants would intervene in emotional exchanges to invite clients to attend more closely to

their sensations and emotions as they interacted. One facilitator provided this example of a body-oriented intervention:

When things would get heated interpersonally I would ask them to slow down and ask them to notice what they were experiencing and where they were experiencing it and how they were experiencing it.

Participants reported that this process of slowing down the interaction itself fostered increased regulation for group. An additional result of this intervention was that clients were able to gain greater insight into their own and each other's experiences. Another participant who used similar interventions as the participant above went on to explain the impact of slowing down the process in times of conflict or emotional intensity in the group: "It allows other people to understand more deeply what the impulse was or why someone felt so hurt or so afraid or whatever because it is slowed down."

Six participants, including all four of the participants who had trauma-specific body-oriented training, shared the view that clients could only effectively metabolize current or prior experiences when they were in a regulated state. These clinicians saw slowing down the therapeutic process as essential to ensuring that clients did not get overwhelmed by traumatic material as it surfaced, further reinforcing the original injury. The majority of all participants, including four without trauma-specific training, indicated that the body was a particularly important tool for effectively treating trauma-specific symptoms. Slowing the process down served to help clients remain in a regulated state that would allow them to use the resources of their nervous system to process material that had previously been so threatening as to be split off. For example, one facilitator explained:

In [trauma there is] that sense of disassociation or disconnection from your body... So I really wanted to be able to slow that way down and be able to just track and kind of teach people how to track their own activation, just by practice, we do a lot of just noticing and then getting more comfortable with ‘this is activation.’ And getting more comfortable with what are some resources that when I’m activated that I can have more of a sense of grounding or resilience that I’m not so overwhelmed with activation, but just observe activation.

By drawing on the resources of the body to titrate clients’ exposure to traumatic material, these clinicians believed they were more effectively helping clients to metabolize traumatic experiences and to become free from post-traumatic symptoms. In contrast, another one fifth of clinicians were less focused on ensuring that the client remained regulated at all times, but worked instead to help the client fully experience and express a repressed sensation or emotion as a means of discharging the experience from their nervous system, believing that this in turn would ultimately facilitate the body’s regulation.

Finally, one third of clinicians expressed a belief in the power of a well-functioning group to facilitate regulation for the individual. As facilitators used body-awareness to remain regulated themselves and body-focused interventions to increase the regulation of the group as a whole, these effects were multiplied by each person’s capacity to impact other group members at a physical level. Over time, some participants believed that simple exposure to the group might support individual members in establishing a new level of self-regulation on an ongoing basis. One participant talked about her hopes for using the power of mutual regulation in the group to support wellbeing among her colleagues as well as her clients. She said:

I have this macro picture of the possibility of what can happen if one nervous system can find regulation and can hang out with other nervous systems and with mirror neurons and personal engagement and mutual regulation...Another reason that looking at body therapy in the group field is really important...Even working with...my colleagues, support[ing] them all on how can we work on our co-regulation as colleagues. How can we notice when we are over-worked or stressed and support each other in this?

Increased affect tolerance. Essential to this mutual and individual regulation, is creating increased affect tolerance for group members and the group leader. Twelve out of 15 participants discussed how they used the body to help clients increase their tolerance for experiencing and exploring affect. Simply by focusing on how affect felt in the body directly, clients were drawn out of the conceptual realm where there might be a tendency to judge or control the experience and shifted instead into becoming an observer of the process of experiencing emotion as it unfolded. This shift in their relationship to their feelings seemed to facilitate their capacity to engage with their feelings. One participant explained:

Having the body as a reference point makes emotion less personal...because people can witness their own experience of an emotion by noticing how it is showing up in their body, and there is something about being able to do that allows [a sense of being an] 'observer' to come into the process instead of just being the experience of the emotion. That in itself, as a group dynamic, makes everyone in the group be slightly more open to being curious to emotions instead of just in reaction to them. That is a really helpful orientation in general for the group because then emotions become something to be curious and observant about rather than fearful and reactive to.

These practitioners observed that as clients practiced engaging with their emotions over time, their comfort with emotions and their capacity to explore their emotions grew. Another participant reported:

I work with a number of people who when they are able to just track with curiosity how their body is responding to a given conflict with a partner or distress around some news at work or whatever it might be, they are much better able to tolerate it and ride it out because they are not immediately labeling it with all these kind of second order emotion words, like anxiety. 'Well you are anxious, well what does that mean?' And if people are able to shift their attention to what they are actually feeling, but emotionally and physiologically, it is not as charged.

Clinicians noted that as clients' ability to observe and be curious about their bodily sensations, emotions, and impulses increased, they were less reactive to strong affect, interpersonal conflicts or moments of transference in the group. As clients grew more comfortable engaging with their bodily sensations and their emotions they were better able to understand the depth of their feelings about particular issues and stay present with their own experience, making them less likely to project those feeling onto other group members. Almost all of the participants who viewed body-oriented interventions as increasing affect tolerance also reported that affect tolerance led to an increase in their clients' ability to recognize and work through more complex interpersonal dynamics such as transference and countertransference as it surfaced in the group.

One fifth of participants explicitly noted a parallel increase in their own affect tolerance as group leaders. They reported that their use of the body as a primary intervention fostered their capacity to entertain a broader variety and greater depth of emotion from their clients and within themselves. As one participant stated: "I notice that the longer I'm engaged in this work, the

more difficulty I'm able to tolerate in the room on an emotional level, and I can feel it in my body." As their affect tolerance grew, clinicians felt increasingly able to remain non-defensive and to guide the group effectively in the face of being the object of strong affect from a group member, experiencing intense countertransference, or mediating a conflict.

Body as guide. As discussed earlier, more than two thirds of participants described using their body as a guide. Related to the concepts of the body as a truth teller and the body as providing authenticity, participants believed that they could trust the messages they were getting from the body. As a result, like their clients, clinicians themselves drew on their own sensory experiences to guide them in their work within the group. Using their bodies in this way was a demanding task and the next sub-themes will discuss some ways that clinicians supported themselves in this work.

Body awareness grounds the work. Because clinicians were continuously using their bodies to direct their interventions as a group facilitator, participants stressed the importance of remaining connected to or "grounded" in their own body awareness to be maximally effective. They emphasized the importance of having done their own work to be able to discern when the physical signals they were receiving represented a personal reaction to an experience, countertransference, or information about the group's process and experience. One participant discussed the importance of having developed strong emotional self-regulation skills in order to be able to respond to body resonance without the therapist's own emotional response getting in the way:

I use language of transference as 'resonance.' This helps guide interventions based upon what is being projected onto you...The goal is to help guide and regulate emotion not add...or go against their process. [To do this] as a therapist, one needs sophisticated

emotional regulation skills...because if it is hard for me to tolerate where this person is then I might have a need to make it better...and that's my issue, not their issue...and we need to get out of the way of their process.

Similarly, participants discussed the need to develop and maintain clear personal boundaries when working on a body level with clients, because the physical focus of the work introduced a new level of intimacy and vulnerability to the client-therapist relationship.

Need for body practice. One way that clinicians maintained a sense of body awareness was to cultivate a body-focused awareness practice in their own lives on an ongoing basis. Almost all participants indicated having personal experiences with body psychotherapy or a body-oriented self-care practice. One participant described the reason she continued to regularly engage in body-oriented practices to support her professional and personal life, saying: “It’s an ongoing process, learning about the body’s messages and one’s truth.” This could mean engaging in body psychotherapy as a client to explore one’s own issues and deepen one’s own capacity for body-oriented work, or it could mean engaging in some other form of body work -- such as massage, dance, or yoga as a means of exploring and processing one’s own experiences through their attention to the body. One third of participants believed that familiarity and comfort with using their own bodies in exploring and working through a variety of affects, sensations and challenges in their own experiences effectively enhanced their ability to guide clients in developing these skills and exploring their own issues. About one third of participants felt that the depth of their own work effectively set a limit on their ability to work with clients. As one participant explained: “The more you know yourself, the more effective you’ll be in your work. You can only take your patient as far as you’ve gone.”

Furthermore, the majority of participants discussed the importance of having personally experienced the body-oriented interventions they were using with clients as a way of preparing to do the work.

I have to say that the only way to do it is to have had a substantial amount of body-oriented work as a therapist yourself. That provides an intuitive sense of the appropriateness of the interventions...[With] your own body work you can intuitively and reflectively discern how your body protects you from your emotions and how your body expresses or does not express the emotions you do have.

Almost all participants (14 out of 15) had experienced some aspect of the body psychotherapy model or body-oriented practice they were using to inform their work with clients and the majority regularly engaged in a body-oriented discipline to continue to explore their own experience and to foster self-development. Two thirds of participants stressed the importance of their own body-oriented practice both personally and professionally.

Need for body-oriented training. Participants also spoke about the importance of specific body-oriented training. The majority of participants recommended adequate body training before applying body-oriented techniques in groups. All participants but one had received formal body-oriented training; all but two had received formal group psychotherapy training. The novelty of utilizing body-oriented psychotherapy in the group setting is indicated by the fact that only three participants had received training that addressed the integration of body psychotherapy and group work.

More enjoyment in work. Participants emphasized the need for adequate body-oriented training and personal body psychotherapy experience to help prepare them to be effective group therapists. Additionally, the majority of participants found that the actual clinical practice of

body-oriented group psychotherapy was facilitative of ongoing renewal and protective against occupational stress. Twelve out of 15 of therapists talked about how much meaning and joy they found in working with the body. One participant stated: "I feel really blessed that I am involved in deep meaningful work all day." One third of participants spoke about working in a body-oriented way as increasing their empathy for clients and/or themselves. Two other participants reported that because they were continuously attending to their own sensations, there was less risk of "taking on the emotions of the group" and "less undigested tension" at the end of the work day overall. Another third of participants similarly commented on experiencing an increased sense of energy, enjoyment and vitality in their work and in their lives since adopting a body-oriented approach to psychotherapy. One participant exemplified the collective sentiment in saying: "I have much more spark. I feel a lot more feelings myself. In particular, I have a lot more joy available. It's much more fun to do the group."

