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Embodied practice : do social work therapists explore client strengths as expressed in the lived experience of the body?

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Do Social Work Therapists Explore
Client Strengths as Expressed in the
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ABSTRACT

This study was undertaken to explore how seven social work therapists attend to client strengths, with an emphasis on embodied experience and embodied strengths where competency and resourcefulness are experienced. Besides asking questions about the obvious markers of a person's physical experience (hobbies, work, etc.), questions about the psychoanalytic concept of body-self and attributes of certain popularized mind/body approaches or techniques social work therapists may use were also posed.

Workers, whose practices are in community mental health, inpatient psychiatry, medical and private practice settings, provided experience-near narrative data. Major findings were workers' belief in the clinical value of using a strengths perspective. Workers also offered a variety of experiences of, and reasons for, the barriers they commonly encounter to using this approach. In terms of *embodied practice*, however, most could not identify more than a few techniques they use currently. Techniques identified, while important, were under-articulated, such as "being present" with clients. (Other language used for this concept was "being grounded" and "mindful" in session, as well as the approach of using "experiential" treatment modalities.) One significant finding was that most workers identified a *decreased use* of embodied practice over the course of their careers. On a positive note, a significant finding was a belief that working in the clients' *environment* greatly facilitates and enhances attending to client strengths, particularly embodied strengths.

EMBODIED PRACTICE: DO SOCIAL WORK THERAPISTS EXPLORE

CLIENT STRENGTHS AS EXPRESSED

IN THE LIVED EXPERIENCE OF THE BODY?

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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CHAPTER I

INTRODUCTION

Every day I walk myself into a state of well-being and walk away from every illness; I have walked myself into my best thoughts and I know of no thought so burdensome that one cannot walk away from it.
                              Soren Kierkegaard (1847)

Carl, a 52-year-old man, an inpatient in a psychiatric ward of a hospital, was admitted to the emergency room for detox. Carl is a veteran who has been previously diagnosed with PTSD. During his admission, one night at 3 A.M. he is making a puzzle in the lounge. A nurse on his ward tells Carl to stop working on the puzzle. He must go to his room, she says, sleep, and show up for group and individual sessions the following morning. Carl protests, but does what he's told. The next day, Carl sees the psychiatrist for med management, and then attends a group. Later, he complains to the social worker that he was not allowed to do one of the only things he enjoys and which, he reports, truly relaxes him.

Theresa, a 21-year-old woman who works part time in sales, is also a painter. She is in private therapy for severe social stressors and for help managing her bipolar disorder. Theresa is at home in her studio hard at work on several paintings for a small group show at a gallery. The days she works, her fingers, and occasionally her hair, have paint on them. She often wipes paint on her pants. The process of painting for the day ends with her pushing brushes into the tins with turpentine in them to get them clean. She stretches her own canvas for large pictures. She wonders, when she is at the gallery opening, will she see her therapist, whom she sent an invitation to and whom she really likes and trusts; will her therapist be there to witness the "embodied" client in an environment outside the therapy room?

Sandra, a 55-year-old woman with diabetes who stays in bed at home most of the time, is depressed. It is difficult for her husband to care for her; she argues with everything he tries to do. He reports to the social worker that he loves her, but she has changed for the worse. Sandra enjoys only one thing, he reports. She finds a way to drag herself down to the bingo parlor each week where she enjoys playing with her friends. Her husband describes her there as an imposing figure at the table, as though a queen, with not a hint of depression. In fact, he reports, Sandra's friends don't know what her life—or his life—is like at home. Why is

Sandra being treated only for her diabetes? Neither the social worker nor other clinicians involved in their care explore the meaning or reality of this lived experience in which Sandra exists among her bingo buddies. One might ask, who is the Sandra outside of her depression and her medical problems? One might also ask, what is it about Bingo that fully engages, even transforms, Sandra?

Michael, a boy of 14, is very disruptive at school. He is being reprimanded with a school suspension. The school psychologist is about to code Michael with a learning disability, lining him up for special ed. Michael's mother is upset about this process. She is confused and angry and feels that the school does not know some important things about her son. For example, she knows that Michael makes braided hemp necklaces in front of the TV at home—a hobby he enjoys and engages in for hours at a time. His mother is aware that at these times Michael is amiable, cooperative, and focused in ways that she feels the school does not see. Further complicating the situation, Michael's mother needs further education herself about the clinical practice of engaging kids with wandering thoughts like Michael in a sensorial, tactile activity to help them better focus. Additionally, Michael's music teacher has special knowledge about Michael's performance in his class, and has a similar take on him as his mother. Unfortunately, the music teacher, the parent, the school psychologist, and special ed teachers do not meet with one another at the same time. In fact, special ed teachers often do not attend special ed team meetings. How can they learn of Michael's self-integrating interests? Is there an awareness that they all should meet and share different perspectives and work as a team?

Joseph, a 71-year-old retired attorney, experienced a significant decline in his health when he stopped playing golf. He had played all his life, and worked his way to having a minus-two handicap. After his doctor told him to stop, he became atypically sedentary. He began to drink heavily. His life became punctuated by triple bypass operations and moody outbursts at his family. Was there anything about a lifetime of playing golf, beside the obvious benefits, that went unnoticed by Joseph or his caregivers? Has anyone explored the meaning this longstanding activity had in his life by what its loss has meant? ; or explored the psychoanalytic area of the body self, and what this may mean for Joseph? Why did Joseph not consciously experience the loss of golf, which he had played nearly every week of his adult life, as an intrapsychic event, not just of mind, but of body? According to one of his children, Joseph never seemed aware of his loss. How was it that Joseph could not verbalize/articulate/be conscious of the importance of this loss? How would awareness, if at all, have affected Joseph's quality of life?

Why do activities such as playing bingo, golf, being in a band, or making

necklaces often not get credited, and are so often not regarded, in psychotherapy? This

same question, as evidenced in the above vignettes, could be asked regarding any lived

experience outside of the psychotherapeutic frame. Our clients usually do not think to

bring their hobbies or work into the clinical setting, and we, as clinicians, often do not

explore those parts of our clients' lives. It is not expected, and it is not done. Our clients

do not, for example, sit in the therapist's presence with a piece of fabric on their lap

sewing a hem, or stand at a workbench joining sides of a box or polishing or sanding a

piece of metal. What might be the costs or limitations in excluding these activities from

the therapeutic frame? Does excluding such activities, or the clinician not expressing

genuine curiosity about them, signify a perceived disinterest on the part of social work in

general? In what ways does the hobby or the work as expressed outside of cognition, and

most notably in what Dennis Saleebey (1992) calls the "energies and orientations of the

human body" (p. 112) of the client get shunted aside, or are seen as irrelevant in working

with people? And why? This study hopes to explore these questions.

Saleebey (1992), most closely associated with the "strengths perspective" in

social work, argued that social workers, like all professionals, had separated the cognitive

and corporeal realms:

> The social work profession has become, in both theory and practice, disembodied.
> That is, attention to the energies and orientations of the human body is superficial,
> if it exists at all. This does not make social work unusual. The hegemony of
> science and the "technical/rationalist" (Schon, 1983, p. 21) professions over
> ordinary culture has been accomplished largely by disembodying individuals and
> groups of individuals, by separating the world of cognition from the corporeal
> world, and by identifying the body and its parts as targets of technical curiosity
> (Romanyshyn, 1986). In other words, in the world of bureaucracy, science, and
> the professions, the body has been all but ignored (p. 112)

Saleebey challenges us to reunite thoughts and action as expressed in the uses of

the body. In this thesis I hope to explore the extent to which contemporary therapists

explore client strengths in their practices, in particular strengths that are expressed in their

everyday "bodily" lives. And what is meant here by "bodily" lives can be taken to mean the lived experience of the body outside of the therapy room.

Examples of lived experience are endless, whether as solitary activities, or those that involve human interactions. Shopping, cooking, playing sports, going out dancing, maintaining tools for work or for the household, playing bingo, being with a pet or other animal—there is no limit to the possibilities. But of these activities, what goes unnoticed? What goes "unstoried"? Michael White (1990) in *Narrative Means to Therapeutic Ends* discusses the lived experience that may be lost or distorted because "dominant" stories often prevail in therapy. By extension, then, "as alternative stories become available to be performed, other 'sympathetic' and previously neglected aspects of the person's experience can be expressed and circulated" (p. 17). One intention of this study is to reveal—through the perspectives of clinical social workers—some of the neglected aspects of lived experience. Further, this study comes to focus on our clients' "bodily" experience, the lived body, and its neglected aspects.

So, why a focus on the body? Jaana Parviainen (1998) in *Bodies Moving and Moved* speaks to the essential beingness of the body. Parviainen writes, "The body becomes our 'point of view upon the world' instead of an object, since we experience the world as the body and through the body. Experiences and memories are not something we *have* [sic] they are also something we are" (p. 34). If we *are* our experiences and memory, rather than possessing them as egos, then we must bring the body into our practices. As this paper progresses, I will attempt to show how therapists explore client strengths as expressed in the lived experience of the body. To begin, I offer a brief outline

of the strengths perspective in social work (Early & GlenMaye, 2000; Saleebey, 1992, 2001; Weick, Rapp, & Kisthardt, 1989).

<div align="center">*The Strengths Perspective*</div>

The strengths perspective is built on the assumption that every individual, family, group and community has strengths and that focusing on these strengths leads to growth and overcoming difficulties. It is generally accepted that therapists who employ the strengths perspective consider their clients to be the best experts about what types of helping strategies will be effective or ineffective. Embedded in most of the preceding case vignettes are life-ways of the client in their lived experience, outside of the therapeutic frame. Mental health professionals often call these ways "coping strategies"; in a strength perspective, these strategies are viewed as strengths and personal resources about which the client knows best.

In Robert White's important paper, *Motivation Reconsidered: The Concept of Competence* (1959), he examines lived experience and strengths (though not in that language). Bringing Heinz Hartmann's (1955) ideas of conflict-free spheres of the ego (p. 308) into his formulation of competence, White merges the idea of ego structure (ego functions and defenses) with the "real and lived world." White calls these conflict-free areas of a person's life places of play or exploration. These "places" exist in times free of conflict and external stressors. Essentially, White is describing "free-time". During these lived moments of free-time a person learns how to gain mastery, to be empowered through effective action, or as White terms it, "effectance". In *Motivation Reconsidered*, White posits a new theory, *effectance motivation*. The motivation which spurs and feeds

essential learning grows from the exploration and play of effectance. Simply put, the feeling of this learning is that of being a cause. According to White, this ability to be a cause, to make something happen, is deeply satisfying and will "often sustain us so well in day-to-day actions. . ." (p. 323). The satisfaction of effectance for our clients is, of course, central to principles of strength-based practice.

The strengths perspective calls upon the therapist to make a strengths-based clinical assessment. What is the "real life" experience of our clients? What are the areas in a person's life that are both satisfying as well as empowering. In *Reflections and Controversy* (1994) Ann Hartman talks of empowering the client who has been disempowered by the expert-helping-system. Hartman writes, "We must listen to honor and validate our clients' expertise" (p. 27). Helping to empower our clients means making a strict accounting of strengths. The biopsychosocial approach, a sister to strength-based practice, requires social workers, as Dennis Saleebey asserts, to "search out and account for the considerable assets and resources that people have within and around them" (2001, p. 209). There is a wealth of practical and "local" knowledge to draw on from the strengths perspective, both general and specific. In terms of practice, work has been done about specific populations for their unique experience. Laird (1989) and others have brought a focus to womens' experience, and Parsons and Cox (1994) to older adults. Overarching theories used by the strengths perspective include the *Life Model of Social Work Practice* (1980) of Carel Germain and Alex Gitterman and the concepts of restorying and "local meanings" (Laird, 1995, p. 150) of Anderson & Goolishian (1988, 1992), Epson & White (1992), and Geertz (1986, 1989), to name a few.

As Robert White (1959) strongly implies in his paper on competence, the ability of the person to learn to become a cause, a creative problem solver, is done in a person's lived life.

A Focus on Lived Experience

Firstly, lived experience obviously is life; life is experienced primarily outside of the social work setting, whether at work, play, or in other areas of free time. Collecting bottles for refund, going to the library, making breakfast, sitting down to pay bills, folding laundry, driving a car, having sex, or any other activity one can think of, is an act of lived experience. Lived experience happens in the person's environment, in his or her "space." (Germain, 1979).

Regarding the strengths perspective, how can social workers tease out the strengths from the deficits, the positives from the problems of the person's lived experience? A friend, and clinical social worker of thirty years, describes a client, who is also schizophrenic, as having a life that is "mostly normal." Even though the client is extremely thought-disordered, the client still has friends and communicates and eats and appreciates a sunny day like everyone else, his therapist attests.

Families, groups, and communities also live in their own space. It is essential that a strength-based assessment is made for each entity. In *The Family in Space: Ecological Assessment,* Hartman and Laird (1983) offer a tool for ecological assessment and intervention, the eco map. By depicting the family in its environment (and in its lived experience) the eco map delineates real life resources and assets people have around them. The authors remind us, however, that "we have been in danger, in the family field,

of shifting in our assessment from an emphasis on the "sick" individual to one on "sick" families" (p. 157). Strengths based practice always challenges us to take care not to fall into this pit. A focus on lived experience trains our eye to look for clients strengths. The assessment and intervention tool of the eco map has been developed, and is used in social work, to effectively go outside of the deficit model. Only there can we look through windows of hope. This study seeks to help formulate new ways of seeing the person's resources, both external and internal, and this is where the body comes in.

"Embodying" Social Work

Much has been written about the body from the perspective of deficit, but little from the perspective of strength. One area (or modality) of social work practice that uses the body is adventure therapy (McDowell, 1999; Moga, 2004; Shaw, 2005). Studies in adventure-based therapy, however, tend not to regard the bodily experience, and particularly the client's body self (Krueger, 1992, 2001) which I will explore in depth in the next chapter. There are some exceptions but they are rare; for example Bonnie Scranton (2007) attests to the strengths of her participants, women who have problems with binge eating, but who also identify strengths through treatment (participation in the study). Another resource for this study is Dance/Movement Therapy (DMT). DMT is a very active area of relevant theory and practice. One of DMT's principles is that it frequently integrates the body with psychotherapy. DMT, however, is not a modality of social work, but rather springs from the expressive arts therapies. Other areas such as psychometrics and learning styles (Sprenger, 2003) and practical intelligence theory (Sternberg & Forsythe, 2000; Sternberg & Wagner, 1986) offer signs along the way. But

where do the paths of strengths, lived experience, and the body cross in *social work*?

Before examining the intersections of strengths, lived experience, and the body, one must meet two requirements. One requirement is that the lived experience of the body be verbalized in therapy. A discussion of this will follow in the last pages of this chapter, and indeed will be the primary focus of this study. But first the subject of power and control must be examined. Power and control are issues that our clients face in many ways, notwithstanding the body. In order to facilitate this examination, a number of carefully formulated questions (see Chapter Three) need to be asked. These questions are designed to elicit clinicians' views on the "dominant stories" or narratives of bodily experience and the "previously neglected aspects of the person's experience" (White, 1990, p. 17).