Summary

The four major themes that have been identified in this analysis overlap in many ways. I visualize the inter-relationships between these themes as being best represented by a spiral, in which each theme feeds into and elaborates upon every other theme (see Figure 1, Appendix K). The theme of "Attending to the Whole Person" is the wellspring of the whole in that it describes the philosophical underpinning of mind-body interconnection that provide the essential rationale for body-oriented psychotherapy, while the details of these interconnections as described by modern neuroscience and determined through the trial and error of the body psychotherapy process determine many of the specific interventions. Each of the remaining three themes, "Body as Truth Teller," "Body Provides Connection," and "Body as a Resource," all build upon the preceding theme, while nevertheless adding a unique dimension to the elaboration of how

this sample of group therapists integrated body-oriented practices to maximize the potential of interpersonal group psychotherapy.

CHAPTER V

Discussion

This grounded-theory study responds to a gap in the literature by illuminating the perspectives and therapeutic processes of clinicians who are integrating body-oriented practices in interpersonal group therapy. This study's findings suggest that despite the variety of participants' training experiences and practice settings, there is a discernable uniting model to their practice of body-oriented therapy in groups. An analysis of 15 interviews revealed key theoretical and process-oriented commonalities among professionals, highlighting some of the unique benefits and challenges of this type of work. Here, I will review why participants were drawn to body-oriented group work, discuss how participants' practices extend traditional talk therapy paradigms for group work by drawing on the body as the central vehicle for change in the therapy process, and explain how this shift to a body focus not only extends but also departs from traditional group therapy, exploring the impact of this development from the perspective of practitioners. I will also discuss some of the key debates and issues that participants identified in this nascent field, and finally, I will assess the strengths and limitations of this study and indicate the implications of these findings for future research and practice in the field.

Toward a Body-Oriented Group Therapy

The primary reason study participants began to integrate the body and the therapeutic process was that they felt something was “missing” in their own therapy or in their therapeutic work with clients. Participants included both traditional talk therapists, who later in their careers

became interested in using the body, and therapists who entered the mental health field intending to include the body in their clinical work. Regardless of background, these therapists all encountered difficulties in accessing affect and eliciting the complexity of the self using talk therapy alone. Body-oriented practices, they felt, offered potential avenues to overcome these challenges. Each of the therapists in this sample created an approach that responded to what they viewed as a gap in traditional talk therapy without entirely rejecting a more traditional psychotherapy model. There was a common view that traditional group approaches and body-oriented approaches can and should be integrated. Although only three of the therapists had received body-specific group training (largely due to the lack of availability), 14 out of 15 received some form of individually-focused body-oriented training. This indicates that there is a shared interest in integrating body-oriented practices in the group format across specific models of body-oriented psychotherapy. Given the diversity of approaches represented by these practitioners, it is also remarkable that so many common themes regarding the fundamentals of body-oriented practices in group emerged from this study.

Extension of Traditional Group Therapy

In many ways, participants in this study used body-oriented practices as a means of fulfilling the traditional goals of group psychotherapy. The body itself was often used to enact traditional interventions such as establishing a here and now focus, making the unconscious conscious, adopting a non-hierarchical approach, and using countertransference as a guide. The majority of participants who indicated receiving group specific training reported training in interpersonal group theory (100%), psychodynamic/psychoanalytic theory (83%), and humanistic approaches (58%). In this study, particular attention is dedicated to how principles from these theoretical traditions have been integrated into participants' new models.

Staying present. Participants largely used the body with a here and now focus and emphasized the importance of direct experiencing. Clinicians would frequently re-direct group members' attention back to their current experience of body sensations to help them maintain an embodied presence in the group as well as help them access the depth of their current emotional experience. While this way of maintaining a here and now focus is distinctly body-oriented, this aim can be seen as grounded in interpersonal group theory. Interpersonal group therapy is focused on using the here and now experience of clients to create powerful experiential interpersonal learning (Yalom & Leczc, 2005; Rutan & Stone, 1993). Encouraging presence and an awareness of the present moment is also a central tenet of the Eastern spirituality that underlies many body-based mindfulness interventions. For instance, Fehr & Sandelier (2010) discuss how concepts of Eastern spirituality that encourage staying in the present moment augment the emphasis on immediacy or here and now learning in interpersonal process groups. Thus, the here and now focus articulated by participants can be seen as theoretically articulated in and likely influenced by two complementary approaches, interpersonal group theory and mindfulness-based psychotherapy. Drawing on these two traditions, participants extended the interpersonal group focus on immediacy by using body awareness as the main way to reconnect clients to the present moment.

Accessing the unconscious. One of the main ways that participants used the body was to help bring unconscious processes to awareness. Noting group members' non-verbal communications, asking them to tune into their body sensations, or helping them adjust their body posture to allow access to repressed experience were common interventions used by participants to help clients expand their capacity for awareness. The body was viewed as a more reliable route to the unconscious than words alone, partly because of its ability to bypass

intellectual defenses. The belief that the body holds much more than we can consciously know is one of the common beliefs expressed by participants and body-oriented psychotherapy in general (Shannon, 2002). Body-oriented psychotherapists frequently write about using the body to access the unconscious. For instance, Levine (2010) discusses how the body is a more base level of experience and thus often knows something before the mind is aware. While we can locate the roots of participants' therapeutic styles within body-oriented approaches, their concern with the unconscious is not a new psychotherapeutic concept.

Psychodynamic theory is uniquely focused on this same aim and uses a variety of verbal techniques to produce insight in clients and help them gain awareness of their unconscious processes. McWilliams (2004) suggests that creating the capacity to bring awareness to one's unconscious is a uniting feature of psychodynamic approaches. Group analysis continues this tradition by focusing not only on the individual unconscious, but also on shared group unconscious processes such as socio-political beliefs and identifications (Ettin, 2001). Bringing light to the unconscious is also an integral part of the interpersonal process group model, which comes from the psychodynamic psychotherapy tradition (Yalom & Leczc, 2005). Thus, while using the body as a primary vehicle to increase awareness and disrupt repression is a novel approach, the therapeutic goal of making the unconscious conscious is a mainstay of psychodynamic thought.

A client-directed approach. A group of participants described using a distinctly non-hierarchical approach and saw the body-oriented stance as an inherent equalizer of power dynamics between therapists and group members. These participants reported an intervention style where clients were viewed as the experts on their own experience. We can see some basis for this empowerment-oriented approach in the body-oriented psychotherapy literature. For

instance, some body-oriented models emphasize helping clients to reclaim a sense of agency and strength in response to the inherently powerless experience of trauma. Ogden, Minton, and Pain (2006) describe how Sensorimotor Psychotherapy clients are taught to “implement physical actions that promote empowerment” (p. xxiv). Additionally, a common perspective in the wider field of body-oriented psychotherapy literature is that an empowerment focus and a non-hierarchical relationship characterized by mutual influence and shared growth between therapist and client is a major factor that differentiates body-oriented approaches from traditional psychoanalysis (Grossinger, 1998).

Despite this distinction, therapeutic approaches that stress the importance of client self-direction can in many ways be seen as an integration of Rogerian and Humanistic traditions. Rogers’ (1951) person-centered therapy is based on the premise that each person has an internal tendency toward self-actualization that can guide their process of growth. Helping the client attend to and process their affect by providing a genuine and empathic relationship is viewed as the central mechanism for change in this paradigm. Participants’ commitment to trusting the client’s ability to find direction through sensing into their body is therefore a natural extension of person-centered principles into the realm of body-oriented therapy. Humanistic group psychotherapy similarly offers an approach characterized by the therapist’s trust in client’s natural capacity to achieve positive change in their lives (Page, 2002). The similarities between the humanistic approach and the body-oriented model articulated by participants is not surprising in so far as the first body-oriented group models arise from the human potential movement of the 1960s (Young, 2010).

Therapist transparency. Similarly, most participants in this sample felt that working with the body required them to be more transparent, whether intentionally or unintentionally.

The findings indicate that group norms which supported clients noticing and commenting on the therapist's body communications and the therapist's self-disclosure of their own body sensations were used to advance the therapeutic process and provide modeling for clients. This intervention style is not unique to body-oriented approaches but is characteristic of the style of interpersonal process group therapists. Yalom and Leczc (2005) discuss how skillful therapist transparency can be used to support the development of group norms, increase group cohesion, reinforce a here and now focus, and encourage reflection on the nature of the interpersonal process.

In addition to using therapist transparency to meet the above goals, a subset of participants self-disclosed in the spirit of acknowledging their common humanity and vulnerability with their clients, feeling that this in itself led to therapeutic change. The humanistic tradition is a major influence in any therapeutic approach that utilizes modeling, self-disclosure, and an acknowledgement of shared humanity as a clinical intervention. As mentioned earlier, Rogers (1951) placed great emphasis on genuineness and appropriate self-disclosure from the therapist as an essential ingredient in therapeutic change. Thus, while almost half of participants saw body-oriented practices as offering a natural opportunity to facilitate client empowerment, their approach to these practices also reflected an integration of fundamental principles from the broader tradition of humanistic psychotherapy.

However, there was a split amongst participants, with a subset believing that using the body made them more transparent as leaders, which could be clinically useful, they were otherwise uninterested in equalizing the power dynamics with clients. This subset was joined by another small subset of participants who held a similar stance about power dynamics in the group, but did not view using the body as impacting level of therapist transparency. This finding

both suggests that body oriented therapy has a range of approaches to power in the psychotherapy relationship, and signals an issue that should be further defined in this paradigm.