Jaana Parviainen's (1998) phenomenological study on the body which draws heavily on Merleau-Ponty's (1989) phenomenology of perception and its theory of the body, speaks to one of the difficulties of regarding bodily experience, whether in social work or other helping professions. One has to transfer narrative therapy and postmodern theory to the body to help examine the problem: that of dominant stories. "The body is shaped," Parviainen says, "by its society. Our bodily way of being, with habits and routines, carries on the values and morality of society" (p. 27). Dennis Saleebey's (1992) statement offered at the beginning of this chapter that society has separated "the world of cognition from the corporeal world" speaks to how "the body is shaped" in the world, and how the integration of body and mind threaten technical/rationalist paradigms. Here Parviainen, using the language of Foucault (1980), describes the "docile" body:

. . . the body is manipulated, shaped and trained by disciplinary technologies. The aim of these technologies, whatever their institutional form, school, prison, army, hospital, is to forge a docile body that may be subjected, used, transformed and improved. This is done through several related ways: through drills and training the body, through standardization of actions over time, and through the control of space. From its very first moments, the body is constructed and controlled by society. (p. 25)

Why is the meta-narrative of power and control important to social work . . . and therefore to this study? This narrative is important precisely because social work deals with people who are often oppressed by systems, often by the systems they depend on for survival. Michael White (1990), the well known social work theorist and practitioner, also cites the work of Foucault and the idea of the person-as-docile-body. White implies that the dominant stories elicited and/or told by helping systems create the actual "individual," the person who is a "vehicle of power" (p. 20). In my case vignettes at the beginning of this chapter one sees the effect of power and control: Carl protests against the hospital that refuses to let him work on his puzzle; Theresa wants her therapist to break the "rule of the 50-minute hour" to witness how she lives, not just in her bipolar experience, but in her world, her lived-world, of art. If Carl and Theresa do not resist the power of the helping system, in this case they become "vehicles of power."

This study hopes to focus away from pathology and toward windows of hope. Michael White (1990) writes that narratives "allow for lived experience to be construed in lived time and rendered eventful by being plotted into a story" (p. 127). The bodily lived experience (or embodied experience) this study attempts to access, however, is shaped by the internal world.

The other requirement to meet before researching the places where body, client strength, and lived experience intersect is to look at the *body self as lived.* In each of the

case vignettes in this chapter, glimpses of body self as lived can be seen. But the seeing is confused. As Parviainen (1998) says, "the social body is rarely reflected on . . . but rather lived in the body" (p. 27).

Still, there is hope to see. While different populations of people experience their bodies in unique ways, all can agree that every person has a body. In this way, each has a sense of self, which, as David Krueger (1989) writes, has "at its core a cohesive, distinct, and accurate body self" (*x*). Krueger sees the body self as a "foundation for self awareness" (2001, p. 244.) This lived body exists in every moment. This body is where, ultimately, we all live. Tor-Bjorn Hagglund in his article *The Inner Space of the Body Image* (1980)*,* refers to Erik Erikson's (1956) phrase, "a feeling of being at home in the body" (p. 257 [Erikson, p. 74]). Most people relate intuitively to this feeling. The feeling of being at home, Hagglund says, is an extension of sense of self (Lichtenberg, 1980) and a person's identity. The body, from the beginning of life to the end, is our foundation. This fact is experiential, "lived", but also supported by developmental theory. In his article, Hagglund reminds the reader that "[l]earning to speak and standing up to walk occur at approximately the same time" (p. 260). A question this study will not pursue directly, but is relevant to the formulation of this study is: How and for what reasons has walking (and embodiment) been divided from verbalized experience, and excluded from the general frame of psychotherapy if walking/talking are so developmentally intertwined?

In sum, using an exploratory and qualitative analysis of therapists' perceptions, my study hopes to provide a resource to other therapists—therapists of any theoretical or practice orientation—of the ways practitioners use, or perhaps fail to use or credit, their

clients' "embodied" strengths. The strengths perspective in social work helps the client become empowered and, as Saleebey says, to reunite thoughts and action as expressed in the uses of the body. An approach of *embodied practice* in social work would require discovering and crediting the lived experience of clients like Carl, mentioned in the preceding vignette, who was denied his puzzle making. Do we regard and credit Carl's experience? And Sandra who seems to disappear from view in her chronic symptoms of depression and diabetes—have we missed her experience outside the therapy room? Somewhere (in the bingo parlor) Sandra is well.

CHAPTER II

LITERATURE REVIEW

As of this writing, no research study has been found in the social work literature that directly addresses my research question: Do social work therapists explore client strengths as expressed in the lived experience of the body? And if they do, how do they? There is, of course, a wide range of literature written about people's experience of their bodies, and about the body. But looking for intersections in social work literature—or related literature from fields such as occupational therapy and adventure therapy—on clients' physical lived experience and actual experienced strengths has presented difficulties. Even search engines that draw on multiple databases have turned up little information on where body, social work, and strengths intersect.

There is a large amount of literature addressing many aspects of people's strengths and resources (nearly 3000 social work abstracts come up when "strengths perspective" is used as the keyword); very few bridge clients' embodied experience to what I will call "embodied practice" in social work, particularly in the area of client strengths. As expected, thousands of titles address the body (yoga to biomedical) and the mind (brain science to psychoanalysis), yet well-crafted studies—even theoretical writing—pulling body, mind, and strengths together, surprisingly, are not extant in the literature.

A minor aim of this study is to try to understand why the relationship between client embodied experience and clinical practice is *not* bridged in the literature. The

question, *Why so few intersections?* is important to this study, and this question will be addressed in this review of the literature. One answer as to why there are so few intersections is clearly that much study has been done on the disease and disorder/deficit model, not a strengths model; deficit is where clinical focus has been when the body is studied. What "works" for the client, by way of a strengths perspective, pales next to the issue of " what is wrong," and the reality of medical necessity—which of course is understandable.

The rationale for this study is based, in part, on Saleebey's (1992) statement that "the social work profession has become, in both theory and practice, disembodied" (p. 112). The literature that will be cited and examined in this chapter, while helpful in understanding what tools social workers use for making biopsychosocial strength-based assessments, is presented here to support this rationale. Because this study is about how social workers regard our clients' embodied strengths and experience, I will explore in the literature, and then with a sample of social work practitioners, what is the status of "embodied practice" currently.

As expected, opposite perspectives from the helping community about mind and body tend to prevail (Saleebey, 1992, 1997, 2001; Scranton, 2007). Psychiatry, psychology, and even social work place the intellect, its narratives and its biochemical brain functions, in a superior position to the body (Saleebey, 1992, 1997, 2001; Scranton, 2007) while physicians work with a bias toward the body.

This chapter will draw upon the social work literature, as well as literature from other helping fields, as Dennis Saleebey (2001) suggests, to help "search out and account for the considerable assets and resources that people have within and around them" (p.

209). A basic tenet of social work is to identify person's resources and strengths, to make holistic and critical accountings of a person's experience.

This review of the literature is organized into three sections, with classic studies or scholarly writings given where appropriate. These three major sections are: strengths, lived experience, and embodied practice. These three sections approximate the questions asked of participants during data collection, and are organized in the same order as the Interview Guide (see Appendix D). The first section on the strengths perspective in social work is broken into three subsections. The first is about strengths in general. In the second I briefly examine collective (non-personal) strengths, including the concepts of empowerment in practice and policy, as well as narrative ideas of empowerment. As reflected in the Interview Guide, issues of power and control are also discussed. In the third subsection of the section on strengths I examine strengths in the individual, including an in-depth look at Robert White's (1959) classic study on competence, a work that still underpins strengths-based social work practice today.

The second major section of the literature review, after strengths, is on *lived experience.* The concept of lived experience is used here as a bridge between the strengths perspective in social work and the third major section which is on embodied practice. The idea of lived experience helps create a platform for the rationale of including a person's body in social work theory and practice. Because a person's connection or lack of connection, literal and metaphorical, to their body is irrevocably embedded in lived experience, this connection must be included in the review of the literature. Because life experience is lived primarily away from the therapy room, the mental health facility, or hospital ward where social workers practice, issues of lived

experience have been treated deliberately in both the data collection as well as the literature.

The third and final section of the literature review is on embodied practice. This section examines the literature from a variety of sources, including mainline healthcare, the expressive arts, and studies in human movement. Social work meta-theory (postmodern and narrative) is also briefly presented through self psychology and psychoanalytic lenses. In this section, by honing in on some of the psychoanalytic literature, I hope to understand how, in Saleebey's (1992) words, the body, its "energies and orientations" (p. 112), is minimized. The title of this sub-section is *Body-Mind Split*. The centrality of the question *Why so few intersections?* will be emphasized in this section. I have also included a few paragraphs on the use of this nebulous and difficult language of "mind/body" theory and practice because it is so often referred to (used in the language) by helping professionals who seek to balance the realities of our clients' bodies and minds.

Relevant Literature Not Included

This study does not intend to measure a person's strengths. It simply assumes that we find them everywhere when we are not blinded by the light of medical necessity. There is much additional literature that could be brought to bear on the subject of client strengths/embodied strengths. First, the intersecting work of positive psychology (Seligman, 2002) —or what is "right" in people and which the authors propose transcends cultural divides—and Buddhist psychology (Germer, Segal & Fulton, 2005). These authors make the case in *Mindfulness and Psychotherapy* for drawing together positive

psychology and mindfulness (Buddhist) practices, so much about the body and the mind's shifting states. This book will probably be viewed by helping fields as a classic someday for its practice and theory applications to working with people outside, or in concert with, a medical model.

Leaving out literature from the field of drama therapy (Landy, 1994) and psychodrama (Moreno, 1940) may appear to some as a glaring omission from the section on embodied practice in the second half of this chapter. The creative and "embodied" modalities contained in these practices would require their own study.

Literature from the field of psychometrics (early and middle childhood education) while related, is beyond the cope of this study. Philips and Soltis's (1998) book *Perspectives on Learning* and Sprenger's (2003) *Differentiation through Learning Styles and Memory* are fine texts on the ways people best learn, from styles that are kinesthetic to auditory. In these and other titles, learning is described not just as best ways to memorize material, but how to most efficiently create lasting pathways in the brain. The reason why education research is mentioned in this chapter—though, sadly, beyond the scope of this study—is because work with children holds within it much that speaks to all populations and their positive abilities to learn healthy and sustainable coping mechanisms. Experiential learning (embodied learning), recognized by educators such as Dewey (1916), is behind what much of this study is about. Learning by doing, of course, involves the body. Experiential learning will be seen as at the center of many embodied practices, yet the field is too large to take on in this study. Additionally, theories of practical intelligence (Sternberg & Forsythe, 2000; Sternberg & Wagner, 1986) and the theory of *Multiple Intelligence* (Gardner, 1999; Kincheloe, 2004) that views the

individual as imbued with multiple, tacit intelligences speaks to how a person develops strengths.

Other areas that will not be covered, but certainly would be covered in a more complete treatment of the literature on client embodied experience and strengths, are insights from occupational therapy (OT) and physical therapy (PT). Much of the work of physical and occupational therapists, while somewhat strengths-based, addresses physical dysfunction, as social workers and other helping professionials treat biopsychosocial dysfunctions. For this reason, as well as limited space, I will leave them out of this review of the literature on social work client strengths as expressed in the lived experience of the body.

It should be mentioned here that occupational therapy, in some ways deeply rooted in the body, holds great promise for having its own strengths perspective. Evans (1987) in *The American Journal of Occupational Therapy*, defines occupation, or the work people do to make a living, as "the active or 'doing' process of a person engaged in goal-directed, intrinsically gratifying and culturally appropriate activity" (p. 627). Another source, Winston-Salem State University's Department of Occupational Therapy (2006), describes occupational therapists as "skilled professionals who use a holistic approach that includes attention to mind, body, and spirit." Looking at how occupational or physical therapists regard embodied experience/embodied strengths would make an interesting study on its own, as would an investigation as to why studies in psychometrics (the study of learning) essentially stops with children and adolescents.

Other literature that will not be covered concerns people's hobbies, sports, lovemaking, work, and home environments. In many genres of literature, from fiction to

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non fiction, gratifying and pleasurable activities are of course extant, though are beyond the scope of this study.

The Strengths Perspective

First, I offer a brief history of strengths in social work literature. Chapin (1995) said that the "importance of building on client strengths is a recurring philosophical and theoretical construct in social work literature" (p. 507) which dates back to Mary Richmond (1922) in her text on social casework. From Richmond, Chapin continues, this "building" advanced through, among others, Perlman's (1957) casework model, and Schwartz's (1971) interactional approach. More recently, the life model of social work (Germain & Gitterman, 1980) and Weick's (1986) health model brought even more focus to the strengths of human beings. More recently, a burst of literature through the period of the late 1980s and 1990s occurred with scholarly writings on client strengths, wisdom, and resources (Hartman & Laird, 1983; Laird, 1995; Saleebey, 1997; Wieck, Rapp, Sullivan, & Kirsthardt, 1989).

The idea of focusing on, and of using, people's strengths, began to appear in the social work literature in the early 1990's. Lee (2001), in her book *The Empowerment Approach to Social Work Practice,* credits Saleebey (1992) with having coined the term, the *"strengths perspective."* Much of this literature applies the strengths perspective in working with clients (Cowger*,* 1997; De Jong & Miller, 1995; Early & GlenMaye, 2000; GlenMaye, 1998; Poertner & Ronnau, 1992; Saleebey, 1992; 1997; 2001; Weick, 1992; Weick, Rapp, Sullivan, & Kisthardt, 1989)*.*

In essence, a strengths perspective urges social workers to regard or discover in

our clients what is right, what is working, or has worked for them in the past. This way of working with clients does not ignore the reality that serious symptoms and problems may exist—as some detractors of the strengths perspective have claimed (Lyons, 2005). The strengths perspective is supra-ordinate to regarding our clients' problems; it regards a person's resources and strengths in the context of our clients developing a better world. (In this "world" our client is not a "disordered individual.")

For many who employ the strengths perspective, it is practiced not just within an individual or family system, but within and with the community or wider society. The context for a strengths perspective is more complex than that, of course. In her book, *The Empowerment Approach to Social Work Practice: Building the Beloved Community,* Lee (2001) tells how people empower themselves. One of the underlying assumptions of the strengths perspective is that people have their own wisdom, their own resources, and lived knowledge about how to best invest their energies. Community and a person's unique, wise self, then, are the two main ingredients of a strengths perspective.

Data collection for this study hopes to elicit individual strengths as well as the person-in-environment, or community. Lee (2001) writes that using a strengths perspective with clients often entails understanding of a person's membership in the community, and that that membership "carries civic and moral strength with it. It also carries responsibility" (p. 360). Accessing and supporting personal agency in a wider context than the individual, Lee proposes, is a vital component to strengths-based practice. (Though I separate some of these concepts in this chapter, in practice they should not be separated.)