Countertransference and insight. In line with the use of body-oriented self-disclosure, participants in this study consistently reported that they relied on body resonance as a means of relating to group members and gaining insight into the group process. As presented in the findings, body resonance refers to the therapist's felt sense and physiological experience of empathy with individual members or the group as a whole. Body resonance can best be understood as an extension of modern psychodynamic theories that focus on therapists' interpretations and use of their own interpersonal reactions to benefit clients' learning processes. In the interpersonal process group model, the therapist's skillful use of their feelings towards the client is seen as a vital element in generating insight on the interpersonal dynamics of clients within the group. As Yalom (1985) tells therapists, "you need to use the delicate instrument of your own feelings, and to do so frequently and spontaneously" (p.168). Similarly, in group analysis, the therapist's own examined countertransference is viewed as facilitating a deeper understanding of the interpersonal dynamics of the group for its members (Hopper, 2009).

Furthermore, we can see a corollary of what Gendlin (1996), a humanistic psychotherapist, refers to as staying in touch with one's felt sense in the psychoanalytic literature. For instance, Stern (2002), a non body-oriented psychoanalyst, describes a concept similar to body resonance when discussing the "unmade meaning" left behind when we try to express ourselves in words and instead "is actually conveyed, re-created, or enacted through its effect on the relationship in which the spoken meaning emerges." Stern goes on to explain the therapist's felt resonance in the following quote:

The unformulated background that accompanies explicit meanings is part of the patterning or emotional atmosphere that underlies the ongoing sense we have of what relationships 'feel like' to us. In our...work with our analysands...often we must resist the temptation to speak, or even to formulate an experience in the privacy of our own minds (to the extent that we control the process), recognizing that any consciously directed attempt to think would be too pale or ungainly to do justice to the moment; we must be satisfied with the feeling of resonance.

Similarly, Holifield (1998) a body-oriented psychotherapist who uses movement to help clients learn about their feelings and experiences writes about the “somatic aspects of transference, countertransference,” offering a case example where she tells the reader: “I was experiencing with her what she could not name, experiences about which she was mute” (p. 68). In these cases, a body-oriented therapist and a psychoanalyst are talking about very similar experiences of their work, but use different vocabularies and to some extent different primary vehicles for accessing and working with their countertransference. This study's findings suggest an incorporation of body sensations into the classic model that advocates paying attention to one's feelings, thoughts, and fantasies, a process that may heighten the therapist's ability to identify and respond to countertransference in individual and group therapy.

Departures from traditional group therapy

In addition to recognizing how this study's findings extend established psychodynamic, humanistic and interpersonal group therapy traditions, there are also ways in which the findings delineate an entirely new way of working that adds something unique to the field of group therapy and fundamentally departs from traditional talk therapy. By situating participants' experiences within the context of the body-oriented psychotherapy literature, I will highlight

common principles underlying participants' diverse approaches to the work that may help to further define the essential elements of body-oriented practices across specific models.

Body as a vehicle. At the most basic level, therapists in this study described a fundamentally new way of working because they used the body - clients' physical sensations and the emotional experiences grounded in those sensations - as the central vehicle to accomplish all major therapeutic tasks from exploration, to insight, to action. I will describe how participants used the body to accomplish standard therapeutic goals in new ways, including: to access affect and learn to tolerate it, to restore a sense of self-regulation and manage dissociation, to explore the unconscious and support the development of intimacy in group, and to act as a guide to the therapeutic process. This section will summarize these findings while situating them within the larger context of the body-oriented psychotherapy literature.

Create opening. A key finding of this study is that clinicians used the body as the primary vehicle to access affect, the unconscious, and information about the relationships in the room. Two main beliefs underlie this use of the body: first, that experience resides in the body and is constantly presenting itself through "somatic markers," and second, that the body offers reliable access to experiences that clients otherwise would not verbally communicate. Participants regarded body expression as particularly reliable since it was unmediated by intellectual defenses. They also viewed non-verbal expression and body sensations as pathways for clients to communicate what could not yet be verbalized.

Calling clients' awareness to their non-verbal behavior and body sensations was seen both as a physical precursor to deeper dynamics and as a major tool to generate self-understanding. This concept of the body has a clear foundation in the theoretical literature. Krueger (2002), the author of "Integrating Body Self and Psychological Self," suggests that the

body serves as a bridge between unconscious and conscious awareness. Clients often cannot express experiences with words that are unconscious or characterized by emptiness and so instead they communicate through body language, physical actions, and somatic symptoms (Krueger, 2002).

This study found that the most fundamental way therapists helped clients gain access to their affect and to the unconscious was by asking them to attend to their physical sensations. This practice has a strong theoretical basis across body-oriented approaches. For instance, Kabat-Zinn, the founder of MBSR, encourages listening and opening to body sensations as a way to connect to a fuller experience of self. He explains that when we listen to the body, “even if we don’t hear much at first, there is no telling what might occur. But one thing is sure. As best it can, the body is listening back, and responding in its own ways” (p. 8, 391). An interest in uncovering a client's inner world is a common therapeutic task. However, a belief that the body offers access to a more complete and authentic form of experience, and thus is a more direct way to access information, constitutes a new way of approaching both individual and group psychotherapy.

Broaden emotional range. Similarly, the common therapeutic goal of building affect tolerance was seen by participants in this sample as most effectively accomplished through body-based interventions. One of the primary ways participants knew a body-based intervention was called for involved their observation that the client was either blocked in expressing emotion or was becoming flooded by overwhelming emotions. For instance, participants consistently utilized the body to address conflict in group. They had group members attend to body sensations to slow the interpersonal process down enough to facilitate self-reflection, foster insight, and clarify the dynamics creating the conflict. In this way, participants used the body to

encourage emotional expression as well as to help group members regain a sense of self-control and better understand the sources of their feelings.

This use of the body to support self-regulation and emotional insight is clearly reflected in the literature. For instance, the widely used intervention of attending to one's body sensations is consistently seen as a way to both help clients access and tolerate the accompanying affect (Holifield, 1998). Levine (2010) discusses how body awareness interrupts our reactivity and allows us to better understand the true nature of our emotions in challenging situations. Thus, in line with many body-oriented theorists, the majority of participants emphasized emotional regulation as both a proximal and a distal goal of group therapy and viewed the body as an essential resource in accomplishing this therapeutic task.

Support group intimacy. Participants viewed restoring self-regulation as an important part of how they used the body to build group connection, cohesion, and support group members' capacity for intimacy. The majority of participants expressed a belief that clients could only build meaningful relationships with others when they had first established a foundation for emotional regulation within the self, which allowed them to tolerate vulnerability and freed them up to be present for one another. In addition, participants used shared body practices such as group meditations or interpersonal exercises with a physical component to accelerate group bonding through shared experience.

Using the body to facilitate connection has a clear basis in the theoretical literature. For example, the following quotation from a volume on the body in psychotherapy articulates a common belief in the body as a source of both intra- and interpersonal connection. Abrams (1996 as quoted in Holifield, 1998) says: "the living body is the very possibility of contact, not just with others but with oneself." Moreover, there is empirical evidence to substantiate

suggestions that using the body increases one's sense of connection with the self and with other members of a group. Qualitative studies in the field of body-oriented psychotherapy found that clients who experienced body-oriented interventions reported increased body awareness and self-connection (Langmuir, Kirsh, & Classen, 2012; Mehling et. al, 2011; Price, McBride, Hyerle, & Kivlahan, 2007; Price, 2011). Several outcome studies indicate that the use of body-oriented practices in the group format is also related to a more positive and empathetic group environment (Leirvåg, Pedersen & Karterud, 2010), stronger group cohesion (Erfer & Ziv 2006) and a greater capacity to build relational connections (Langmuir, Kirsh, and Classen, 2012).

A recent study that integrated Sensorimotor Psychotherapy into the group process came closest to addressing whether increased self-awareness is a prerequisite for group intimacy. The study reported:

Clients developed a greater capacity to be aware of their here-and-now experience and to communicate to one another about that experience. This facilitated relational connections by enabling them to notice how they were impacting one another and provided opportunities to experience intimacy within the safety of the group container (Langmuir, Kirsh, & Classen, 2012, p. 219).

Interestingly, Yalom and Leczc (2005) suggested an inverse relationship, arguing that group cohesion fosters the individual's capacity to undergo self-exploration and broadens self-awareness. In their model, group cohesion develops only after the successful completion of previous stages of group development, including experiencing the emergence and resolution of conflict.

In summary, body-oriented group practice is geared toward using the body to facilitate internal and relational connection. The perspectives of participants offer further support for the

literature's suggestion that using the body to establish self-regulation helps create group intimacy. Contradictions remain regarding the causal relationship between self-awareness and group cohesion; that being said, these differing positions are not mutually exclusive because emotional regulation, self-awareness, capacity for intimacy, and group cohesion can be seen as in a constant state of non-linear mutual influence. Further theoretical and empirical exploration of this issue would provide needed insight. Suffice it to say that this model departs from traditional group psychotherapy in that it uses the body in a variety of ways to create self and interpersonal connection including through helping individual clients regulate their own emotions.

Manage dissociation. Participants in this sample described using the body as a tool to prevent dissociation by helping to ground their clients more firmly in the present moment. The theoretical literature promotes body-oriented psychotherapy as a means of fostering present moment awareness and addressing various forms of psychic numbing ranging from repression to dissociation (Levine, 1997; Levine, 2006; Levine, 2010; Ogden, Minton, & Pain, 2006). Helping clients increase their capacity to engage with the totality of their experience through body awareness is consistently described as a particular goal of body-oriented psychotherapy (Gendlin, 1996; Kabat-Zinn, 2005; Levine, 1997; Levine, 2006; Levine, 2010; Ogden, Minton, & Pain, 2006). Several recent empirical studies have suggested that body awareness and body-oriented skills acquired in individual and group psychotherapy help clients manage dissociation effectively (Langmuir, Kirsh, & Classen, 2012; Price, 2005). Increasing the ability to tolerate and regulate affect and concurrently reduce dissociation is also seen as a key aspect of trauma recovery (Van der Kolk, Pelcovitz, Roth, & Mandel, 1996). Almost half of the clinicians in this study believed that the body played a special role in treating trauma that centered around its utility in surfacing, metabolizing and managing memories, affect, and sensations that were either

inaccessible or overwhelming to clients in other forms of therapy. Thus, participants' experiences add to theoretical and empirical literature that highlights the potential of body-oriented psychotherapy in trauma treatment. Further research is needed to refine our understanding of the potential efficacy of body-oriented practices and to elaborate on the role of the body in trauma treatment.

Treat body as co-leader. In addition to using the body as a way to intervene with clients, participants used their own bodies or their body resonance, as introduced earlier, to guide them in leading groups. The body was seen as a way for therapists to stay grounded, present, and clear in the room. Participants spoke about body resonance as a more direct and intuitive method of attuning to the individual or the group than what they could access intellectually. This section will begin by discussing how body resonance is conceptualized in the body-oriented psychotherapy field and then discuss ways in which it departs from traditional talk therapy notions about countertransference.

The concept of body resonance is similar to what is referred to in the literature as somatic or embodied countertransference. According to Field (1989), in one of the first articles on this concept, somatic countertransference is a “spontaneous arousal of physical feelings that may be unrelated to the patient's manifest material or even in direct contradiction to it” and is a medium to receive “unconscious communications from the patient” (p. 512). Stone (2006) suggests that therapists can use these somatic reactions to a client as “a tuning fork” to better understand the client and guide their interventions (p. 109). Gendlin (1996) coined the term “felt sense” to appropriately describe the experience of body resonance or somatic countertransference and why clinicians are apt to follow and trust this even before they quite intellectually understand it (Holifield, 1998). Gendlin (1996) defines “felt sense” as follows:

A felt sense is the holistic, implicit bodily sense of a complex situation...A felt sense contains a maze of meaning, a whole texture of facets, a Persian rug of patterning – more than could be said or thought...a felt sense is more reliable than reason because more factors can be sensed in it than reason can manage (p. 58).

Rather than somatic countertransference simply being an extension of other aspects of countertransference, as discussed in the previous section, participants in this sample placed a special value on somatic countertransference. First, there was a sense that body resonance contained more information about clients than could be obtained through conceptual understandings of countertransference reactions. Second, the body was seen as a more reliable way to gain information and be guided in a constructive way in the group. For example, participants reported trusting the information they received from body resonance over a content-based conceptualization. The result of this was that the majority of participants felt more permission to feel in their body-oriented groups, as well as trust in their own internal sensory experience to guide them as clinicians. Clinicians displayed a markedly new way of leading groups in that they were more focused on following the lead of their own body rather than being guided by an intellectual decision. Consequently, participants felt they were able to let the group process unfold and were less anxious about their “performance” as leaders.

Finally, therapists felt that being connected to their body resonance was an invaluable tool in making sense of their own countertransference reactions. Countertransference experiences that had previously been seen as difficult to unpack, except through careful examination in one’s own therapy or with a supervisor, became more reliably accessible and clearly understood. Thus, using body sensations to guide countertransference helped therapists interpret and legitimize previously inchoate experiences. There is some literature supporting the

usefulness of “somatic attunement” or therapists’ awareness of their body sensations in therapy sessions as a tool to more clearly understand and therapeutically employ their own countertransference issues (Rand, 2002). Therapists in this sample did not rely exclusively on body resonance or guide their process only through their bodies. Instead, they flexibly applied a wide range of traditional notions of countertransference as well as crafting a unique approach that privileged and made sense of information from the body.

A focus on direct experiencing. Another way that the model of body-oriented group psychotherapy described in this study departs from traditional group therapy is in its emphasis on direct emotional experiencing. Although participants helped clients integrate body-oriented experiences through conscious awareness most of the time, they also discussed ways in which healing occurred through the body alone. Interpersonal group therapy and psychodynamic approaches both endorse the importance of viscerally felt experiences and strong immediate emotional experiencing in creating change (McWilliams, 2004; Yalom & Leczc, 2005). In many ways, this is similar to body-oriented psychotherapy’s focus on emotional reactions. However, participants departed from traditional talk therapy by suggesting that it is not always necessary to verbalize experience to metabolize it, and by valuing affect and sensation over content-based discussion and reason.

First, both body-oriented psychotherapies and interpersonal group therapy use a here and now focus to help clients identify existing patterns and address them. Yalom and Leszcz (2005) suggest that verbal reflection of the interpersonal process concurrent with emotional experiences is a necessary ingredient in the change process. In contrast, most participants suggested that healing could occur through the body alone - verbalized, intellectually-based understanding was not always required. For instance, almost half of participants used grounding or body-oriented

practices at the beginning of group sessions to foster a more relaxed and open environment, and felt that it was not always necessary for clients to share their experiences of the exercises. Similarly, when participants noticed shortness of breath, physical tension, isolation, dissociation or emotional flooding, they would use the body as a way to give clients a new experience of something, and saw this as valuable without necessarily connecting it to clients' "stories." Body-oriented interventions designed to create a new regulating experiences were also used preemptively. For example, in situations of "enactments," therapists in this sample were more inclined to interrupt and correct rather than allowing the situation to play out and eventually be analyzed. The study's findings suggest that since healing was viewed as arising from body-based shifts, there was less of a reliance on verbal content. This finding contributes to the ongoing discussion in the field of interpersonal neurobiology and body-oriented psychotherapy that questions whether conceptual understanding and processing is necessary to create change (Allison, 1999; Boston Change Process Study Group, 2010).

Second, while participants also included verbal interventions and strove to help their clients arrive at conceptual understandings, they went about this in a unique way. Clinicians were uniquely focused on affect and sensation as ways to help clients create shifts in their lives. There was a sense that sensations and emotions allowed clients to access change at a conceptual level. The body-oriented literature conceptualizes lasting change as occurring only through "emotional experiential" learning and mindfulness arising from "bodily feeling" and "body awareness" (Levin, 2010, p. 307, 338, 345). Grossinger (1998) offers a picture of how experiences accessed through sensation are then integrated through the support of the psychotherapeutic relationship where "the authenticity of emotion between the parties allows? mutually discovered insights to become part of the patient's inner landscape" (p. 98).

A common theme in the body-oriented psychotherapy literature is that an effective therapeutic style is characterized by being “bottom-up,” emotionally-based and sensation-oriented rather than “top-down,” i.e., conceptually and intellectually-oriented (Ogden, Minton & Pain, 2006; Levine, 1997, Gendlin, 1996). Participants certainly saw value in this bottom-up approach. However, they did not hold as strong a position as much of the body-oriented literature, which is quite critical of talk therapy and its focus on achieving insight into clients’ stories. For instance, Grossinger (1998), a major proponent of the integration of psychoanalysis and somatotherapy, offers a common body-oriented critique of traditional talk therapy, saying that “when psychotherapy works, it is rarely because of the quality of verbalized insights... [which] remains on-again, off-again New Year's resolutions, difficult to apply in the heat of the battle” (p.97).

In summary, while participants in this sample were less critical of traditional talk therapy than some theorists in the body psychotherapy field, in that they valued the coupling of direct experiencing with conceptual insight and verbal expression, they did not believe it was always necessary. Instead they endorsed the sentiment articulated in the *Encyclopedia of Body-Oriented Psychotherapies* that, common to all body-oriented approaches, is the idea that “to effect a real and lasting change in a human psyche...you must work through the physical body” (Allison, 1999, p. 380). Participants’ emphasis on emotionally-focused experiential learning that occurs through the body alone departs from traditional group therapy and offers a new way of working, while still maintaining a connection to insight-oriented psychotherapy.

Impacts group experience. From the therapists' perspectives, working in the body-oriented way described in this study profoundly impacted the group experience. At its most fundamental level, using the body was seen as deepening and enlivening the therapeutic and the

interpersonal process. Therapists reported that compared with their experiences in talk therapy groups, using the body provided a means of surfacing a broader range of issues and introducing a greater degree of self-disclosure and authenticity into the group process on the part of both therapists and clients. Participants stated that they felt more in touch with their own experience, were able to be calmer and more effective as group leaders, and experienced a greater degree of connection to themselves and to others in the group by using the body. Participants were confident in the effectiveness of body-oriented approaches. They reported witnessing clients experience significant shifts in symptoms, affect, behavior, outlook and personality that they felt could not be as readily accomplished through talk therapy. They believed that body-oriented approaches provided a means of working that helped sustain them as therapists, while also equipping their clients with the skills to take care of themselves and promote ongoing transformation in their own lives. Although these findings reflect the experiences of a select group of body-oriented psychotherapists, the literature is beginning to offer empirical support for some of the claims, which can serve as a jumping off point for building an agenda for future research in the area.

Impacts therapist experience. Participants found that integrating the body into their groups helped them enjoy the work and manage their stress more effectively. The finding that working with the body sustains therapists professionally is supported in the literature. For instance, Foster's (2001) empirical dissertation found that the use of body awareness by therapists to manage countertransference was related to lower rates of vicarious traumatization. Similarly, Leitch's (2007) study focused on how Somatic Experiencing and the Trauma Resiliency Model can be used as effective self-care strategies to prevent burnout and vicarious traumatization for social workers and service providers dealing with acute client trauma. Lastly,

therapist mindfulness, a measure that includes awareness and acceptance of body sensations, has been strongly linked to greater wellbeing and lower rates of burnout (May & O'Donovan, 2007).