The literature on strengths consistently presents people as being the best experts

about their lives. But what are the obstacles (another aim of the Interview Guide for data collection) to regarding the client-as-expert? It is probably true that many social workers take account of a person's, family's, even a community's strengths? But there are barriers to maintaining this perspective. A wealth of scholarly writing and social work practice emerged during the period of the 1980s and into the 1990s, that developed constructionist, feminist, narrative, and other lenses. Scholars developing these perspectives argued that strengths are often obscured by helping systems that focus almost exclusively on deficits or problems. The strengths perspective, then, resists a problem-focused stance. Chapin (1995) writes:

> Effective social policy is built on the cornerstone of careful problem definition. This basic tenet has led to meticulous examination of social problems from the perspective of various stakeholders and has generated spirited debates about the objective existence of social problems (Chambers, 1993; Miller & Holstein, 1993). However, this problem-centered approach to policy formulation with its intense focus on problem definition and assessment has not been coupled with similar attention to assessment of the strengths of the people and environment that the policy targets. (p. 506)

From a slightly different perspective, Saleebey (1996), in the journal *Social Work,* agrees with Chapin's view; a person's weaknesses are emphasized:

> A conglomeration of businesses, professionals, institutions, and individuals— from medicine to the pharmaceutical industry, from the insurance industry to the media—assure the nation that everyone has a storehouse of vulnerabilities born of toxic experiences (usually occurring earlier in life) that put him or her at risk of everything from sex addiction to borderline personality disorder. (p. 297)

Above are some of the barriers to clinically regarding client strengths, and particularly client-as-expert.

If there is a rule of thumb for strength-based practice, it would be to look for what is right, not what is wrong. According to Lyons (2005), "Wherever there is a problem in

the client/family, look for the inherent strengths that can be used as a starting point for further growth . . ." (p. 3). Lyons (2005) suggests social workers create ". . . a valid inventory of positive characteristics that are the foundation of the work you will do together" (p. 3). According to Lyons, a problem, for example, could be that a child runs away from home; the corresponding strength could be that the child has "street smarts" or survival skills. A problem could be that the parents fight; a corresponding strength could be that the parents are still married or continue to communicate. A problem could be that the family resists agency intervention; a corresponding strength could be that the family believes in taking care of its own (Lyons, 2005). As I comment on later in the chapter, the perspectives on client problems alluded to above, are located in the life experiences of the family members, in the "life space" of the family.

But how do we get beyond words, and work towards change? Empowerment principles (and also narrative ideas of empowerment), which I will present in the following two sections, coax the practice of strength-based therapies into a larger strategy for change. Like a strengths perspective, theories of empowerment are partly developed to counter dominant cultural narratives. In social work, and other helping professions, change can only be measured in a relative sense. So we must ask, What are "problems?" and what are "non-problems?" Participants for this study were asked questions about how problems are defined in relation to their clients' strengths.

To help to understand the relative potentials for change we also must ask, How are the problems defined? Laird (1995) asks: "How are the problems defined, who is the client, and what constitutes change?" (p. 150). Who holds truth? Who claims truth? "How are assessment and intervention conceptualized?" asks Laird (1995, p.150). Laird

proposes that—in terms of empiricist science—there are *alternative ways of knowing*,

that this knowing must regard how "knowledge is perceived by the marginalized, the

dissidents, [and those who do not assume] a special hold on truth" (p. 152). Drawing on

narrative ideas (which I will present briefly following the next section), Laird also argues

that

> problems should not be located inside people or even in the relationships between
> people. People have problems because they and/or others have or are making
> sense of (or authoring) their life experiences in ways that inhibit their moving
> forward and consequently are disempowering. (p. 153)

How client problems are defined is crucial to how social workers proceed.

"Problems are a part of the human condition" (Early & GlenMaye, 2000). In fact, "living

as a problem-solving process has the effect of normalizing problems" (Early &

GlenMaye, 2000, p. 121). This idea of "normalizing problems" must be examined

critically. If problems are seen as within people, and are not externalized, a power

imbalance is set up between worker and client. Hartman (1994) writes, "As professionals

we are supposed to be experts, but the power in our expertise can disempower our clients

and thus subvert the goals of our profession" (p. 27).

The need, then, for having a strengths perspective in the helping professions, and

in social work in particular, is to some extent perceived as to *resist* the "problem-centered

approach to policy formulation with its intense focus on problem definition and

assessment [which has] not been coupled with similar attention to assessment of the

strengths of the people and environment that the policy targets" (Chapin, 1995, p. 506).

With this in mind, I will go on to ideas of empowerment.

Empowerment in Practice and Policy

As in strengths based practice, in an empowerment practice social workers seek to move away from focusing on pathology, instead focusing on opening up windows of hope. The strengths perspective, like empowerment practice, is a place from which to view hopeful possibilities. The concept, the view, of empowerment in people (Cowger, 1997; Cox & Parsons, 1994; Foucault, 1980; Germain & Gitterman, 1996; Hartman, 1994; Lee, 2001) does not, as Laird (1989) assures her reader, locate the problem inside the person or the family.

Yet, because knowledge is socially constructed, power often operates unconsciously, thus shutting down possibilities for hope and growth in more oppressed people. Freire (1973) calls this disguised, often hidden, feature of oppressive forces of culture, *mystification.* The tacit quality of power and knowledge-making solidifies the power of brokers and helpers alike (Foucault, 1980). A person is thus disempowered, as their oppression becomes internalized. (I will treat *individual* empowerment later.) Laird (1998) suggests that local knowledge (Geertz, 1983) possessed by a person and/or community may be suppressed due to lack of power and knowledge. She also suggests if we remain alert to how narratives (which idea I will present shortly) operate "in unjust and colonizing dominant discourses" (p. 113) then we can open up conversation and potentiate alternative narratives. The concept of being aware of privileging discourses (Power/knowledge) (Foucault, 1980) bridges gaps between policy and macro practice, helping social workers understand how a client may be disempowered by the helping system itself. (These ideas of personal and local narrative-telling will be further explicated in the section on narrative ideas of empowerment.)

What brought on an increase in ideas of empowerment practices and policies was the need of the times. These were times when large issues of social justice infused social work. Gitterman (in Simon, 2004) describes the 1980s and 1990s as a time when social workers saw an increased number of clients who were becoming more economically and socially powerless, as well as under more extreme personal stress, than in the three decades prior to that (*viii*). These profoundly vulnerable populations inspired new collaborative approaches (partnerships between worker and client), an emphasis on strengths rather than weaknesses, and a focus on individuals and their social environments (Levy, 1988). A disempowered person does not sense her or his feeling of efficacy, of competence in the world. So a new idea came from the period, that of "the client as expert" (Anderson & Goolishian, 1992). The client-as-expert idea has roots in anthropology (Geertz, 1983) and the concept of knowledge being local, not imposed or created from above or outside; the top down, paternalistic stance, for example, that social work took in the past (Simon, 2004).

Lee (2001), in *The Empowerment Approach to Social Work Practice,* lists principles of empowerment practice; through different lenses the social worker is assisted to *see* the experience of poor and oppressed people. Lenses include a feminist perspective, a global perspective, a historical view of oppression, and a critical perspective to view all of these lenses together. Another principle—and this ties into strengths perspective practice—is that "people empower themselves: social workers should assist" (p. 62).

Lee (2001) writes that many clients do not have support in their community. For those who do, she says, it is of course better to help clients locate others in their life space

to be with. For those who are least connected, we might ask, What are the resources in the community, in the family, that legitimately involve us, the workers? Workers who use an empowerment approach to social work practice might explore these places in a client's life. A good example of this is a community-based therapeutic change process called the *wraparound process* (http://cecp.air.org/ wraparound/intro.html, 2007). Empowerment practices emphasize group work (Friere, 1973; Lee, 2001). Another concept important for much of macro empowerment practice is that of "joining" with the client (Lee, 2001). The wraparound process uses these two concepts, group work and joining with the worker. Clients are known in this process as *consumers* (usually children and families). The Wraparound Process is designed to help communities develop a team to come up with individualized plans of care. The "team", however, can not be comprised of *more* than half professionals. This team, while it must have broad representation within a particular community (agencies, schools, cultural leaders, law enforcement, clergy, and family) must also be *identified* by the child and the family, the "consumer." A facilitator "does a thorough strengths discovery to identify the strengths, values, preferences, cultural identity, and norms of the child and family. *The wraparound process cannot be done without this step"* (http://cecp.air.org/ wraparound/intro.html, 2007). "No interventions," this website states, "are allowed in the plan that do not have matching child, family, and community strengths" (http://cecp.air.org/wraparound/intro.html, 2007).

The idea that people empower themselves is central to my study's question, Do social work therapists explore client strengths as expressed in the lived experience of the body? The concept of seeing the "client as expert" (Anderson & Goolishian, 1992)

continues to form connections to my study, and an important aspect of it, *embodied practice* (a term I will subsequently introduce). In embodied practice the ways in which the client's body, the client's physical experience, is credited and assessed, may be empowered, or disempowered (Foucault, 1980; Parviainen, 1998; White, 1990).

Moving away from collective (group) ideas about empowerment to individual ideas of empowerment, I will present concepts of narrative therapy that have been developed by family therapists.

Narrative Ideas of Empowerment

As mentioned earlier, the concepts of empowerment and strengths have been developed in social work over many decades. A related and very exciting set of ideas emerged in the family therapy field beginning in the 1980s. Narrative ideas were converging in the postmodern era from a wide number of disciplines and directions: anthropology, literary criticism, linguistics, philosophy, social constructionism, feminist theory, etc. (Anderson & Goolishian, 1988; Bruner, 1987; Geertz, 1983; Gergen, 1991; Gilligan, 1983; Foucault, 1980; Derrida, 1981). Family therapists began to develop the idea that self-defining narratives take place in a "social and local context involving conversation with significant others, including oneself" (Gergen & McNamee, 1992, p. 31). Family therapists in the 1980s, as mentioned above, helped create new avenues for the therapeutic relationship and narrative approaches (Diamond, 1996; Epston, 1986; Epston & Freeman, 1997; Hoffman, 1993; Morgan, 2000; Payne, 2006; Tomm, 1993; White, 1988, 1990, 1991). Women's realities were central to these ideas. The feminist principle of "authoring" one's own life, for example, ties in with principles of narrative

therapy. Carol Gilligan's (1982) classic work, *In a Different Voice,* speaks to the

importance of voicing women's realities, and restorying (though that is not her term)

women's lives. Developing our true, or an alternative, voice to help re-author our lives, if

nothing else, creates a starting place from which to go forward.

As in the strengths perspective as developed in social work which looks for what

is right in a client's life, in a narrative approach therapists help clients to develop more

empowering accounts of the experience that have handicapped their lives. What is unique

about narrative approaches is that lives are re-authored by the person. In the process of

re-authoring, therapists help clients to look for alternative stories and "sparkling

outcomes" (White & Epston, 1990). To restory one's life is a concept that challenges

social workers to generate, with the client, ever more possibilities.

A second central concept of narrative ideas of empowerment is, as mentioned in

the macro empowerment section, the idea of the client as expert. On the one hand, write

Gergen and McNamee (1992), our sense of self and identity is "fundamentally socially

and culturally embedded. On the other [hand], no single cultural script is all powerful" (p.

117). The person or family collaborates with helpers to express multiple ideas and

possibilities of their stories (Laird, 1998). Narrative approaches to empowerment allow

clients to shape his or her own self-concept.

> The person's story is allowed to float, and truly emerge from the person's life.
>
> Rather than instituting a dependency upon "expert knowledges," this therapy
> enables persons to arrive at a point where they can take recourse to certain
> alternative and "special" knowledges that they have resurrected and/or generated
> during the therapy. (Epston & White, 1992, p. 13)

The notion of "story" is vital in narrative meta-theory. Lynn Hoffman (1993) writes that

"there are no events that we can apprehend objectively; all we have are stories about these events" (pp. 105-106). Each telling of a story is only one possible version of that story. There is no one true account of the events of our lives (White and Epston, 1990). Instead, as White (1991) writes, "[t]he narrative metaphor proposes that persons live their lives as stories—that these stories are shaping of life, and that they have real, not imagined effects—and that stories provide the structure of life" (p. 143).

Well known to narrative-based social workers is an individual's ability to possess knowledge (and alternative knowledges). A person also possesses a personal knowledge of her or his sense of mastery and competence. The concept of individual strengths—a major theory for how a person gains a sense of efficacy in the world posited by Robert White in 1959—will be the subject of the next section.

The Individual and Strengths

In his classic study, *Motivation Reconsidered: The Concept of Competence* (1959), Robert White looks at the development of mastery and/or a sense of competence, in the individual. White's work with development of the self, in this paper, was with young children with implications for subsequent stages through adulthood. Robert White (1959) writes:

> According to Webster, competence means fitness or ability, and the suggested synonyms include capability, capacity, efficiency, proficiency, and skill. It is therefore a suitable word to describe such things as grasping and exploring, crawling and walking, attention and perception, language and thinking, manipulating the surroundings, all of which promote an effective—a competent— interaction with the environment. (pp. 317-318)

> Drawing on the work of Hendrick (1942) and Fenichel (1945), White talks about

the instinct to master and "an inborn drive to do and learn how to do" (Hendrick, 1942, p. 307). He also reports that Fenichel (1945) believed, based on animal studies, that mastering behavior is a way to reduce anxiety. On a positive note, Fenichel wrote that there is "a pleasure of enjoying one's abilities" (White, p. 307). In Freud's last year (1945), he questioned the degree to which mastery was a function of instinct and self preservation, but perhaps was related to pleasure seeking. While the concept or feeling of pleasure (White's phrase "a pleasure of enjoying one's abilities") is not treated explicitly in my study or in this literature review, pleasure often is "what is right, not what is wrong" with the person. Anna Freud (1952) pointed out soon after Freud's pleasure principle, writes White, that walking after the first few weeks in children serves "the child impartially in situations of conflict and those that are free from conflict" (p. 308). From here, White begins to work out, with the help of Heinz Hartmann's (1956) *Notes on the Reality Principle,* the idea that "adaptive skills developing in the conflict-free sphere may have a decisive influence on the handling of conflicts" (p. 308). In other words, learning without conflict clearly helps later in times of trouble, of conflict, when the person is at a disadvantage.

The idea that children best learn to deal with conflict in conflict-free spheres may seem counterintuitive to some parents for how our children best adapt/survive under stress. Hartmann's (1956) "conflict-free spheres" encompass pleasure, and a place of exploration and creativity without anxiety. (Later in this chapter, we will see how this relates to embodied practice, notably in the expressive arts therapies.) Psychotherapists see a client who is relaxed often as a client who can benefit from sometimes difficult learning moments. Relating this to White's theory of mastery motivation, his description

of Mittelmann's (1965) work with young children is telling: The motor urge in the second and third years of childhood "dominates" all other urges. But pleasure and newfound freedom influences these urges. White says, "The child makes tremendous efforts to learn to walk, and to walk well, and he exhibits joyous laughter as he attains these ends" (p. 311).

Competence, White says, is related to curiosity, manipulation, and mastery. White calls these "very vital common properties which have been lost from view amidst the strongly analytical tendencies that go with detailed research" (p. 318). Much of this research on motor and other urges up to that time had been done with laboratory animals. When Piaget (1952) came onto the scene during the early 1950s, publishing his work on his own children, *The Origin of Intelligence in Children,* White was given data to galvanize his work of developing a person's competence as a process of discovering the effects a person has on her or his environment. Of Piaget's findings, White writes, "The child's play can thus be viewed as serious business, though to him it is merely something that is interesting and fun to do" (p. 321). White further describes Piaget's findings: "[. . .] he shakes the chain more and more vigorously and laughs uproariously at the result obtained (p. 319)."[. . .] the child appears to be occupied with the agreeable task of developing an effective familiarity with his environment" (p.321).