In addition, participants believed that integrating the body into their work made them more effective therapists, and reported feeling more present, more relaxed, and more empathetic to their clients. There is some tentative evidence to support their claims. For instance, research has shown that therapists' practice of Mindfulness Based Stress Reduction techniques is connected to increases in self-reported empathy (Shapiro, Astin, Bishop & Cordova, 2005). A recent review of the literature examining the impact of mindfulness practices on health care providers' clinical outcomes suggests a more mixed picture, ranging from negligible to unambiguously positive impact (Escuriex, & Labbé, 2011). There is little to no literature exploring the impact of regular body practices, such as dance or personal body psychotherapy, on therapists' clinical outcomes. However, it can be surmised that if therapists' use of body-awareness and body-oriented practices is linked to decreased vicarious traumatization and increased therapist wellbeing, that in the long-term this could lead to better clinical outcomes. The connection between vicarious traumatization, compassion fatigue and lower level of client care is both intuitive and well established in the literature (Figley, 2002). To reiterate, the literature offers tentative support for study participants' claims that a body-oriented approach at once sustains therapists and improves their effectiveness with clients.

Towards a common theory. Underlying the approach described so far is a common theory that departs from traditional models of individual and group psychotherapy. At its most fundamental level, this theoretical understanding included a belief in the unity of body and mind and a desire to help clients create a greater degree of integration between the two in their lives. Therapists saw many of their clients as suffering from chronic disconnection between body and

mind—a problem they viewed as symptomatic of a larger societal trend. Thus, participants were interested in helping clients create more integration in their lives through experiencing and re-connecting to their whole self.

Participants' shared beliefs reflect the common philosophical foundations underlying diverse forms of body-oriented psychotherapy. Wholeness or a greater integration of mind and body is a concept frequently referenced as an important aim of body-oriented therapies (see Gestalt therapy, Allison, 1999, p. 380; Kabat-Zinn, 2005). Similarly, a central tenet of body-oriented approaches is the non-duality of body and mind (Allison, 1999). The idea that experience is stored in the body extends from this belief in the unity of body and mind. As Hanlon Johnson (1998) states, “bodies are not separate machines, but expressions of a larger life” (p.6). Therapists believed that every experience occurs and is felt first and foremost in the body. Again, this is a common concept in the literature, where the “body is not simply the material receptacle of the mind...it is the medium through which we experience” (Allison, 1999, p. xxx). The body, mind, and emotions are therefore seen as being united in a constant state of reciprocal influence. *The Encyclopedia of Body-Oriented Psychotherapies* summarizes the body-oriented perspective as follows: “The functioning of the body influences the functioning of the mind and the emotions. In like manner, thoughts and feelings have a profound and direct effect on the body” (Allison, 1999, p. xxx).

The belief that experience is stored in the body and influences the mind and emotions is a core reason that participants considered body-oriented work as being key to trauma treatment. A foundational belief of body-oriented trauma treatment is the idea that the body is a receptacle for unprocessed traumatic memories. One hallmark text on trauma summarized this concept in the title *The Body Remembers*. The following quotation explains how unconscious or repressed

memories are both stored in and expressed through the body: “Traumatic memories persist primarily as implicit, behavioral and somatic memories, and only secondarily as vague, over-generalized, fragmented, incomplete, and disorganized narratives” (van der Kolk, 2003, p. 176).

This study also revealed the common belief among participants that the body contributes authenticity to the therapeutic process. This concept of the body providing a more unmediated truth is frequently echoed in the theoretical literature. Diana Fosha (2005), the founder of Accelerated Experiential-Dynamic Psychotherapy, articulates a common view when she suggests that “deeply felt experiences of...truth...are shown to be seamlessly linked to the bodily rooted experience” (p. 513). Aposhyan (2004) adds that the quality of “authenticity” itself “flows out of our bodily selves” (p. 50). This notion that the body provides access to a privileged sense of knowing is at times the basis for critique of the field. Hilgers (1995) criticized attempts to integrate body therapy and psychoanalysis as an unproductive intrusion on clients’ “intimate space,” arguing that the idea of “ultimate truths” residing in the body is overly idealistic (p.288). Still, participants articulated key ideas that form a common philosophical underpinning for diverse approaches to body-oriented psychotherapy and constitute a sharp departure from traditional group psychotherapy.

Debates in the Field

Findings from this study serve to outline ongoing debates among body-oriented practitioners and in the field of psychotherapy as a whole. To begin with, the question of how and when to use non-verbal versus verbal interventions arose among participants, highlighting a divide between body-oriented and traditional talk therapy practitioners. Additionally, the disagreement among participants on the issue of working to help clients titrate emotion versus aiming for catharsis is mirrored in the larger field. Similarly, participants were divided between

those who use or do not use touch in psychotherapy. Lastly, this study raises important questions about which clients may benefit from body-oriented approaches and what settings are most conducive to this form of treatment.

Speaking from the body. A key finding from this study is the fluid relationship participants had with verbal versus non-verbal interventions. Although participants believed in the power of healing through the body alone, or expressed confidence that clients could achieve healing through direct, non-verbal experience, they also felt that verbal and non-verbal experiences had a reciprocal relationship, and that clients could at times benefit from giving voice to their experiences. This idea of a complementary relationship between non-verbal and verbal interventions mirrors participants' interest in integrating body-oriented practices with more traditional talk therapy training, allowing them to blend the best of both models. These approaches acknowledge that each intervention serves a unique but important purpose. Supporting this view, Grand (1997), editor of *Body in Psychotherapy*, advocates "a somatic understanding of psychodynamics" (p. 171). Weighing in on the verbal versus non-verbal debate, Grand suggests that language should be used "as a building structure" to "help form possibilities" in psychoanalysis; he warns, however, that it can also be misused as a tool of "deception and avoidance" in order to "move away from the immediacy" of present moment pain (Grand, personal communication, June 1st, 2011). Similarly, Sensorimotor Psychotherapy emphasizes that body-based interventions should be integrated with cognitive and dynamic therapeutic approaches to create the most lasting therapeutic change for trauma survivors.

However, a number of seminal theorists in the body-oriented psychotherapy movement are more critical of the traditional emphasis on verbal processing in talk therapy, which they view as being in opposition to direct forms of experiencing that may more effectively promote

change. For instance, Gendlin (1996) writes about the “dead end unchanging feelings” that can characterize traditional psychotherapy where therapists “go right on talking,” failing to notice and pursue non-verbal cues or capitalize on ways that patients experience non-intellectual and visceral opening to new possibilities (p. 12). Similarly, van der Kolk, a controversial but respected expert in the neurobiology of trauma, said of his initial motivation toward body-oriented psychotherapy: “it was pretty obvious that as long as people just sat and moved their tongues around, there wasn’t enough real change” (Wylie, 2004, p. 34). Levine (2010), another trauma theorist and the founder of Somatic Experiencing, refers to the “Merry-Go-Round of Therapy” where therapists mistakenly equate insight, understanding and talk, with change, despite the fact that they “frequently have little relationship to one another” (p.308). This study's findings suggest that the somewhat dogmatic approaches of body-oriented therapies concerning talk psychotherapy becomes more nuanced for practitioners on the ground, the majority of whom recognized the strengths of both approaches and used them in a fluid and non-conflicting way.

This study demonstrates in many ways that clinicians on the ground transcend traditional distinctions between verbal and non-verbal approaches to therapy. This complication is furthered and supported by Stern (1983), a psychoanalyst who does not explicitly discuss working with the body, but introduced the idea of “unformulated experience,” or that which can not yet be put into words. Stern acknowledges the “depth, resonance, power, and nuance” associated with non-verbal experiences of self, and advocates for respecting experiences that “cannot and should not be...a verbally articulated thing at all,” since clients cannot be “forced to translate the untranslatable” (p. 221). Stern places equal value on that which can be conveyed verbally and that which can only be felt or sensed in the therapist-client relationship. Stern (2002) suggests that even therapy that uses only verbal non-body oriented interventions can still

communicate and activate the experiential non-verbal change suggested by Gendlin.

Additionally, it is important to note that many mental health clinicians who do not utilize body-based interventions, per se, still pay close attention to facial, voice, and body communications and place importance on the non-verbal communications that take place between therapist and client (McWilliams, 2004). This study's findings suggest that the development of integrative models that combine body-oriented practices with talk therapy approaches may better represent how many group therapists are actually utilizing body-oriented practices in the field.

Titration versus catharsis. Clinicians in this study whose body-oriented training focused on working with trauma erred on the side of a titrated approach, rather than seeking catharsis. By contrast, other therapists in the sample believed that encouraging the full experiencing and release of pent-up emotions was key to healing, believing that clients had the capacity to tolerate and benefit from the cathartic experience.

The cathartic method can be traced back to Breuer and Freud, who suggested that pathological symptoms are the result of repressed emotions and traumatic memories that can be brought to consciousness and resolved through strong emotional releases. Once the emotional blockage or repressed memory was released through catharsis, patients would experience relief (Nichols & Efran, 1985). Although Freud later rejected the cathartic model in favor of the conflict theory, which suggested that disowned conflicts and repressed impulses were the source of symptoms, the legacy of the cathartic approach is present in many subsequent theories (Nichols & Efran, 1985). For instance, catharsis has long been championed as a way to release emotional blockages and resolve traumatic memories in Bioenergetic therapy, although recent trends in the field have emphasized the importance of fostering clients' emotional self-regulation and supporting the re-integration of the cathartic experience into patients' daily lives (Klopstech,

2005). Primal therapy, too, which has been acknowledged as a powerful method of reaching emotional release, has been centered on catharsis. However, it has been criticized as limited in its ability to create lasting change due to a lack of cognitive processing or integration of the cathartic experience (Yassky, 1979). In the trauma treatment field there are also some controversial approaches focusing on catharsis that have been criticized as re-traumatizing. For instance, “attachment therapy” is designed for children who have experienced trauma and uses physical interventions and sometimes overt aggression “to provoke the child to catharsis, ventilation of rage, or other sorts of acute emotional discharge” (Chaffin et al., 2006, p.79).

On the other hand, there are a number of body-oriented trauma treatment approaches such as Somatic Experiencing or Sensorimotor Psychotherapy that favor a titrated method of emotional expression. Theorists in these approaches are critical of cathartic expression without body awareness, seeing it as possibly constituting an addictive cycle of traumatic re-experiencing that does not lead to any lasting change (Levine, 2010). Instead, recent body-oriented approaches advocate for a measured approach to the work where an optimal amount of activation is maintained to instigate powerful change without overwhelming or re-traumatizing the client. There is also a strong emphasis on creating a new sense of empowerment, as well as providing resources to gain mastery over previously overwhelming experiences (Levine, 1997, 2010; Ogden, Minton, & Pain, 2006). In summary, while for the most part body-oriented clinicians work to ensure adequate emotional stability and support opportunities for integration before and after cathartic experiencing, there is a divide in the field on whether to emphasize catharsis or titration. Given that the body is seen as tool to provide access to a repressed or split-off emotion, further research is urgently needed to investigate the most therapeutic way to facilitate emotional expression and the potential dangers or contributions of each approach.

The use of touch. There was a sub-group of participants in this sample who used touch as a therapeutic intervention. These clinicians in particular spoke about the misunderstanding and prejudice they faced in a field that has traditionally been "phobic" of touch-based interventions. Additionally, perhaps as a sign of widespread hesitancy towards touch, the participants who used touch all worked in private practice and many of them suggested that they could not imagine doing the work they are currently doing in an agency setting.

This finding is reflected in the literature, where touch remains a controversial topic with fervent advocates and equally strong detractors, even within the body-psychotherapy field (Asheri, 2009; Young, 2007). Those who oppose the use of touch generally do so as a way to protect clients against boundary violations that feel unsafe and may be either sexually exploitative or interpreted as such (Zur, 2007). For clinicians who use touch, there is a sense that with careful countertransference examination, theoretical clarity, and clinical justification, touch can profoundly and uniquely support the healing process (Asheri, 2009; Young, 2007). Participants in this study who used touch emphasized the need for clear and strong clinician boundaries. The use of touch as a clinical intervention is clearly a subject where further training, an explicit theoretical rationale, and clear guidelines with attention to protecting against potential dangers, especially in regard to its application in a group setting, are needed.

Including every body? Participants generally suggested that anyone able to participate in a process group who was interested and capable of responding to their body experiences, would be able to benefit from a body-oriented process group. Given the option, participants tended to advocate for screening participants for their willingness and capacity to tolerate working in a body-oriented way before including them in a group. Some participants did not feel that ability to identify body experiences would be necessary at the outset since participants could

develop that skill in the group. This finding suggests that a certain amount of self-awareness, an interest in body-oriented interventions, and a lack of acuity are required in clients.

At the same time, participants suggested that body-oriented approaches could be beneficial for a broad range of clients provided that substantial adjustments or perhaps less-explicit use of the body was made. However, no consensus developed around the kinds of clients that would require significant modifications of the approach. Especially given the fact that managing these types of individual adaptations at the group level may be significantly more complicated, this lack of clarity is concerning.

Although most participants reported screening potential group members for several individual sessions, some participants reported that they were not able to because clients were assigned to their group by the agency. According to the American Group Psychotherapy Association (2007), pre-group screening and adequate preparation is seen as best practice across treatment settings, time duration, and theoretical models (Budman, Demby, Soldz, & Merry, 1996; Rutan & Stone, 2001; MacKenzie & Grabovac, 2001). An article published over ten years ago in the *Psychiatric Times* drew attention to how important adequate screening and pre-group preparation were in good clinical outcomes, and the increasing absence of either due to cost management pressures. This article suggested that increasingly, clients were automatically assigned to groups without first meeting with an individual therapist to evaluate their therapeutic needs and the appropriateness of a group modality (Fried Ellen, 1999).

Lack of advance screening and specific guidelines for inclusion in body-oriented groups is concerning partly because there is some evidence to suggest that in some cases body-oriented approaches can be particularly triggering. This concept is supported anecdotally by participants, one of whom recalled having several participants who were acutely symptomatic and assigned to

their trauma-focused group end up terminating prematurely after they became too triggered by the information provided about the neurological impacts of trauma. This participant felt that while they could work with these clients it would be necessary to construct a specific group geared toward clients in a relatively acute place. In addition, there is some literature about the risks of body-oriented psychotherapy, especially with regard to possible re-traumatization (Young, 2006). Leijssen (2006), an advocate of the integration of a body perspective in psychotherapy, warns that “body-oriented interventions can trigger strong affective or traumatic memories” and should be used “with caution, especially with vulnerable clients” (p.136).

Lack of clear guidelines around screening participants for body-oriented groups, especially at an agency level, may also reflect the fact that this approach is generally new at agencies. The average years of experience of participants working in agencies is nine, significantly less than the average of 26.6 years for participants in private practice. Additionally, the participants working in private practice were working for the most part with financially well-to-do clients. All participants in private practice, except one, reported that the vast majority of their clients are private pay. Furthermore, many of their group members came to them specifically because they were interested in a body-oriented approach, possibly implying these clients had readiness and prior knowledge about body-oriented approaches. In contrast, participants working at agencies tended to see more clients who paid low or no fee and thus had more limited treatment options. This lack of financial resources and/or access to a variety of therapy options may be something that is important to pay attention to in body-oriented groups. For example, one participant working at an agency suggested that the clients who tended to do the best in their body-oriented group and stay the longest were the ones who also had an individual therapist or extensive experiences with individual therapy before entering the group.

Yalom & Leszcz (2005) suggest that individual therapy concurrent with group therapy is especially indicated as supportive in cases where significant psychological issues are being stirred up in group for the client that may warrant more individualized attention.

It is therefore important to develop clearer guidelines regarding what level of acuity, presenting issue, current capacity for self-awareness and affect tolerance is appropriate for inclusion in body-oriented groups and what adjustments should be made to accommodate a wider range of clients. This need for screening and inclusion guidelines may be particularly pressing as more of these groups shift to an agency setting where clients are not as financially well-off or, in some settings, have less say about what group they are assigned to, and where opportunities for advance screening are limited for group leaders (Fried Ellen, 1999). This is not to say that body-oriented practices should only be used in settings predominated by clients with financial resources or low level acuity. In fact, the literature shows that body-oriented interventions have been used effectively with a wide range of symptom severity and presenting issues including anxiety (Berg, Sandell, & Sandahl, 2009; May, 2005), chronic medical concerns (Bohlmeijer et al., 2010), somatoform disorders (Röhricht, 2009), schizophrenia (Goertzel et al., 1965; May et al., 1963; Nitsun, Stapleton, & Bender, 1974; Röhricht, 2009; Röhricht, F., Papadopoulos, N., Suzuki, I., & Priebe, S., 2009; Röhricht & Priebe, 2006) and trauma (Leitch, 2007; Leitch, Vanslyke, & Allen, 2009; Miller & Leitch, 2010; Parker, Doctor, & Selvam, 2009). It is notable that each study cited above was conducted with participants with similar presenting issues and levels of acuity and thus interventions were specifically oriented toward meeting the needs of that population. Additionally, for the studies that concerned clients with more severe symptoms, inclusion criteria suggested that clients must be stable on psychiatric medications (Röhricht, F., Papadopoulos, N., Suzuki, I., & Priebe, S., 2009)

Another notable issue is that in this study the majority of clients seen were reported to be white and all of the group leaders were white. This reflects the predominately white body-oriented psychotherapy world (Ablack, 2009). That being said, existing studies exploring the efficacy of body-oriented group work have been conducted in a wide array of countries in Europe, Asia, the Middle East, Canada, and the United States and with clients from diverse socio-economic strata (Erfer & Ziv 2006; Gordon, Staples, Blyta, & Bytyqi, 2004; Gordon, Staples, Blyta, Bytyqi, & Wilson, 2008; Langmuir, Kirsh, and Classen, 2012; Leirvåg, Pedersen & Karterud, 2010; Liu et al., 2008; Nickel et. al, 2006; Payne, 2009; Staples, Abdel, and Gordon, 2011). Similarly, Ablack (2000) offers a compelling account of how body psychotherapy can be particularly tailored to the “black woman client” as well as offering some recommendations for practicing with a wide diversity of clients. One participant raised an important point about how cultural responsiveness in a body-oriented setting required new considerations, given that the meaning of body language and comfort with the body is culturally relative. Further research should build on these studies by exploring ways in which current body-oriented practice models reflect a particular cultural and economic context and identify adaptations that could make these approaches increasingly available and relevant to a broader range of client populations.

In many ways, the lack of clarity or consensus among participants about what client populations are best suited for body-oriented interventions is also reflected in the field of body-oriented theory (Shannon, 2002). This section argues that a lack of clear guidelines and screening procedures is a concerning aspect of this new model, particularly since the group format may make it more difficult to individually tailor the type of body-oriented interventions used. As this format is increasingly used in agency settings, there is a need to advocate for

agency support for adequate screening guidelines and develop groups that use the body in an individually relevant and culturally responsive way.