Finally, in his classic paper, *Motivation Reconsidered*: *The Concept of Competence,* introduces the concept of effectance (efficacy, or being a cause in one's environment); he calls this "the motivational aspect of competence" (p. 321). "Some objection may be felt," he says, "to my introducing the word *competence* in connection with behavior that is so often playful" (p. 323). It is clear that, with the help of Hartmann

(1956), performing the work of competence in ways that are free of conflict enables the child (the person?) to be creative, to explore, and be curious.

Others after White's Study

Many have drawn on White's original work on competence and mastery motivation. Harmon, Morgan, and Maslin-Cole (1990), in their article *Mastery Motivation: Definition and Measurement*, define mastery motivation as "a psychological force that stimulates an individual to attempt independently, in a focused and persistent manner, to solve a problem or master a skill or task which is at least moderately challenging for him or her" (p. 318). Jennings, Martin, and Yarrow (1984) in their study, *Mastery Motivation and Cognitive Development: A Longitudinal Study from Infancy to 34 Years of Age*, assessed mastery motivation and cognitive functioning in 35 people from 1 to 32 years of age, finding differences in gender, but generally finding that developmental continuities over the lifespan can be expected.

Another study conducted by Spinath & Spinath (2005) shows how children's competency beliefs were moderately to strongly associated with their learning motivation. Others use White's (1959) concepts to help measure how school-age children perform (Aunola & Nurmi, 2005; Durick, Eccles, & Eccles, 2006; Eccles & Wigfield, 2002).

White's (1959) early work, along with Hartmann, Mittelmann, and others, compels social workers to ask: Do social workers, trained in a biopsychosocial approach to assessment, see the person *outside* of the problem-system, enjoying themselves, however they do? When do social workers see their clients free from conflict? It would

be worth looking back at White's (1959) work as a challenge to social work. Many

studies that borrow from White's concept on competence have helped create criteria for

school success or failure in children (Tietze, 1987) and one which showed how

competence beliefs in children actually decreased over the elementary school years

(Spinath & Spinath, 2005). Can social workers help to foster a person's own belief in

their feelings of efficacy? But that is a subject for another study.

How do social workers regard a client's strengths? Weick, Rapp, Sullivan, and

Kisthardt (1989) say, in their article in *Social Work,* ". . . social workers must use their

expertise in the service of capitalizing on client resources, talents, knowledge, and

motivation" (p. 351). "Social workers" they write, "must devise strict and accurate

accountings of clients' assets" (p. 352). Yet, it needs to be remembered that the

cataloguing of the assets and resources the authors speak about to some extent depends

on what values the social worker places on a person's "strengths." Examples of lived

experience are endless, whether as solitary activities, or those that involve human

interactions. Shopping, cooking, playing sports, going out dancing, maintaining tools for

work or for the household, playing bingo, being with a pet or other animal—there is no

limit to the possibilities. But of these activities, what goes unnoticed? What goes

"unstoried" (White, 1990)?

Lived Experience

As I said in the previous chapter, examples of lived experience are without limit.

Whether alone or in relationship with other persons, everything from shopping to dancing

to walking the dog are what a person does in everyday life. But of these activities, what

goes unnoticed by the social work therapist? What goes "unstoried"? Michael White

(1990) in *Narrative Means to Therapeutic Ends* discusses the lived experience that may

be lost or distorted because "dominant" stories often prevail in therapy. By extension,

then, "as alternative stories become available to be performed, other 'sympathetic' and

previously neglected aspects of the person's experience can be expressed and circulated"

(p. 17). The reason why I ask my participants in this study (data collection) what they

know of their clients outside of their private practice or agency setting is because the life

experience of their bodies does not come into the setting as much as cognitions. Further,

the neglect of a person's embodied experience—and notably their embodied strengths—

implies, for that person, the unimportance of that aspect of the person. A client, who is

often disempowered to begin with in the domains therapists typically attend to, may also

be disempowered-as-body. White (1990), citing the work of Foucault (1980), uses the

term "the person-as-docile-body". The phrase "docile body" implies the literal body, but

also the individual entity which can be, as White (1990) says, "acted upon." When

Seleebey (2001) talks about the importance of understanding the relationship between

individuals, families and groups and their environments, he says also that it is "crucial for

[social workers] to factor into this equation the compelling role of our bodies and our

status as organisms with a genetic history" (p. 15).

How do social workers "factor in" the client's body, or embodied experience? Do

we do that by asking what they do for work or for play? Is the work of psychotherapy

enhanced when we privilege our clients' competencies and actions of the body for which

they might be proud, or at minimum, help to sustain them? Engaging in a sport, playing

cards, going to soccer games with friends, vacuuming the carpet: These are activities that

lie outside of the therapeutic relationship; not only that, these activities in a person's lived experience are often adaptive and healthy.

What from the *outside world* of the client's (lived) experiences enters the consultation room? Questions for my study participants (clinical social workers) have been designed to explore this area. Many studies have been done on problems that make up the material of therapy. How many times have I heard client's concerns that they wash the dishes too much, or are fretfully worried how their house looks, or how upset they get when their child spills something? This behavior speaks to something, surely: a maladaptive coping mechanism; a mature defense against anxiety or low self esteem, or simply frustration. But the behavior—the simple activity of washing the dishes, trimming and watering houseplants, or grooming and petting a cat—is natural—and may be therapeutic for the client. How do we, as social workers, explore what *works* for our clients?

Michael White (1990) writes that narratives "allow for lived experience to be construed in lived time and rendered eventful by being plotted into a story" (p. 127). How do we locate strengths in our clients who may be caught in crisis or chronic problems? How do we find meaning in the alternative stories of our clients? What is the purpose of regarding "lived time", and what is a purpose of crediting "lived experience"? Crediting lived experience is a tool for social workers to view the client in his or her environment, one way of exploring potential of actual client strengths as are embodied in their everyday lives.

In *Human Behavior in the Social Environment,* Germain and Bloom (1999) talk about worksites and school in the client's environment. In their chapter, *Schools and*

Worksites as Special Contexts, the authors write, "social workers sometimes overlook the influence of work and the workplace on the lives of individuals, families, and communities" (p. 114). They talk about the connections between work and a sense of competence, self-esteem, and self direction…and not just for the individual; they talk about how work has important influences between family members, depending on the quality of the employment experience.

Work, play, and school, are some of the places where our clients exist outside of therapy. Hartman and Laird (1983) created an assessment tool, the *ecomap,* from their work with families which helps locate the individual or family its complex environment, in all the places the person lives. In using this creative world-view (which is also graphic), systems are treated, not just symptoms (pp. 157-158). Within these lived-systems the person or family also exists physically. Hartman and Laird say we might learn something from healers of other cultures about how to view our client's lives; they write that, in the words of Ndeti (1976):

> Such healers account for the powerful influences and interplay of an individual with his family, his culture and his environment. All these affect bodily states. Also [the healer] recognizes the fact that human beings are constituted of psychic and physical realities which are distinct but not separate. (n.p.)

From the point of view of ecologically-minded (Germain & Gitterman, 1980) social workers, "the complex interrelationships among physical, social, psychological, and cultural forces" (p. 158) are brought into focus. In their classic work, *The Life Model of Social Work,* Germain and Gitterman (1980) talk about how human beings need effective interaction with the environment. [This goes back to Robert White's (1959) classic paper on mastery and competence described earlier in this chapter.] In *The Life*

Model, the authors write:

> Repeated experiences in which this need [effective interaction with the environment] is satisfied leads to feelings of competence. While competence motivation may be covered over or dampened by harsh environments, it can be mobilized and supported by imaginative provisions of opportunities for action. And finally, effective coping requires willingness and ability to turn to the environment for information, resources, and support. (p. 101)

These "imaginative provisions of opportunities for action" are found in the environment of our clients. "In White's view," say Germain and Gitterman (1980) "successful adaptation requires: securing adequate information about the environment…" (p. 134). In this study on client embodied-strengths and experience, I explore how social workers access the client's environment and lived-life for these experiences.

Germain and Gitterman (1980) describe other "locales of service" (p. 60) than the consultation room, depending on the need. These are: "Home visits, office visits, and other sites such as school, work place, playground, library, senior citizen center, hospital waiting room, park bench, tenement stoop, automobile or any other point in the client's life space . . ." (p. 60). People's bodies exist in all these places, functioning in ways that often do not correspond to the problem-focus of their treatment.

Embodied practice is the subject of the next major section of this review of the literature. What embodied practice does is to pay attention to the essential physical experience of clients. What the literature shows is that where social work uses embodied practice the most are in the areas of residential treatment, adventure-based therapy, and "mindfulness" exercises. Embodied practice is simply clinical social work practice that includes a person's physical experience.

The next section presents embodied practices that do not share one terminology; I

will not attempt to classify them into groups. They share language and terminology from various spiritual traditions, western and eastern healing traditions, and fields of human motor movement from different parts of the world. Some embodied practices are described and operationalized with language that is from the psychoanalytic tradition. It is helpful, I have assumed, to give examples of what practices social workers, other mental health practitioners and body workers use that do regard embodied experience/embodied strengths.

After a short introduction to this next section, I start with an in-depth look at some of the classics of embodied practice, and one in particular, *Sensing, Feeling, Action,* by Bonnie Bainbridge Cohen (2003, revised). Following the "classic" section, I will review a sample of specific embodied practices. While reading this and other sections it would be useful to be mindful that much of the language is a conglomeration of terminologies; there are many connections to popularized areas of "mind/body" healing practices. Because these key words (in some combination together), "mind" and "body", are found in much of the literature, I will offer a short section called *A Brief Note on Language: Body-Mind, Mind/Body.* In a section called *Body-Mind Split* I discuss the duality of body and mind that is so prevalent in much of western culture. This section is offered to help understand, through the literature, why there are so few places where client strengths, the body, and social work theory and practice come together. A brief section on the contemporary activities of somatic practitioners completes this discussion.

Embodied Practice

It is, then, the social worker's obligation to help clients regard and experience the

body as an instrument of effective action and to give clients permission to take control of their body sense, image, and energy. (Saleebey, 1992, p. 115)

Saleebey, with roots in social work, implies the importance of fostering competence and strength in the person ("the body is an instrument of effective action"). Bartal and Ne'emen (2001) in *Movement, Awareness, and Creativity* describe their practice with clients as an attempt "to discover the healthy organic principles common to all human beings [. . .] and the basic expressive impulses inherent in humans and animals" (p. 5). While the language of "body/mind" workers like Bartal and Ne'eman ("basic", "expressive", "inherent") appears different from other helping professions like social work, it *is* the language of a strengths perspective. As stated earlier in this chapter, however, the terminology that has not been worked out from one practice to another makes communication, and certainly any idea of cross-pollination between the practices, problematic.

Where some agreement is found is through the work with psychiatric and physical illness (Ventling, 2002) —and not, unfortunately, with the concept of a person's embodied strengths. Body psychotherapists see the body as being the person (Ventling, 2002). Christa Ventling, a body psychotherapist and the editor of *Body Psychotherapy in Progressive and Chronic Disorders*, states that "chronically ill patients expect to be healed!" (p. 2). Ventling believes that patients ask no less from body-oriented psychotherapists than to see them to the other side of the irreversible damage that their bodies have experienced. Embodied practitioners, therefore, look past the patient's damaged body and mind, by seeing the person as not separate from their body; that work with the person attunes to the feeling of being damaged, rather than the project of fixing

the body as though it were separate from the person.

Body-oriented psychotherapy, stemming from the early work of Alexander Lowen (1975) and Wilhelm Reich (1933, 1961), is directed at "the biological, the concrete and energetic body with its tensions, armoring (the physical form of resistance), and frozen emotions, all of which [need] to be activated into life" (Ventling, 2002, p. 4). All fields, says Ventling, that treat body and mind together concur on certain techniques: touch, movement, and breathing (p. 4). While many body-oriented psychotherapies are based on westernized, psychodynamic and psychoanalytic principles, there are many more that are not typically associated with the term psychotherapy.

Some of the embodied practices with origins outside the dominant white, westernized culture in the United States might help us understand the existence of healing and natural wisdom that is the body. Yoga, for example, is becoming a technique in Western settings (Benson, 2006; Beta de Boer-van der Kolk, 2007; Scranton, 2007). Even shamanic healing is sometimes referenced in the western literature drawing on non-Western practices of embodied practice. Notably, this "minority" set of cultural activities practiced in the West is usually within the context of chronic mental and physical disorders; used where there is a problem.

Within Yoga and other practices, however, the will, and the intention, of the student of the practice of Yoga (the "patient" or "client" in the dominant culture's language) helps alter the person's being. (The word "being" implies an acceptance that *the body is the person*.) Volition enters into the psychosomatic domain. Conversely, if psychosomatic diseases really exist, then it is logical that psychosomatic health does, too (Green, Green, & Walters, 1979).

Embodied practice functions at a bodily, psychosomatic level; it also functions at other levels of human experience, namely lived experience, social experience, and self experience. Yet, people do not *think* on so many levels. As Parviainen (1998) says, "the social body is rarely reflected on . . . but rather lived in the body" (p. 27).

We understand that the lived experience of the client's body (Gallagher, 1995; Hartley, 1995; Lichtenberg, 1983) is, typically, not verbalized in psychotherapy (Krueger, 2001; Saleebey, 1992). Social workers and other mental health professionals tend to focus on the mind—on thoughts and cognitions—and on the emotions. Unless someone is clearly physically disabled, the body and its meanings and uses in the client's life, may be ignored. This fact must be emphasized to assess the value of embodied practice. *Do social work therapists explore client strengths as expressed in the lived experience of the body?* The exploration of embodied strengths by the therapist is, therefore, a crucial aspect of embodied practice.

Cohen, and Restorying the Body: A Classic Work

Cohen's (2003, revised) and others' (Aposhyan, 2004; Hartley, 1995; Reich, 1933, 1961) work, particularly Body-Mind Centering (Cohen, 2003, revised; Hartley, 1995) is supported by brain science (Carroll, 2004; Meekums, 2004) yet also defies scientific inquiry. Enigmatically, lines are blurred between researcher and the researched. The investigator is also the practitioner. This theme is seen throughout this second half of the literature, on embodied practice. Clients and their bodily lived experience are the data. And data is generated and collected in relationship with those who can facilitate the work. Is this a form of attunement, a concept so often described in social work practice classes? Does this idea of embodied attunement have implications for the strengths

perspective aspect of this study?

A form of restorying (my idea) of electro-chemical channels can occur. Ideas of client-as-expert are also transferable (my idea, attempting to find points of intersection) to the process of Body-Mind Centering (BMC). BMC uses a process called cellular repatterning which alters/transforms old body and mind patterns. To help explicate this repatterning process, Hartley (1995) offers a distinction that BMC practitioners make between mind as information and mind as "the immaterial substrata or flow of that information" (*xxvii*). The awareness of the practitioner, the "bodyworker" and the "intuitive mover", can regard a mind's information (mental functions) with the flow of that information. The awareness, not just of the practitioner, but of his or her own cellular being (and that of the client) is within each cell of our bodies. Each cell has consciousness.

In Susan Aposhyan's *Forward* to Cohen's (2003, revised) classic, *Sensing, Feeling, Action,* she asks Cohen, who began her career as an occupational therapist, about blockages in the body. Where do these blockages come from? Cohen answers: "It's mind watching itself" (*vii*). Is this the interrupted flow of information or energy that makes it difficult to regard client strengths as expressed in the lived experience of the body? Aposhyan's reaction to Cohen is: "This answer was the most direct and enigmatic I could imagine, and its meaning has continued to unfold for me over the years" (*vii*).

Hartley (1995), a BMC practitioner in England, a cohort of Cohen's from the beginning, in her first book *Wisdom of the Body Moving,* offers another piece of how "mind" works in the body. After first stating that it is "through movement that we first learn and establish a foundation for further growth" (p. 4), she writes, "[w]e begin this

current life, this step on our journey, as that single cell with its own unique and individual consciousness" (p. 4); we can experience other "states of being and perception [. . .] through awakening our awareness at a cellular level" (p. 4). "The movement patterns we experience is the 'mind' of that pattern or system, and is an expression of the integrated body-mind" (*xxvi*). The body (and brain) has many minds.

Citing Aposhyan and Hartley, I have highlighted Cohen's work, *Sensing, Feeling, Action,* because it is one of the few texts which (pictorially as well) regard people's lived experience and unique wisdom (strengths). *Sensing, Feeling, Action* is full of photographs of people from different cultures and economic classes. The photographs show people, not in session, but in natural positions and situations on the street, in neighborhoods, in their homes. Cohen includes text for each photograph describing specific diagnostic Body-Mind Centering work. Photographs of people in their environment rather than in therapy make a statement: that all people are integrated into their environment. Whatever their problems, they are wise—just *because* they are human animals.

Going back to language—words used in a strengths perspective—fundamentally, BMC and many other embodied practices, use these languages. The language used by embodied practitioners and theorists focuses on what is right, not what is wrong. Typically heard in the literature are words like "wisdom", "creativity", "consciousness", "healing", etc. By way of an analogy to narrative therapy, these are "alternative" words to problem-oriented words. These words can help to author "alternative stories" (White & Epston, 1990).

Similar Bodywork Studies

Besides Cohen's (2003, revised) *Sensing, Feeling, Action,* there are many serious theory and practice texts of embodied theory or practice worth mentioning, though I will only offer a few for review: One is also about BMC, *Wisdom of the Body Moving,* by Linda Hartley (1995). This book also draws from the same family of ideas and language as many expressive arts theorists. Authors of other classic works of embodied practice who have written seminal works on breathing, play, creativity, and body consciousness are: Don Hanlon Johnson (1995), Anna Freud (1963), Heinz Hartmann (1955), Wilhelm Reich (1933), Mabel Todd (1937), and Anna Wise (1981).

Within all these works, if not the connections of terminology, the connections of a strengths-based approach shine through. Hartley (1995) in *Wisdom of the Body Moving* says that balancing the two processes of sensing and feeling in activity helps us express our "personal truth" through "clear and artful form" (p. 270). This way of viewing people as unique; this idea is paralleled in Heinz Hartmann's (1955) paper on creativity and sublimation which talks about an individual's "signature" seen in an act of how a brush is moved across a canvass.

Specific Embodied Practices

Don Hanlon Johnson (1997) describes the mélange of embodied practices as having private languages and rigidities that still "share[d] an assumption that one's direct experience of his or her body [is] central in the healing process. That assumption set[s] these schools apart from medicine, physical therapy, mainstream psychotherapy, chiropractic, osteopathy, and traditional exercise technology" (p. 9).

"Embodied practice" is practice that, at a minimum, does more than augment

talking in the consultation or therapy room. I do not propose that social workers should use, if they don't already, these practices. Instead, I offer this sample because their underlying theories speak to embodied practice. This general overview is about practices that are additive to psychotherapy but by no means a complete account of what is out there. By presenting this sampling of embodied practices in a random order I merely imply that the good outcomes/best practices that all claim, are value laden. Also, by using a random approach, I attempt to resist my own biases. Embodied practices used by clinical social workers are scattered among these practices, and noted where applicable.

In this section on embodied practices, I will present these areas: expressive arts therapies, Body-Mind Centering, dance/movement therapy (DMT), adventure-based therapy, residential treatment, mindfulness-psychotherapy, and physical activity. I start with the largest field, expressive arts therapies, which encompasses many therapies, including art and music. For reasons stated at the beginning of this chapter, I have not included drama therapy and psycho drama which would be under the expressive arts therapy umbrella. All embodied practices presented below have connections to social work, some more, some less, with residential treatment at the top of the list.

Expressive arts therapy is a term that covers practices deeply developed over recent decades. Expressive arts therapy is an umbrella term for practices such as dance/movement therapy (DMT), art therapy, drama therapy, and music therapy. Each form of therapy claims good results with certain populations and disturbances.

One concept heard frequently in the arts therapies literature is that of "potential space" (Winnicott, 1971). Potential space is a theoretical space where unconscious and conscious co-exist. Congruent with expressive arts therapies, the potential space is also a

place of play and creativity. Meekums (2002), in her book on a *creative* approach to

psychotherapy, blends the work of Blatt (1991) and Stern (1997) by drawing on another

of Winnicott's principles that it is only in being creative that the individual discovers the

self (Meekums, 2002). Referring back to the work of Hartmann (1955), the idea of a

person having a signature (personal artistic stroke) and the potential for self-discovery

helps explain psychology's partnership with arts practices.

　　As with most good social work practice, art therapy seeks the client's strengths,

even when working with client deficits. Halprin (2004) emphasizes the need to look at

strengths. The concept of disease, which is manifested in symptoms that should be fixed,

is antithetical to art therapies, and to "living artfully." In *Principles and Practices of*

Expressive Arts Therapy (2004), Halprin writes that disease (suffering) is "mind and

spirit or soul in the act of expressing itself. In this view, disease is approached as a kind

of messenger who carries an important code to be deciphered. There is a saying, 'Don't

kill the messenger' " (pp. 148-49); in other words, eliminating symptoms of disease

should not necessarily be the main focus of treatment.

　　Treatments are simple, creative, and use a hands-on approach. In *Practical Art*

Therapy, Buchalter (2004) who works with people diagnosed as depressed, borderline,

bipolar, schizophrenic, and addicted describes a wide range of projects/techniques in

working with them—mostly using drawing and sculpting with various materials.

Buchalter writes that "this keeps the clients as well as myself motivated, energetic, and

involved. Experimentation," she continues, "allows for growth and new insights" (p. 7).

(The idea of keeping the *juices flowing* of the therapist is a recurring theme in the

expressive arts literature as well as in other embodied practices.)

Mindell (1985) describes six major 'channels' of experiencing and communicating: visual, auditory/verbal, movement, proprioception (body-felt sense), relationship, and world. Some expressive arts therapists apply these ideas. Mclelland (1993) in *The Art of Science with Clients: Beginning Collaborative Inquiry in Process Work, Art Therapy and Acute Stress,* describes the therapeutic technique used with clients of drawing impressions of trauma, allowing them to access some of Mindell's six *channels*, through the expression of the act itself. In *Principles and Practices of Expressive Arts Therapy,* Levine (2004) describes expressive arts therapies as "particularly suitable for the traditional practice of healing insofar as they always involve both a physical and a psychological dimension" (p. 17). McLelland describes how this is done by occupying Mindell's channels that are "not occupied" or "free" to be used. Important connections to support Mindell's ideas can be made by looking at the neurobiological trauma research of van der Kolk (1994) and Ogden and van der Kolk (2005).

As should become clear as I present the remaining embodied practices, there are many connections between them. For example, in *Movement, Awareness, and Creativity,* Bartal & Ne'eman (2001) talk about how the 'old' brain organizes the body on a level far deeper than can be achieved intellectually. What these practitioners describe are principles and terms, such as *deeper levels* and *deeper than intellectual,* that are used in general with embodied practices.

Dance/Movement Therapy (DMT) is tied, as with many of these embodied practices, to other similar, yet distinct, theories and practices: BMC and bioenergetics are

one example of this. Some of the ideas of Kohut (1971), specifically "mirroring" and "talent," crop up frequently in DMT and other expressive arts therapy literature. The concept of the body-self, referred to frequently in recent DMT doctoral dissertations (Parviainen, 1998: Pylvanainen, 2004), which I will treat in more depth in the last section of this chapter, also originates from psychoanalytic theorists. DMT diverges, however, from psychodynamic and other theory after taking what it needs. By this I mean, DMT stays clear of unnecessary complications of theory. As medical doctor and DMT practitioner Barbara Meekums (2002), in her book *Dance Movement Therapy: A Creative Psychotherapeutic Approach* says, much psychotherapeutic practice is discarded because "talking therapies . . . are mystifyingly full of jargon" (p. 13).

Meekums describes dance/movement therapy as having the body-mind relationship at its center. Theories that are most relevant, says Meekums, are nonverbal communication, interpersonal relationships, and personal change. The ideal form of movement, with both its physical and metaphorical potential "provides a unique medium through which clients can find expression, reach new interpretations and ultimately achieve a greater integration of their emotional and physical experience" (p. 17). Meekums writes that the change process is facilitated by body-mind repatterning (Cohen, 2003, revised) of relationships, emotions, cognitions, and behaviors; and, incidentally, she writes, is supported by empirical brain research (van der Kolk, 1994).

DMT began with Marion Chase in her work with patients in hospitals. Origins of DMT theory stem back to Laban Movement Analysis (LMA) and Bartenieff fundamentals. In the DMT session and/or theory, the effects of creative movement on brain functioning and/or structure as well as other biological functions, are literal,

palpable. Dance and performance, however, are not the goals of DMT. The term "dance" is deceiving. Psychomotor expressions witnessed in sessions often does not resemble dance. It may just be an extension of arms, the making of a fist, or a gesture with the head (Levy, 1988). In her book describing DMT, Levy (1988) describes this field as having clinical applications in mental health settings with many people, including those with eating disorders, victims of sexual abuse, hospitalized psychiatric patients, normal and neurotic adults, and brain injured or physically handicapped people.

Of note, DMT empowers a person's physical experience, as well as reconnects the person to their learned sense of efficacy ala White's (1959) theory of competence motivation. Many of the expressive arts practices (and embodied practices in general) function similarly by fostering these embodied strengths.

Body-Mind Centering (BMC) (Carroll, 2004; Cohen, 2003 revised; Hartley, 1995, 2004; Levy, 1988) is a practice of "how the mind is expressed through the body" (Cohen, 2004, p. 1). I have given extra space to this seminal theory and practice in pages above. The work was developed by Bonnie Bainbridge Cohen and others at The School for Body-Mind Centering which was founded by her in 1973. As with other embodied therapies, notably DMT, Body-Mind Centering shares much theory with other somatic psychology practices. Roz Carroll (2004) in a *Review of Body-Mind Psychotherapy* says of the work of Cohen, she "developed and expanded the discipline of experiential anatomy and movement repatterning" (p. 166).

Adventure-Based Therapy, oft cited in the social work literature, is treated in many qualitative studies (McDowell, 1999; Moga, 2004; Shaw, 2005). Adventure-based therapy originated in the 1920s with Outward Bound and education-experiential educator,

Kurt Hahn. Hahn, who believed classical education disregarded the age, stage of development, and interests of children, developed adventure therapy to be used in therapeutic settings. Hahn and others after him have shown the value of such important concepts as *disequilibrium* and *group development.*

The typical client is an at-risk youth. The work takes place in group settings with trained clinicians, in which physical tasks are performed, such as ropes courses and hiking difficult terrain for extended periods. All activities are designed to involve problem solving with others and often rely on the body to negotiate and solve these "problems." While there are many studies, many neglect to mention, or tend to minimize, the benefits of the physical experience as lived in the participants' lives. This may be due, in part, to the problem focus of the work. Adventure-based therapy has shown good results, with improvement in self regulation, confidence, relationships, problem solving, and individual empowerment (McDowell, 1999; Moga, 2004; Shaw, 2005). Again, research on adventure-based therapy looks more at relationships and problem solving than what I believe to be the deeper reality of non-cognitive body-self experience. In terms of client strengths, embodied experience/embodied strengths are not brought together with the domains of problem solving and social relationships.

Residential Treatment is another therapeutic environment which fits in with embodied practices. One study of residential treatment which comes very close to linking social work, embodied practice, and a strengths perspective, is Gilligan's (1999) *Enhancing the Resilience of Children and Young People in Public Care by Mentoring their Talents and Interests.* Gilligan, a senior lecturer in Social Work and head of Department of Social Studies, University of Dublin, works with children trying to "find a

more positive pathway through, and out of, life in care" (p. 185). Gilligan writes:

"Leisure time involvement may thus be one possible way of enhancing the resilience of

young people confronted with the adversities of life before, during and after care, and one

domain of functioning . . ." (p. 187). When one considers the domains in which a young

person in care may live out daily relationships, they include family, care setting, school,

peer group, neighborhood, workplace, and leisure time interests and activities. Each of

these domains is a source of potential relationships which may contribute positively to a

young person's progress while in care.

Gilligan (1999) focuses on the domain of leisure time interests and activities and

ways they might be used to help young people find a more positive pathway through, and

out of, life in care. Leisure time interests and activities may offer opportunities to

marginalized young people, such as those in care, to "join or re-join the mainstream"

(Smith & Carlson, 1997).

Gilligan (1999) then cites a range of actual examples of interests and activities

and related mentoring gathered from foster care givers, residential workers and social

workers in Ireland and Scotland. She goes on to consider the nature of adult roles in the

care process and argues for recognition of the mentoring role in relation to leisure

interests.

Physical Activity and Exercise is, of course, used in embodied practices. In

Scranton's (2007) study on the effects of group cycling with women who have eating

disorders, she cites "ample research that shows the positive impact of exercise on mood

and psychological well-being" (p. 43). Scranton (2007) also calls attention to the dualistic

approach which "encourages specialized attention to be paid to each part of the body and

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self, fostering separation rather than integration" (p. 10). Scranton credits Kate Hays

(1994, 1999), who focuses on walking and running with her clients, with maintaining a

"focus on the complex interplay of mind and body rather than colluding with their clients

to accept the competing, sometimes antagonistic mind/body split" (Scranton, p. 44).

Mindfulness and Psychotherapy is a practice based on Buddhist psychology and

meditation which is being used more and more in psychotherapy settings, including

social work practice (Germer, Segal, & Fulton, 2005; Linehan, 1993; Linehan, 1993). In

Germer et al.'s (2005) book *Mindfulness and Psychotherapy,* the authors describe a

process of knowing as simply seeing or feeling "where your attention is" (*xii*).