Strengths and Limitations of this Study

In many ways this sample was comprised of a diverse group of participants. They ranged in age from 29 to 70 years old and covered a cross-section of experience, including those who were relatively new to practice, with as little as two years of experience, all the way to expert therapists with 40 years of experience. Similarly, psychiatrists, MFTs, professional counselors, psychologists, and social workers were all represented in the sample. While two thirds of the sample was comprised of women, this is representative of the overrepresentation of women in general in the mental health field; in 2003, 79% of Social workers were estimated to be women (NASW, 2003). That being said, the lack of racial and ethnic diversity in the sample as well as the bias toward working with white private pay clients, as mentioned earlier, does limit the analysis offered in this study. The goal of this study is not to offer findings that are generalizable to other populations, but rather to paint a rich picture of the experience of these particular participants. Thus, this study is situated in a particular social, racial, and economic context.

Another limitation of this study is the lack of a member check. Although this was planned as part of the original design, it could not be completed due to the time constraints of this project. There were several common sub-themes that emerged in the course of analysis that had not been foreshadowed in the interview guide. Thus, there might have been other participants who would have agreed or disagreed with these themes, but since they did not mention the topic they were not included in the final counts of participants who affirmed each theme or sub-theme. Similarly, being able to review the findings with a sub-set of participants

and hear their feedback about how well the ideas fit their experience would no doubt have enriched the study.

This study contributes to the literature by exploring the experiences of clinicians who are integrating body-oriented practices into group psychotherapy. It helped to provide a view from the field of the process of integration, isolating many defining features of body-oriented psychotherapy across models. This discussion describes how this new model is both situated within, yet innovates upon, established approaches to group therapy. It describes the central interventions that are being used and explores their impact on the process of group psychotherapy from a clinician's perspective. It identified many of the most salient debates within body psychotherapy and explored the opportunities and challenges that body psychotherapy presents to the field as a whole. It also highlighted salient areas for future research and for the development of practice guidelines to continue to advance the field.

Need for guidelines

While the vast majority of participants integrated psycho-education, interpersonal process, and body psychotherapy, the actual process of integration was extremely varied, even amongst practitioners who had received the same type of body-oriented psychotherapy training. Participants' approaches to using the body in group are individualized, creative, and unique. Research has similarly pointed to the large differences in the way that mindfulness-based interventions are conceptualized and practiced across disciplines (Chiesa & Malinowski, 2011). This is an important finding because it directs us to the need for additional theoretical and practice-based guidelines around body-oriented psychotherapy groups. Past research has been focused on establishing the efficacy of body-oriented practices in group without first establishing a clear theoretical justification for the blending of group and body-oriented psychotherapy.

Further theoretical literature could build upon the common foundation of therapeutic practice described in this study. Once this theoretical justification is better established, empirical researchers can more effectively investigate the effects of a body-oriented approach to group psychotherapy and subsequently adapt and refine practice to best meet the needs of client populations. As highlighted throughout this chapter, certain areas merit particular attention for future theoretical and empirical inquiry: impacts on group cohesion, affect tolerance, direct emotional expression, access to the unconscious, deepening ability to be present and capacity for intimacy, and lastly, the body as a tool for knowing,” and self care for therapists.

Need for training

The development of literature would be a first step in addressing another important finding: the lack of body-oriented group training. While participants were able to effectively create body-oriented groups by adapting individually based body psychotherapy training, many of them spoke to the challenges of following an “uncharted path.” Furthermore, all participants spoke about the importance of their own personal experience and professional training in the body-oriented model they were practicing. Unfortunately, for the most part, due to lack of available models, they were not able to experience this in the group format. Further training is needed within body psychotherapy to address and support group practitioners. Similarly, in the group therapy field further training addressing both the theoretical basis and practical application of body-oriented practices in group settings is needed. Participants all stressed the importance of a professional support community, but this was lacking for many of them. The creation of specific training programs, consultation groups, and literature would fill this void.

Another area where there is an urgent need for training and support concerns the findings in this study and the literature that body resonance or somatic countertransference can be an

extremely useful tool to help clinicians navigate and gain a deeper understanding about the complexities of the client and group process. However, as Yalom (1985) stated of therapists' use of their self in group, "it is of the utmost importance that this instrument be as reliable and accurate as possible." Including one's own physical sensations and body resonance adds another layer to sift through in addition to one's emotions and fantasies about a client. Despite an increasing use of body resonance, at least by participants in this sample, there is little training geared toward helping clinicians navigate and utilize somatic countertransference. Further research could explore this topic further and training is needed to help therapists integrate this tool effectively in both group and individual therapy.

Summary

This chapter situates participants' use of the body within the broader fields of both body and traditional talk psychotherapy, suggesting ways that group therapists at once draw on common therapeutic principles and depart from them. As the chapter demonstrates, clinicians participating in this study rejected the sort of dogmatic approach that can be found in the body-oriented world as well as in traditional talk therapy. Instead, they blended techniques and theoretical stances, choosing interventions that they felt most effectively supported their clients' healing. Rather than viewing a body-focused, non-verbal approach as a replacement for traditional verbal interventions, participants felt that using the body enriched common therapeutic tasks. Indeed, many non-body oriented group psychotherapists will likely identify with at least some of the therapeutic principles offered in this integrative model, and possibly the interventions as well. This is because the described model not only provides a new way of working in group, but also creates a framework for any group therapist to consciously and skillfully receive and make use of bodily communications.

This study as a whole serves to broaden the knowledge base about the process of integrating body-oriented practices and group psychotherapy. It also establishes common body-oriented theoretical principles, as well as a clear picture of how, when, and why participants integrate the body into the therapeutic process. Additionally, the study shows that therapists generally agree that the body can be used to deepen and enliven the group process. Despite all of this, however, and despite therapists' enthusiasm about this new approach, there is a striking gap in training opportunities and there is little empirical or theoretical literature to unify the field. Participants lamented the absence of professional networks and the shortage of knowledgeable supervisors to help guide them in their work and training. Moreover, the study revealed a concerning lack of consensus regarding screening procedures, as well as theoretical disagreement about the clinically appropriate uses of touch, titration, and catharsis. Further research and the development of clinical guidelines are urgently needed to provide support to current practitioners as well as to broaden knowledge about this promising new model.

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Appendix A

Informed Consent Form

Dear Participant,

My name is Alissa Kimmell. I am a master's student at Smith College School for Social Work. I am conducting a research study exploring how clinicians integrate somatic/body-oriented practices into therapy groups with an interpersonal process component. The use of body-oriented practices in group psychotherapy is a promising intervention, yet neglected in clinical research. This study is intended to: 1.) explore how clinicians develop an interest in somatic practices and begin to integrate them in group psychotherapy 2) describe how somatic practices are being integrated into group psychotherapy 3) identify relevant considerations in the process of integrating somatic practices in group psychotherapy, and 4) explore the impact of integrating somatic practices on the group process from a clinician's perspective. The data from this study will be used for my master's thesis in Social Work and potentially for presentations and professional publications.

You have been asked to participate in this study because you are a licensed mental health clinician over the age of 18 who has facilitated at least one psychotherapy group that regularly integrates body-oriented practices in the last year and you have indicated that you are comfortable being interviewed in English.

Your participation in this study will involve an audiotaped interview that will be conducted by telephone, in which you will be asked to share your experience as a group leader who integrates body-oriented practices into their work. The initial interview will range between 40 minutes and 1 hour and will be arranged at a time that is convenient for you. The interview will be transcribed by myself or by a research assistant who has signed an agreement to hold the information that you share in the strictest confidence. Once I begin to work with the information you have shared I may contact you by email to clarify specific questions or ask you to participate in a follow-up interview to give you the opportunity to comment on the themes that I have developed based on participant interviews. You may decline any further contact and the follow-up interview, which would last no longer than 40 minutes, if you so choose. I will also ask you to respond to a brief demographic survey regarding your background and prior training before the initial interview so that I can describe the population of people choosing to participate in the study as a group. In this survey, I will ask about basic demographic information as well as information about the type of population and setting you practice with.

If you choose to participate in this study, there are few risks to you. You will be asked to recall and discuss details of current and past groups, which might raise feelings about group experiences that were challenging or unproductive. Although no financial compensation is being offered for your participation, you may also benefit from the study in a number of ways. The process of reflecting on your experiences may generate increased insight that could positively impact your work as well as helping you to recall rewarding experiences in group. You may also gain satisfaction from having the opportunity to share your clinical experience and contribute to building knowledge about the new area of incorporating somatic practices into group psychotherapy.

I will keep both your identity and any information that you provide to me confidential. Only myself, and a research assistant who will help with transcription will have access to the original tapes or transcripts and only after signing a confidentiality agreement. Pseudonyms will be used to disguise your identity and transcripts will be stripped of identifying information before being shared with other researchers such as my advisor who may assist with the process of data analysis.

Individual quotations or vignettes used in presenting the results of the research will be carefully disguised. All other data will be presented in aggregate form. I ask that you do not disclose the identity of any individual clients during the interview to protect their confidentiality. All study data will be stored in a secure location for a period of up to three years as required by federal guidelines. After that time, all data will be destroyed unless it is needed for professional publication in which case it will continue to be kept secure and destroyed once it is no longer needed.

Your participation in this study is entirely voluntary. You may choose not to answer any specific question. You will also be able to withdraw from the study without repercussions at any time during the interview and have all data related to you destroyed. You may also choose to have all your data removed from the study until one month from the date of your interview, at which point your data will be so woven into the larger analysis that it will be impossible to extricate.

If you have any further questions about this study, please feel free to contact me via email _____@smith.edu or phone at (###) ###-####. Thank you for your time and participation in this study. If you have any concerns about any aspect of this study or your rights, please contact me via email _____@smith.edu or you may also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant _____ Date: _____

Signature of Researcher: _____ Date: _____

Researcher's Contact:

Alissa Kimmell
Master's student at Smith College School for Social Work

(###) ###-####

Appendix B

Recruitment Letter to Individuals

Hello,

My name is Alissa Kimmell and I am a graduate student at Smith College School for Social Work. I am conducting a study for my master's thesis on how therapists utilize somatic, or body-oriented practices in therapy groups with an interpersonal process component. The use of body-oriented practices in group psychotherapy is a promising intervention, yet neglected in clinical research. By participating in this study you will contribute to developing knowledge on the role, impact, and issues related to the integration of body-oriented practices in group psychotherapy.