Mindfulness and psychotherapy practices include the body because they use breathing

techniques with meditation, exercise (p. 108) and general awareness of the body. As with

yoga, mindfulness practice directly experiences the body and its subtle sensations are

directly experienced (Daubenmier, 2005; Green, Green, & Walters, 1971). Germer

(2005) describe the techniques as "easily experienced by anyone" . . . "but cannot

adequately be described. Mindful awareness is mostly experiential and nonverbal (i.e.,

sensory, somatic, intuitive, emotional)" (*xii*). Best results are with anxiety disorders,

because, as Germer (2005) writes, "the anxious person is particularly determined to avoid

the discomfort of fear" (p. 152).

> A feared stimulus can be *external,* such as snakes (simple phobia), a mall
> (agoraphobia), or office parties (social phobia); or it can be *internal,* such as a
> racing heart (panic disorder) or blasphemous thinking (obsessive-compulsive
> disorder). (p. 152)

Germer explains that the patient's attention is turned "toward the fear as it is

happening, exploring in detail with increasing degrees of friendly acceptance" (p. 152).

This sounds a lot like restorying techniques used in narrative therapy coupled with physical awareness, as well as cognitive behavioral therapy.

Jon-Kabat Zinn's (1990, 1994, 2003) practices of mindfulness can be found in many a mental health center, as explicated in his classic book *Full Catastrophe Living: Using the Wisdom of your Body and Mind to Face Stress, Pain, and Illness* (1990). Kabat-Zinn (1994) says that meditation is not just something you do, but something you live. Breathing and meditation practices are at the heart of his work, which he attributes to the teachings of Buddhism. Ruth Baer (2003) writes that Kabat-Zinn's "interest in incorporating mindfulness into clinical interventions in medicine and psychology is growing" (p. 126).

Mindfulness and psychotherapy also have strong connections to "mind/body" interventions in health care, which according to the Benson-Henry Institute, "nearly half of all Americans used . . . in 2002" (Benson-Henry Institute, 2005). The relevance of mindfulness to this study, again, is that mindfulness accesses the simple reality of the body by bringing attention to the *present moment.* This is accomplished by using meditation, breathing, and other simple awareness techniques. The research of the Benson-Henry Institute for Mind Body Medicine (2006), finds that "over 35-million US adults use mind/body approaches for better health" (para. 2).

A Brief Note on Language: Body-Mind, Mind/Body

"Body-mind," "mind-body," "bodymind," "mind/body" represent different theories and practices. Other practices with these words embedded in them, such as

"psychophysiotherapy" and "body psychotherapy" also represent different theories and practices. What experienced BMC practitioner Hartley (1995), in her book about body-mind centering, means by "mind" is perhaps not what we expect; to Hartley, the mind has a direct effect on what we would normally think of as autonomic body functions: "It is the mind" she writes, "that stops the flow and a change of mind that will release it too. We simply follow the course of nature, the natural pathways and rhythms, with our mind, and the fluids will respond" (p. 270). Don Hanlon Johnson (1997) talks about the body not just as muscles, nerves, and fibers, but as "shapes and movements of cells" (p. 7). (Johnson is not a biologist but does work closely with psychobiologist George Solomon and psychoneuroendocrinologist Seymour Levine who, he writes in *Groundworks* (1997), helped "his entourage" recognize the scientific import of what they were doing with their embodiment practices.)

Body? Mind? Fluids? Movement? Shapes of cells? Meditation? Body armoring? Emotional regulation? Allostasis? The terminology across body-mind disciplines does not flow back and forth easily. While there are important distinctions and emphases, for the purpose of this study regarding client strengths as expressed in the lived-experience of the body, I will gather the numerous terms into one term: *body-mind.*

Still, it is not easy to settle on terms. While Herbert Benson (2000), a medical doctor who has done much research on chronic pain, uses the term *mind/body,* Cohen (2003, revised), occupational therapist and bodyworker, uses the term *body-mind.* The common thread joining these embodied practices, however, is that they work on multiple levels; they are operationalized in body and mind, and are never limited solely to the physical level or the intellectual level. While this multilevel approach could be

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generalized to all living phenomena, I will reduce the concept "multilevel" to be the inclusion criteria for the embodied practices of this review of the literature.

Some do not separate mind and body. Some view the body as fully integrated with mind; they believe that the concept of a duality is a false concept. Susan Aposhyan (2004) says that our fascination with "our prefrontal lobe's ability to envision, plan, and create" (p. 24) has limited our pursuits of what is possible, of what "*feels* right to the rest of our bodily selves" (p. 25). Aposhyan and many others see body as mind, mind as body.

The concept of the "body-mind split," as a cultural phenomenon and/or a phenomenon of our autonomous selves, deserves some examination. This examination starts with an overview of the assumed duality, then will look at body-self literature, including touch studies in the nursing profession. For this study, the purpose of presenting these two areas is to make connections between mind and body, as well as shed light on the phenomenon of embodied experience/embodied strengths. Below I offer a poem by Adrienne Rich (1973) as an example of intersections and levels of body-mind, as well as segue to the next section. Many of the embodied practices presented in this review of the literature access multiple levels of body-mind reality.

> *All night dreaming of a body*
> *space weighs on differently from mine*
> *We are making love in the street*
> *the traffic flows off from us*
> *pouring back like a sheet*
> *the asphalt stirs with tenderness*
> *there is no dismay*
> *We move together like underwater plants*
>
> *Over and over, starting to wake*

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I dive back to discover you
still whispering, touch me, we go on
streaming through the slow
citylight forest ocean
stirring our body hair

But this is the saying of a dream
on waking
I wish there were somewhere
actual we could stand
handing the power-glasses back and forth
looking at the earth, the wildwood
where the split began
                                        Adrienne Rich (1971)

Suggested in this single poem are a variety of ways mind and body can be integrated: the way of transcendence from physical to spiritual (or ephemeral); the way of human pleasure and togetherness; the use of metaphor; the blending of languages; confidence in our capacity to have vision; and being connected to the earth (or ground). The process in this poem of integrating body and mind—a process that works on multiple levels—is also a process, most interestingly, that leads us to the perception of a duality of body and mind.

Body-Mind Split

Overview, and Introduction to a Body Self

Conceptually, at least, the elements that are split off from one another are *body* and *mind*. Cohen (2003, revised) and others above have written about mind as being, roughly, consciousness in the body. Johnson (1997) and others have written about the body and its orientations in their work with the mind of the body. Cohen, Johnson, Hartley, Aposhyan, and others in the section on embodied practices agree on many

aspects of their work with the body and mind. However, in terms of psychotherapy, much of the literature on the body has been written by psychoanalytic thinkers, not body workers. In the ideas of these authors, we find some of the clues for why body and mind are perceived as split, with this split causing disintegration in our sense of self.

The self, a longstanding subject of psychoanalysis (psychic structure, etc.) exists in the body. Stern (1985) believed that through experiences the body comes to consolidate the sense of core self. Over the lifespan, the sense of self comes to include "a sense of agency, physical cohesion (self-coherence), affectivity, and selfhistory" (Pylvanainen, 2004, p. 48). What protects the self, our person, from threat, both psychic and physical? According to Pylvanainen (2004) in his article, *Body Image: A Tripartite Model for Use in Dance/Movement Therapy,* our defenses are seen as primarily psychological. The "psychological self" is viewed, however, as aligned with the "body-self". The body-self, according to Krueger (1989), is not conscious to us, or at least in in vivo cognitions. He writes: "Sense of self [body-self] is not a cognitive construct, it is an experiential integration" (p. 49).

Dichotomies of body and mind, the split between body and mind, according to some psychoanalytic theorists, may cause disintegration in our sense of self. Further complicating this matter, how we "see ourselves" (body image) is to a degree socially constructed; we are, in the words of Foucault (1980), "vehicles of power." The "lived body" exists not only in an individual reality but in a context of "dominant stories" (White, 1990) of our "embodied experience" (what we might call embodied stories). This study attempts to examine embodied experience through querying clinical social workers about their own experience with the lived-body of their clients, a lived body which is

influenced internally, and also by forces from without.

To help simplify this proposition of understanding our clients' embodied experience, I will examine the concept of body-self. Pylvanainen (2004), citing Pallaro (1996), proposes that a person's "lived sensations, when they form the core content of the lived body, are contained within the idea of the body-self" (p. 45). Further, "Western cultural perspective" writes Pylvanainen (2004), "emphasizes mental powers and visual perception" (p. 45). The logic of narrative therapy inspires a question here: Is this hierarchy of mind over body a "dominant story"? Is this the plot—that psychological experience triumphs over embodied experience—that we enact?

We are now engaged in abstract discourse about aspects of empowerment and embodiment. It seems this abstraction, or way of metaphor, may be the only way of forming connections between theories of psychotherapy in relation to the body; and this has been a question put indirectly but purposefully to clinical social workers for this study. To look outside of the frame of psychotherapy as well, into a person's lived experience, also facilitates making connections. Consistent with the use of narrative (restorying) techniques, I repeat that "narrative modes of thought privilege the particulars of lived experience" (White, 1990, p. 80). On the subject of minimizing "lived experience" in healthcare, White (1990) continues:

> In the logico-scientific mode, the particulars of personal experience are eliminated in favor of reified constructs, classes of events, systems of classification and diagnoses. (p. 80)

While it may seem a contradiction, we see in the literature how mind and body are separated, or "classified," as a means to understand what questions might be asked that integrate them. [As seen in the poem above (Rich, 1971), the opposite of this is also

possible, integrating mind and body through metaphor as a means to "experience" the separation of the two]. These ways of seeing how mind and body are integrated in juxtaposition to how they might be split are worthwhile as they relate to bringing theory of the body together with actual embodied practices.

In the following sub-section, I will present some ideas on therapeutic touch, how we perceive touch in health care. Quantitative, Westernized studies (see below) reinforce dichotomies of body and mind. These studies tend to "classify" the parts of persons (mind, brain, spirit, and body) in order to study them. Thankfully, some qualitative studies, because they probe for narrative, experience-near data, do not eliminate "the particulars of personal experience" or lived experience. (I present these studies below). The qualitative study of touch is relevant to this study in the context of Foucault's (1965) ideas about the "objectification of people's bodies" (White, p. 66), and the tendency for people since the 18th-century to "forge themselves as docile bodies" (White, p. 24). We "forge" ourselves as a means to "improve and extend social control" (White, p. 66). Narrative practices (as well as qualitative research about embodied practice) and the technique, as White calls it, of "externalizing of problems" "may be considered as counter-practices to cultural practices that are objectifying of persons and of their bodies" (p. 75).

The literature presented here continues to emphasize the idea that we sense the world through our skin, our bodies, and through the "particulars of lived-experience." In the next sub-section of this literature review on strengths and embodied practice, we see how studies on therapeutic touch point to how Westernized societies are "touch starved." Additionally, according to Betta de Boer-van der Kolk (2007), therapeutic touching in

our society is often confused with sex (Sakiyama & Koch, 2003). Sex, itself, in our society is confused with control and power. While these may be "globalizing" statements, we can see that we may be alienated from the pleasures of touch, as well as sex (Rye & Meaney, 2007).

Therapeutic Touch

In this section I treat two areas that are relevant to therapeutic touch in the helping professions: one on nursing studies on the use of touch/therapeutic touch; the other on healing therapies (or ways of life) such as yoga and massage.

Betta de Boer-van der Kolk (2007) mentions the "increase in the use of massage therapies among the general population in the USA [as] an indication that many individuals are hungry for touch" (para. 2). A licensed clinical social worker in Massachusetts, she has integrated touch in her psychotherapy practice using her background in somatic and Eastern healing traditions. She writes: "It is time that we open the discussion of what constitutes 'healthy' touch and when touch could potentially be harmful" (para. 1). A law is on the books in California which makes it illegal for "all state-approved psychiatrists, psychologists, counselors and trainees [to touch] their clients" (Sakiyama & Koch, 2003, p. 80). Because touch is confused "in all its many forms with sexual touch" writes Betta de Boer-van der Kolk, "many people, particularly traumatized clients, cannot experience touch safely" (para. 2). Interestingly, this author and social worker is partnered with Bessel van der Kolk (1994, 2005), who has done extensive neurobiological research on trauma, and who now does research on therapeutic touch, neuroimaging, psychophysiology and yoga.

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In a Finnish touch study, *The Right to Touch and Be Touched* (Routasalo & Isola, 1996), the authors report on the ambiguous nature of touch with patients, as both therapeutic and potentially violating personal space. This was a small quantitative study, as most studies have been over the past 30 years (Routasalo, 1999). However, according to Routasalo (1999) in *Physical Touch in Nursing Studies: A Literature Review,* qualitative studies are increasingly being done that use methods such as ethnography or grounded theory. (Some important variables Routasalo identified for his study that have an impact on the findings of how touch is given and received were the cultural background, personality, and life experience of the nurses. Could these factors be applied to psychotherapists, for example, as important, not just for using touch, but for embodied practice in general?)

In Routasalo's (1999) study, the author states with confidence that while most Western nursing studies on the use of touch in nursing report contradictory results, they tend to support the notion that

> Physical touch is an integral part of nurse-patient interaction in virtually all nursing situations. The more the patient needs help in daily activities, the more the nurse will try to help by means of touching. Touch also plays an important part in complementing verbal communication, in turning a patient's attention to verbal communication, In calming a patient and In showing caring to a patient. (n.p.)

Interestingly, even though these are "Western" studies, the implication may be that even in "touch-starved" nations where individuality is prized over collectiveness (Germer, Siegel, & Fulton, 2005; Sakiyama & Koch, 2003), touch is deeply connected to life style and people's ideal expectations for life.

In their article, *Touch in Dance Therapy in Japan,* Sakiyama and Koch (2003)

cite Mindell's (1985) idea that "we divide the personality into mind and body, good and evil: the body has been made into the devil" (Mindell, 1985, p. 167). Sakiyama and Koch (2003) describe the benefits of touch in "large segments of the general population" (p. 167) as being lost due to these attitudes. Citing Field (2001), they write that some of the benefits of touch ". . . are decreases in stress and anxiety . . . and the positive effects that touch has on growth, brain waves, breathing, heart rate, even the immune system" (Field, 2001, p. *ix*). The authors believe there are important differences between touch in Japanese society and Westernized society; that for the Japanese, "the body is not perceived as evil. People are in close physical proximity and there is no taboo about touching" (p. 84). Sakiyama and Koch (2003) quote an American medical doctor, Remen from an interview with Bill Moyers in 1979:

> You know, touching is a very old way of healing. We don't touch each other in this culture, and touching is often misunderstood or even sexualized. As a physician, I was taught that you touch people only to diagnose them. (p. 355)

I do not mean to imply that social workers should touch their clients, as nurses or doctors or healers must do; but to understand touch, to examine persons as bodies and how the person has a sense of self that can be touched in many ways, as well as through their own embodied lived experience, is one aim of this study. This study asks social workers, What do we know of touch, of skin, of bodies, and of embodied experience? How do social workers experience their clients, as bodies? The way we sense ourselves in body and mind, according to some of literature presented here, "is not a cognitive construct, it is an experiential integration" (Pylvanainen, 2004, p. 49).

<u>Body-Self</u>

While all persons experience their bodies in unique ways, everyone can agree that

every person has a body. In this way, each has a sense of self, which, as David Krueger (1989) writes, has "at its core a cohesive, distinct, and accurate body self" (*x*). Krueger (2001) sees the body self as a "foundation for self awareness" (p. 244.) This lived body exists in every moment. This body is where, ultimately, we all live. Tor-Bjorn Hagglund (1980) in his article *The Inner Space of the Body Image,* refers to Erik Erikson's (1956) phrase, "a feeling of being at home in the body" (p. 257 [Erikson, p. 74]). Most people relate intuitively to this feeling. The feeling of being at home, Hagglund says, is an extension of sense of self (Lichtenberg, 1980) and a person's identity. The body, from the beginning of life to the end, is our foundation. This fact of foundation is experiential, "lived," and also supported by developmental theory.

In his article, Hagglund (1980) reminds the reader that "[l]earning to speak and standing up to walk occur at approximately the same time" (p. 260). A question this study will not pursue directly, but is relevant to the formulation of this study is: How and for what reasons has walking (and embodiment) been divided from verbalized experience, and excluded from the general frame of psychotherapy if walking/talking is so developmentally intertwined? How, indeed if as professor of psychiatry at Baylor College of Medicine, David Krueger says, "the self and the body integrate throughout development." Krueger (2002) writes:

> We are always embodied, though aspects of that embodiment may be disavowed, disregarded, or ultimately disembodied by association. The self that seeks embodiment, and the body that yearns for residence in the mind, integrate throughout development. The subtleties of mental states are interwoven with inchoate bodily states, and the two minds and bodies in the consultation room interact at multiple levels. (p. xii)

Can we, as social workers, afford not to "interact at multiple levels"? We surely already

do, but do we pay attention to that? And how do we know, or apply, that?

Pylvanainen (2004) says that the "body-self" is essentially what a person is; that the body-self is a person's sense of self; and that "it is through the sense of self that we interact with others" (p. 48). Can we call this interaction a kind of dance between people?

Another question: Can we come to understand that our own integrated sense of self (of body-self), as social work practitioners, is as a way toward being more *present* with our clients?

The body-self is the self that interacts with others. Also, as Pylvanainen (2004) says in his study on the body-self and dance/movement therapy, "the body-self relates to the environment through movement" (p. 50). If social workers accept the idea that "the body-self, the sense of self, is not a cognitive construct," that it is "an experiential integration" (Pylvanainen, 2004), then the reader can see the essential need to pay attention to a person's movement in the environment, however minimal this movement may be.

One reason for presenting theories of body-self has been to juxtapose body-self, as a construct, with psychological self. Psychological self, while a theoretical construct, has been a basic foundation for traditional psychotherapy. Whether or not we accept a presumptive split between body and mind, and the implications of that split, we would want to know how to better integrate our clients' embodied experience into our practices. "The body-self," as Lichtenberg (1978) writes, "is not a static entity . . . rather, body self refers to the dynamic changes of the body in action and the body in constantly altered states of need. The plasticity of body-self experience accounts for its dual effect [body/mind split] on the sense of self-cohesion" (p. 377). Lichtenberg's "dual effect"

needs to be considered. Clinical social workers have surely sat with clients who are in "constantly altered states of need." As persons, as bodies, we are comfortable, at home (Erikson, 1965), yet we may not know the applications of that idea of "being at home" (embodied experience/embodied strength) in our practices.

Body-self theories help in understanding at least some of the inhibitions, restrictions, and limitations experienced in talk therapies. Parviainen (1998) writes that "there is always gap, an abyss, between touching and touched. . ." ". . . My left hand touches my right hand even as it is touched by the right, and this relation of touching— being touched—can be, in the next instant, reversed" (pp. 64-65).

In this review of the literature on embodied practice, nearly all practitioners agree on basic ideas: that the body is the self, that the body is conscious, and that the lived body exists in every moment. As shown in this section about the duality of body and mind (the split) it is evident that there are important questions for social workers to consider regarding the clients' embodied experience. If body-self knowledge is "understanding the human body as conscious in itself" (Parviainen, et al., 1998, p. 34) and therapeutic touch studies reveal good outcomes, then what are some of the implications for clinical social workers and the therapeutic relationship? Clinical social workers may not touch clients directly, but how do we dance or walk with them? Do we breathe with them?

Conclusion

In this chapter I have tried to show how therapists, using a strengths perspective and ideas of empowerment, pay attention to clients' experience of competence and mastery of mind as well as body. Consistent with the goal of this study which looks at

client strengths as expressed in the lived experience of the body, I propose that lived experience is embodied experience. This proposition is supported in the literature. In order to pay attention to embodied experience and embodied strengths of our clients, body-work therapists and psychotherapists use many tools and techniques—and in some unusual settings. I have offered a sample of their work. The ones that I have presented show how practitioners access multiple levels of consciousness, often extending (even straining) a mainstream, western view of mind and body. I have also tried to show some of the barriers encountered by therapists and clients, including imposing on our clients "expert" knowledges as well as the perplexing problems presented when seeking to integrate body with mind.

Clinical social workers whom I interview draw on the practice and theory presented in the literature reviewed in this chapter. My problem for research is to explore how these social workers draw on these resources, and if they do not—or if they cannot identify resources that are not presented herein—then why not? This study assumes, to some extent, that clients do not bring their hobbies or work (places where they may experience effective, competent activity in their lives) into the clinical setting. If this is so, I ask, why not? Those areas described in this chapter where social workers most clearly take account of and integrate embodied practices are residential treatment and adventure-based therapies. It may be that some aspects of creative and/or movement-oriented therapies are or may become integrated into practice as ways of accessing our clients' strengths, and thus be revealed as important variables for future study. The question, How do clinical social workers pay attention to embodied experience to attend to client strengths, is not easily answered; there is a lot to learn and apply that may not be

treated presently in social work curricula. While some of the literature presented in this chapter is not directly from the social work field, it is confidently assumed that theory and practice of social work indirectly draws from this literature in order to access client strengths.

The methodology chapter which follows describes a flexible approach to data collection on embodied experience and strengths. This approach will hopefully create a platform from which participants (social workers) can reveal, in their own words and concepts, how they pay attention to client strengths as expressed in the lived experience of the body.

CHAPTER III

METHODOLOGY

How do I know what I think until I see what you say
Clifford Geertz (1983)

This exploratory study is a qualitative analysis of therapists' perceptions of, in a larger sense, their use of a strengths perspective and, within that, the ways they use, or perhaps fail to use or credit, their clients' body-based strengths. This study also hopes to provide rich information to other therapists—of any theoretical or practice orientation—about strengths-based social work practice, with an emphasis on embodied practice.

In this chapter, my own subjectivities and biases will be discussed, specifically my reaction to case vignettes (see Appendix E) recorded in the beginning of Chapter One of this study. The reaction becomes a question: *Do ordinary but important activities such as playing bingo, golf, being in a band, or making necklaces often not get regarded or credited in psychotherapy?* If not, why not? This question arises from a lack of attention in social work and other helping professions to our clients' strengths and their lived experience outside of the therapy room.

The gap or problem may in part be attributed to the heavy reliance on the medical model used by helping professions. Such reliance on a medical model compartmentalizes aspects of the complete lived-experience of persons in psychotherapy (Hartman & Laird, 1983; Germain & Gitterman, 1980; Saleebey, 1992, 2001), thus minimizing the body self and separating mind from body (Kruger, 1989, 2001). This researcher brought his experience to the interviews via the aforementioned case vignettes. The subjective

experience—found vignettes—of this investigator's personal and professional life that has been made by the intersubjective interactions with others helped to inform the study, and should be understood as being part of its methodology (Anastas, 1999). The biases and assumptions are embraced as my own.

Client strengths in general and the body in particular are given scant attention in psychotherapy. Why is this so? This study was designed to explore this question, and others, regarding our clients' strengths and lived experience. According to Krueger (2001), "the body and its evolving mental representations have been largely absent from developmental and psychoanalytic theory" (p. 238). This study hopes to inform theory and practice, vis-à-vis Krueger's statement, using a methodology that solicits meaningful data.

In designing this study, I take from the case vignettes three overarching themes, or categories. These show the strengths perspective in social work practice, lived experience and embodied practice/embodied strengths.

Research Design

Using a qualitative analysis of therapists' perceptions, this study explored clients' strengths, with an emphasis on body-based strengths. Because this research was exploratory it remained flexible enough to elicit the real practice experience (stories and/or case vignettes) and practical outcomes of the therapists who participated.

This study assumed that there is a special place in clinical social work for the client's lived experience which is made up of psychological as well as physical characteristics. This study further assumes the phenomenological integration of the

psychological self with the body self in lived experience. Still, a person's physical self

(body self) and his or her embodied strengths are important facts to consider alone and/or

separately. As Anastas (1999) suggests, to obtain a good picture (or narrative data) about

any phenomenon

> . . . a flexible method study may be used to describe significant facts more completely. What such studies offer are often characterized as "rich", "thick", or "experience-near" depictions of social and psychological phenomena in context. (p. 61)

A Flexible Approach

In the section on the data collection, I will go into more detail about how the

flexible method will be employed. It was necessary to take special care to keep the

method reflexive in nature due to the small number of participants who are also all

practicing clinicians and social workers. Reflexivity, the ability to look back at

information or experience, is good social work practice, and necessary for making fluid

assessments. In addition, these clinicians, presumably, are skilled at making

biopsychosocial assessments which are, by nature, indeterminate and global—another

reason this research is qualitative; the data itself was about clients who change, in reality

or perceptually.

Besides doing qualitative research about the strengths perspective which directs

interventions to be client-centered, the notion of objectivity—one of the privileges

research, in general, can abuse (Foucault, 1980)—was not a pretense of this study.

However, as Phillips (2007) writes, "the Researcher is ultimately the author of the text"

(p. 112), which, to be sure, is a definite claim to truth and power. In this vein, the data

collection method of this study about clients' strengths/embodied strengths was designed

to change, or to be *re-operationalized* as needed. In fact, the reflexive (and

intersubjective) method of data collection was important precisely because an individual

clinician's perspectives and intersubjectively-derived experience can shift over the span

of a career, or even the vicissitudes of practice from one client to another.

A clinician who may, at one time, have used an object relations model, may have

shifted to a relational or other model, or combination of models. This ability to shift—to

move laterally as qualitative data collection may require—is necessary for the researcher

as well. Phillips (2007) says about her own research on deafness/hearing issues that it

was "conceived from one perspective but developed and was *(sic)* operationalized over

time from a changed perspective" (p. 112). An example of this from the point of view of

this study is that much of the research already done about body-based therapies comes

from the psychoanalytic perspective, and much of it is interpreted through the lens of self

psychology. This theory may not be the perspective of others in social work who may

have a significant contribution to make; therefore this study has attempted to allow for

theoretical shifts in order to make enough gathering space for "experience near,"

narrative data.

Room to move can only be created by asking open-ended questions (though they

must be purposeful to the study as well). Here I offer a metaphor for this method of data

collection: a container that changes shape to make room for different experiences and

perspectives. This shape-changing metaphor requires that any interview guide remain

strictly a *guide* and not a fixed template, i.e. the questions (the container itself) can vary,

interview to interview; questions must not only be non essential, they must be also be

interchangeable. However, it should be remembered no matter how flexible the method

used to collect narrative data that the researcher is still coming from *some place*. My

place, for this study, was an interest in the lived body. This "place," I assumed, found

connection with social work practice through the strengths perspective; I started from

there. So, a reflexive methodology remained important to further a study based on

subjective experience. On method and reflexivity, Phillips writes:

> Bordo (1990) speaks further of the subject of conducting reflexive qualitative
> research in emphasizing the impossibility of a researcher embodying a "view
> from nowhere" or an objective, value-free knowledge. What is demanded instead
> of the researcher is an acknowledgement that there is always a place from which
> we speak. (Phillips, p. 107)

This "place" must be understood to be part of the researcher, and as perhaps a *useful*

attribute; to justify an awareness shared between researcher and subject of this attribute,

the researcher elicited the subject's place which locates their own lived experience and/or

professional clinical experience; the attributes of participants themselves.

Creating the Instrument

Borrowing from ideas of Marecek, Fine, & Kidder (2001), Phillips describes a

format for questions, which is not formal or fixed, but is "curiosity-centered" (p. 140).

Furthermore, this study makes the methodological assumption that there is no center,

mean, or average of therapists' perspective on the central thesis, awareness of our clients'

lived experience or their own embodied practice.

Briefly, data were collected through open-ended, semi-structured conversations

(or interviews). The instrument, or <u>Interview Guide</u> (see Appendix D), to generate

stimulating conversation (data) for this study was designed to examine three areas

relevant to this study. Firstly, the strengths perspective was examined. Secondly, areas of lived experience, of clients and possibly of the participants themselves, were discussed. Once data about strengths and lived experience unique to each participant were brought into view, questions about embodied practice/embodied strengths were then asked to bring into sharper focus issues of embodiment that this study hopes to address.

I anticipated, in a reflexive conversation, that other spontaneous questions relevant to the topic would emerge. A large range of possibilities must be allowed for in any good qualitative, narrative-based study.

As I hoped to solicit one or two anecdotes or case vignettes from the participant, pre-prepared case vignettes (see Appendix E) were formulated to stimulate conversation if useful narrative data did not first flow from the participant. From there, the conversation would be allowed to follow the subject's own thought process so as not to prejudice the data with the assumptions or biases of this study. Additionally, the questions did not always follow one after the other, as they appeared in the interview guide. The interview guide provided an overall structure, but it was merely a guide. I anticipated that many spontaneous follow-up questions and responses would occur. As many questions as I could include in the guide were formulated toward this end. (Ultimately, I did not need to use my own vignettes shown in Appendix E.)

Terminology and Concepts

As for the meanings of terms and concepts (such as "body self") used in the interviews (and this paper), I have defined them in the text where appropriate. While all

of the terms come from the literature, they were not developed collaboratively with the participants, and therefore must be clearly stated as the researcher's own.

Sample

Participants

The sample for this study was small (seven participants), so that any effort at statistical significance or generalizability would be meaningless. Nevertheless, I made every effort to recruit a sample that was diverse in terms of gender, race or ethnicity, years of experience, location of practice (urban or rural), and type of practice setting. Such diversity, it was hoped, would yield results that stimulate interesting questions for future research. Additionally, the sample was clinical social workers because the strengths perspective comes from the social work literature, and rich data would be expected to ensue.

For reasons of feasibility, all participants were in practices that are located within the five states of New England. This criterion was in part due to practical considerations of travel and cost, but also to ensure that interviews would be face-to-face, and therefore more intersubjective in nature to allow for "thicker," more "experience near" narrative data.

Exclusion criteria were implicitly defined by the fact that the sample was social workers. For example, practitioners who employ dance/movement therapy techniques are not social workers; practitioners who do occupational therapy techniques with the client and her/his body are also not social workers. However, in order to help enrich this study's data and the discussion chapter, the recruitment letter was written to appeal to social

workers who may at least think the topic is interesting, and/or may use or would be interested in using strength-based/body based practices.

Recruitment

Participants were found by word of mouth, one clinician to another. This was accomplished through contact with agency directors or a clinical social workers in private practice. This is also known as the snowball method. Due to the small size of the sample—as well as the recommendation of others—a reasonable assumption on my part was that potential participants would be interested in participating in this study.