In order to learn more about this topic, I am seeking to interview licensed mental health clinicians who have integrated somatic practices into group psychotherapy over the last year. The focus is on groups with an interpersonal process component as opposed to peer support groups or groups that are primarily psycho-educational in nature. Although there is little current research in the area, clinicians themselves are developing the field by drawing on the body as a resource in group psychotherapy. If you or someone you know who may be interested in sharing their experiences of attending to the body in their group therapy practice, please contact me by phone or email to learn about the study or to schedule a telephone interview. The interview will take between 40 minutes and an hour and can be conducted at whatever time may be most convenient to you.

Thank you very much for your help in furthering this important study!

Alissa Kimmell
Master's student at Smith College School for Social Work

@smith.edu
(###) ###-####

Appendix D

Recruitment Flyer

Participants Needed for Research Study on Body-Oriented/Somatic Practices in Group Psychotherapy

I am a graduate student seeking volunteers to participate in a research project examining how therapists integrate somatic/body-oriented practices in group psychotherapy. I am writing a master's thesis on this promising therapeutic integration that has been neglected by clinical research.

- Are you a licensed mental health clinician?
- Do you (or have you in the last year) run group[s] with interpersonal process components?
- Do you regularly utilize somatic or body-oriented interventions or do you regularly attend to the body in your group[s]?

Are you interested in participating in an interview in which you would have an opportunity to reflect on your own practice and contribute to research working towards building an expanded notion of the body as a therapeutic resource in the mental health field?

I invite you to contact me, Alissa Kimmell, with more questions or to set up an interview _____@smith.edu or (###) ###-####. You may also contact my research advisor, Annemarie Gockel, Assistant Professor at Smith College School for Social Work, at (###) ###-#### or _____@smith.edu.

Appendix E
Screening Questionnaire

1. Are you a licensed mental health clinician?
2. Are you over the age of 18?
3. Are you comfortable conducting an interview in English?
4. In the past year, have you been the lead clinician in at least one therapy group with an interpersonal process component?

(If necessary, give examples- do you incorporate a focus on the group process and the interaction between group members as part of your approach to group therapy?)

5. If so, have you regularly attended to the body and/ or utilized somatic or body-oriented interventions in your group[s]?

(If necessary give examples- for example, do you incorporate exercises which ask group members to attend to where in their bodies they may experience a sensation or an emotion, or to notice changes in body posture or in chair positioning relative to the group as a whole?)

Appendix F

Interview Guide

Dear Participant,

This is a guide for the questions that I will ask during our interview. The questions are followed by probes that will be used as needed to further develop and guide the information provided. It might be helpful for you read through this guide before the interview in order to stimulate your thinking. The purpose of the interview is for me to get as rich a description as possible of how you conceptualize and integrate body-oriented/somatic practices in group. There may be other questions which you think are more relevant for me to include, in which case you will not be limited to these questions.

If you have any further questions about this form, do not hesitate to contact me at _____@smith.edu or (###) ###-####. You may also contact my research advisor with any questions, Annemarie Gockel, Assistant Professor at Smith College School for Social Work, at (###) ###-#### or _____@smith.edu.

1. What caused you to get interested in attending to the body or using somatic- practices in group?

a. What professional training or personal experiences did you have that prepared you to do this work?

2. How do you understand the role of the body in your therapeutic work?

- a. What language do you use to describe interventions which use the body?*
- b. Why do you think it is important to attend to the body?*

3. Could you describe what a typical group session looks like?

- a. If I were a client in your group, what would I be experiencing? What would you be asking me to do?*
- b. At what point in the group process do you integrate somatic practices?*
- c. How do you know that a particular intervention is useful for your group?*
- d. Do you assign homework? Are group members expected to use the body-oriented practices outside of the session?*

4. How does your integration of somatic practices fit with your prior group psychotherapy training and experience?

a. Do you experience any conflicts between the two approaches? If so, how you resolve them?

5. How has the integration of somatic practices changed your work in group?

- a. how is it different to facilitate a body-oriented group vs. a talk therapy group?*
- b. how does the introduction of somatic practices affect the group process and the stages of group development?*

- c. How does the use of somatic practices change your screening or assessment criteria and process?*
- d. How does the integration of somatic practices change how you work with conflict or create cohesion in the group?*
- f. How does the use of somatic practices change how you work with transference and countertransference in the group? Does it impact facilitator and client boundaries in the group setting?*

6. What professional challenges did you encounter, if any, as you started incorporating somatic practices into your groups?

a. *What professional supports helped you develop or overcome challenges in this new modality?*

7. Are there any dos and don'ts of integrating somatic practices into groups that you would like to pass on to new clinicians?

Closing Questions-

1. Are there any questions or topics that I didn't ask you about that you think would be important to explore?

2. What was doing this interview like for you?

3. I am still looking for more people to interview, do you know of anyone else running similar groups who might be interested in talking about their experiences? Would it be okay to indicate that you referred me?

Appendix G

Demographic Questionnaire

Dear participant,

Thank you for agreeing to participate in this study. I am asking all participants to provide some demographic information and background information about their training and current professional setting in order to be able to situate their experiences in context and assess the diversity of my sample. Please complete this survey and send it back through email, fax, or snail mail *before* your scheduled interview.

You have the right to not answer any of these questions and still participate in the interview and study. If you have any further questions about this form, do not hesitate to contact me at _____@smith.edu or (510) 394-2492. You may also contact my research advisor with any questions, Annemarie Gockel, Assistant Professor at Smith College School for Social Work, at (###) ###-#### or _____@smith.edu.

Thank you!

1. What is your age? _____
2. With what gender do you identify?
 - Male
 - Female
 - Other, please specify: _____
3. With what Race/Ethnicity do you identify?
 - African-American
 - Hispanic/Latino
 - American Indian/ Native American
 - Native Hawaiian or Other Pacific Islander
 - Other (please specify) _____
 - Asian
 - White
 - Multi-Racial
4. How many years have you been practicing as a mental health clinician? _____
5. What type of professional license do you hold? _____
6. What is the professional setting of the groups you run? (check as many as apply)
 - a. Inpatient
 - Outpatient
 - b. Community Health Clinic
 - Private practice
 - Day treatment program
 - Medical setting
 - Other (please specify) _____

7. What is the demographic makeup of the client population in your group?
Predominant racial/ethnic makeup (egs. mixed race groups, white, Latino)

Socioeconomic status (egs. private pay patients, Medicare, indigent)

Any particular diagnosis?

Gender? _____

8. Have you received any formal training in group therapy?

Yes No

9. If so, what type of group training?

Psychodynamic/Psychoanalytic

Interpersonal/Process Group

CBT

Behavioral

Gestalt

Humanistic/Experiential

Other (please specify)

10. Have you received any formal body-awareness, body-oriented or somatic practices training?

Yes No

11. If so, what type? _____

Appendix H

HSR approval letter



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

November 11, 2011

Allisa Kimmell

Dear Ali,

Your corrections are all good. This is an exciting study and I wish you the best of luck!

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.

Sincerely,

A handwritten signature in cursive script that reads 'David L. Burton'. The signature is written in black ink and is positioned above a horizontal line.

David L. Burton, MSW, PhD
Chair, Human Subjects Review Committee

CC: Annemarie Gockel, Research Advisor

Appendix I

Table 1

Participants' Demographic Information

		Respondents Total- 15
Age		
	20-29	1
	30-39	2
	40-49	3
	50-59	5
	60-69	3
	70-79	1
	Average Age	51.6 years
Gender		
	Male	5
	Female	10
Race/Ethnicity		
	White	15
Years Practiced		
	1-9	4
	10-19	4
	20-29	3
	30-39	2
	40 +	2
	Average	19.6
Professional License		
	LCSW	7
	Psychologist	4
	MFT	1
	LPC/LAC	2
	MD	1

Practice Setting (can choose more than one)

Private Practice Only	9
Agency Outpatient	6
Private Practice and Agency	3
Medical Setting	1
Community Health Clinic	2
Inpatient	1

Formal Group Training

Yes	12
No	2
Did not answer	1

Type of Group Training- (of 12 respondents, can choose more than one)

Interpersonal/Process	12
Psychodynamic	10
Humanistic/experiential	7
CBT	2
Gestalt	1
Other	4

Body-oriented Training

Yes	14
No	1

Body-Oriented Training

Body psychotherapy	13
Body work training	1
Somatic Experiencing	4
Rubinfeld Synergy	2
Massage Therapy	2
Yoga	2
EMDR	2
Other-	11
(Bioenergetic, Neo-Reichian, Hakomi, NIA, Focusing, Team Building, Mindfulness, Intuitive Eating)	

Appendix J

Table 2

Participants' Clients' Demographic Information

		Respondents Total- 15
Race/Ethnicity		
	Racially/Ethnically Diverse	5
	Some diversity, majority white	7
	White	3
Gender (can choose more than one)		
	All Male/Predominately Male	3
	All Female/Predominately Female	4
	Mixed Gender	8
	Transgender clients	1
	All Gay Men	1
Socioeconomic Status		
	Private Pay Only	6
	Private pay and sliding scale	4
	Insurance	5
	No (or very low) fee for service	4
	Across the spectrum	1
Primary Diagnosis		
	Anxiety/Depression	5
	PTSD	3
	Addiction	4
	Eating Disorder	2
	Mix	2
	"High functioning"	1
	Did not answer	1

Appendix K

Visual Representation of Themes