Contact information was collected by word of mouth, making phone calls to agencies, or consulting published telephone directories. Once the mailing address of the potential participant was obtained, a brief letter of inquiry (recruitment letter, see Appendix C) was sent with the informed consent letter (see Appendix B). In some cases, the recruitment letter was emailed to the participant when the mailing address of the participant was unknown or otherwise incomplete. If this was the case, the informed consent letter was sent by email attachment. In order to respect the privacy of the potential participants, any contact, by whatever means, was only made through their place of work, social work practice.

Regarding the order of consent, once initial contact was made with the potential participant, a follow-up contact was then made. The eventuality of this follow up contact was stated in the letter of inquiry. The purpose of the follow-up contact was to make an opportunity for the potential participant to ask any questions. Once the participant agreed

to participate in the study by signing the informed consent form, a conversation occurred about when and where the interview would take place.

Ethics and Safeguards

During the course of data collection, confidentiality was maintained in accordance with Federal regulations (2007) and the NASW Code of Ethics (2007).

The identities of all participants were further protected by assigning numbers. The chosen venue for the interview was based on the following criteria: the participants' convenience, a sense of privacy, comfort, and a good working environment for the study, such as an office or a room at a local library.

All data used for this study has been stored in a locked file for at least three years (beginning June 1, 2008) and will destroyed after that time.

Risks and Benefits of Participation

Potential risks to the participants were addressed in the Informed Consent Form (see Appendix B). Each participant was asked to read and sign this form, which essentially stated the subjective nature of the research questions. The form also clearly stated that this investigator would honor any request on the part of the participants not to participate in any part of the interview process; this statement was also reinforced verbally at the beginning of each interview session. However, the benefits to participants were framed as an opportunity to share important experiences relevant to this study, as well as to help to shape the study itself. The benefits, as well as the risks, were briefly discussed with the participants at the beginning of each interview.

Data Collection

The flexible method of data collection is philosophically consistent with other functions of the research design (Drisko, 1997) as described earlier in the chapter. The data collection method was designed to capture—or perhaps throw a loose net around—individual clinicians' perspectives on their clients' body-based and other strengths. Actual data collection consisted of face-to-face interviews. All interviews, lasting from 45-minutes to 1-hour, were audiotape recorded. Every effort was made to approach each interview in a similar manner. However, because the emphasis of flexible method research is "usually on the discovery of new phenomena or on the redefinition of phenomena in a way that remains close to the experience of research participants themselves" (Anastas, 1999, p. 57), the interview process remained as open-ended as possible while still collecting important data. The opportunity to explain, clarify, and elaborate responses to questions was encouraged as well as the possibility for reformulating questions or creating new questions.

Data Analysis

An assumption was made prior to collection of the data that revealing and valuable data would be collected in the form of stories and/or actual case vignettes. From the perspectives of participants, stories and case vignettes were expected and purposefully elicited. Due to the small number of participants, the narrative data was expected to be co-constructed between participant and investigator. From this thick, experience near, and local, narrative data, themes were expected to emerge.

As demonstrated by the literature, very specific findings were expected—and were be consciously elicited. An example of such findings was the expected clinical regard and attention by social workers to some forms of strengths-based practice. However, it was also expected that there would be gaps in strengths-based practice, particularly a lack of clinical awareness of a clients' body self outside of therapy (in their lived experience), and outside of the problem-system, where the individual, family, or other entity is "sick." While the stated assumption as put forth in the introductory chapter—that "clients do not bring their hobbies or work into the clinical setting because it is not expected, and it is not done" —was made to elicit data on this theme, the study and its data collection method maintained a focus on remaining open to whatever data flowed from stimulating conversation. This open stance was facilitated by the "curiosity centered" interview guide (see Appendix D) and by the investigator placing added emphasis on framing questions in ways that induced the social worker to share information about their practice with enthusiasm and connection to the topic.

CHAPTER IV

FINDINGS

In the preceding chapter, I state that this exploratory study is a qualitative analysis of therapists' perceptions of their use of a strengths perspective. Within that larger view of therapist's perceptions, the methodology is designed to probe ways clinical social workers use, or perhaps fail to use or credit, their clients' body-based strengths. Further, I state that this study also hopes to provide rich information to other therapists—of any theoretical or practice orientation—about strengths-based social work practice, with an emphasis on embodied practice. In general, I found that each of the seven licensed clinical social workers whom I interviewed responded with a feeling of interest and engagement, and each was uniquely rooted in their own professional experience.

The research instrument (see Interview Guide, Appendix D) was designed to ask participants to describe what they think a strengths perspective is. They were asked how a strengths perspective is applied to their own practice. They were also asked what they perceive as possible barriers to using a strengths perspective. Further, most of the participants were asked to describe what ideal practice they would have, or even to re-create the field of social work, using a strengths perspective with, or without, a body-based focus. They were asked questions about empowerment, power and control, and some special consideration questions about the "medical model" or their own agency's policies. They were asked questions about their client's embodied lived experience, and questions about body-self. They were also asked what percentage of "embodied

practices" that ideally they would like to see in the clinical setting, as well as what they perceive as barriers to using embodied practice. In this chapter, I present the findings of these questions in the order in which they were asked. From these findings, themes emerged from use of the research instrument, as well as a few surprises.

As stated in the previous chapter on methodology, specific findings were expected—and would be consciously elicited. An example of such a finding is the expected clinical regard and attention by social workers to some form of strengths-based practice. This did bear out, as the findings will show. It was also expected, however, that there would be gaps in strengths-based practice, particularly a lack of clinical awareness of a clients' body-self (and lived experience of the body) outside of therapy. In order to *make space for the gaps,* questions that were asked in the first two or three interviews about what knowledges therapists had about "embodied practices"—their own or that of others—had to be re-formulated for the next few interviews to allow the conversation to flow more naturally about the social workers' own experience, in their own conceptual range, rather than to reach into external, un-traveled areas. The discussion chapter reports which questions were reformulated and how that was done.

I have made the choice to try not to use certain language in classifying the data presented here. The reason for this is to be philosophically consistent with a strengths perspective. Instead of using the word "behaviors" I may, for example, use the word "activities"; and instead of using the word "intervention" I may use the word "embodied practice." While this may lack a certain clinical precision, it reflects the language of participant narratives; a language that was "local," in plain-speak, almost layman-speak, and this is what I would like to reflect in this chapter.

Demographics

Of the seven participants interviewed for this study, all are licensed clinical social workers between the ages of 27 and 65. The average age is 45. One of the participants is a female African-American and six are white, four women and two men. The white clinicians identified themselves as of Western European descent—except for one who said Eastern European—and the African American simply as "a black woman from the south raised during the middle of the civil rights movement" and "a child of the 50s in a segregated city, in a segregated state." One of the white women therapists strongly identified as a feminist who bases her work on issues of the women's movement (and started, and is currently leading, a group of female war veterans in the outpatient clinic where she works.) This same clinician states emphatically that she is a self-in-relation practitioner; another that she is "relational, but uses whatever theories that would apply to a treatment plan, and depending on the situation." One clinician describes the principles/practice of Christianity as an important influence on her work with a population of mostly Latina clients; another describes Buddhist practice principles as important to his work with clients. In addition, one clinician identifies as Jewish; one as agnostic. Neither clinician mentioned aspects of these religious preferences as relevant to their work. The remaining clinicians did not make reference to any religious preference.

While most of the seven participants refer to their theoretical base of practice as eclectic and variable, cognitive behavioral models (CBT) with concurrent pharmacological in-house referrals/resources predominate in the settings in which they currently practice. One participant uses Dialectical Behavioral Therapy as her primary mode of treatment with a strong link to psychiatric medication. One participant describes

her focus as using "collaborative and narrative models." Two others describe their approaches as "self-in-relation" and "relational/eclectic." All treat low-income clients, including the one participant in private practice. Four of the seven work with low-income clients primarily.

Four of the clinicians practice in small New England cities, one in a large New England city, and two in small towns. The participants work in a variety of settings. Two are in outpatient medical, two in adult community mental health, one in child community mental health, two in community mental health Dialectical Behavior Therapy, and one in private practice. As mentioned, some of the participants have begun professional organizations or clinical programs on their own; some have worked in other helping professions, such as psychiatric nursing or recreation therapy. In addition to her part-time practice in a poor Latino neighborhood in a large city, the African American participant also currently teaches advanced practice classes and empowerment/policy classes at a New England school for social work. The therapist who is presently in private practice has taught family practice to psychiatry students at a major university earlier in his career. All therapists, except one, have been practicing social work for more than 10 years, with two having practiced for at least 25. Two did not begin as social workers, though all started their professional lives in health care, with 4 being in health care (including social work) for more than 15 years, and 3 for more than 25. In other words, the participants are experienced clinical social workers.

Strengths

All participants could articulate strengths-based theory and practice. All

participants, except one, either strongly or moderately regard a *strengths perspective* as an important part of social work, including their own practice. Narrative data provided by participants on a strengths perspective was rich and varied across the sample. Within the narrative data were a number of themes about strengths and embodiment, for the most part woven together, difficult to separate.

Participants often used the same language and concepts as those presented in the literature. For example, a social worker who works in community mental health described a strengths perspective as using "what is working for someone" and "how they solved problems in the past . . . how they draw from that . . . there isn't just . . . just, you know, one way to solve a problem." Another social worker, also in community mental health, said, "There's so much more to the person than what you see [in therapy sessions]." There were some narratives that showed more balance, perhaps, between working with strengths and weaknesses. One participant, a social worker in private practice, described viewing his clients' overall picture quite differently; that "sometimes when a person feels good about something, I try to look for the problem." And, "Yet, when, ah, they, um, are so down, so depressed, I try to find a strength, something they're good at." In this vein, an adult therapist in community mental health said, "There's no ideal path . . . there's just circling around, looking for the right time [to regard a client's strength]." She goes on to say about a strengths perspective during a conversation about clients who self harm: "When they're stabilized you can say, ah, what's under that? What's under that behavior . . . under that is the self, what is uniquely you as opposed to all those things [symptoms of depression, etc.]."

Participants, as stated above, gave varied and specific responses when asked

about a social work strengths perspective. For example, an outpatient medical social worker described the practice of "joining, as Minuchin used to do" as what is "meant" by a strengths perspective; a community mental health social worker describes a strengths perspective technique during client intakes as asking the client for "things they like about themselves" when she is making the client's genogram.

Mastery and Competence: To Re-Mediate or to Newly Create?

Most social workers interviewed knew the term "competence" and its motivational aspect a la Robert White (1959). While we did not define competence— (and I did not ask questions about this concept explicitly)—participants were able to operationalize the term vis-à-vis their own practice. Four participants used the term competence (as well as mastery) manifestly. The other three operationalized the concept of "being good at something" latently in their narratives. For example, one clinician who works with the chronically mentally ill also expressed interest in group therapy (and dynamics), and linked group physical games and learning skills with the "pleasure" of learning. (She used the term "pleasure" a number of times in relation to mastering tasks). White (1959) talks about a feeling of efficacy as being satisfying in day-to-day interests; the participant who links pleasure with tasks uses that. Another participant showed latent content of mastery/competence concepts by describing strengths-based social work as attention to "what is working for someone . . . how they see their own capabilities and how they can draw from that."

One explicit reference to competence motivation (effectance) and what White (1959) calls "an organism's capacity to interact effectively with its environment" (p. 297),

is shown in the following narrative; this response typifies how my participants

operationalized White's concept:

> . . . that's always the overarching issue [competence/mastery] . . . that all revolves
> around employment and *parenting* issues . . . and, um, you know, trying to, sort of
> develop a sense of competency and proficiency in some kind of work-related
> thing that sort of motivates people, for most of my clients anyway.

> Another participant said, "Yes, strengths-based . . . I always think of mastery."

This same participant who is also an outpatient social worker at a veteran's

hospital shared some interesting data which I will highlight here as it relates to

competence/mastery. (This data was also corroborated latently by two other participants.)

In the course of her work with clients who have been sexually abused in the military, this

social worker described a process of *re-mediating* traumatic events, such as being able to

walk outside in the woods again after having been raped in a secluded place. In two

separate anecdotes she linked mastery and competence with re-mediation. This idea (or

behavioral technique) of re-visiting a stressful time and place, therefore gaining mastery

over it, is different from White's. White talks about a process of learning over time; of

effective and even pleasurable learning as facilitated in situations that are not stressful,

that are in "conflict-free spheres" of life (see Chapter Two). I will discuss this apparent

contradiction between competence motivation through creative and pleasurable

exploration (less stressed) activity and the idea of using a traumatic event as a path to the

satisfying consequence of having competence. This is an interesting finding with

implications for what motivates people, with three participants stressing pleasure, three

stressing re-mediation, and the remaining participant offering no data on the topic.

Competence and mastery are probably useful concepts for any social work client

population. The acts of doing, of creating, of having activities that are satisfying, of building a better life, are always regarded when using a strengths perspective. What are some of the things that make practicing a strengths perspective difficult?

Barriers to Strengths

Of the seven therapists interviewed, three strongly resist a problem-saturated focus—a concept discussed at length in the literature on strengths perspectives—with clients. Of course, they also work to alleviate symptoms and problems, as they said. These three participants describe their work as trying to look beyond the clients' problems; that problems are not the main focus of treatment. The remaining four generally feel their agencies' range of treatment options, mostly cognitive behavioral therapy (CBT) and psycho pharmaceutical intervention that primarily alleviates symptoms and puts problem-solving at the top of the treatment list, is appropriate for their clients. All participants admit to regarding a client's strengths while working with them. A strengths focus, according to the literature, views the client-as-expert; most participants, whatever their sense of loyalty to the agency setting in which they practice, believe they find a way to empower their client, even as they often find this difficult to do.

To illustrate this, a female veterans hospital outpatient worker said this of using a strengths perspective in her agency:

> If you work in a system of care that promotes the disease model as opposed to the wellness model, or the strengths model, I think it can be very easy, as any kind of worker, social worker, therapist , doctor, psychologist, it doesn't matter, to get

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into that, um, you know, out . . . this is a little off tangent, but the way we bill is not based on strengths, it's based on weaknesses, it's based on DSM-III, or the DSM-IV, or, you know, IVCM-codes, or whatever; we *don't* base on strengths.

And you have to document, sometimes carefully, as you're addressing the issue-du-jour, but also fostering *them* . . . [their strengths].

Another participant, who works in the same treatment facility, demonstrates strong feelings about the "problem system":

The time spent on writing notes has made the client smaller, more disempowered.

I found that narratives from the interviews tend to reveal overlapping themes usually centered between barriers to a strengths perspective and the client strengths themselves. There was no concerted agreement across the sample on what reasons a strengths perspective is difficult to practice. Two participants feel that "client readiness" is the most significant factor; two feel that the system of managed care is the most significant factor (three do not); a few feel the "artificial setting" of psychotherapy is one of the main barriers to using a strengths perspective.

In the next section, besides special considerations which stem from questions near the end of my interview guide, I will offer some narrative data on barriers to a strengths perspective to demonstrate some of the variation I found.

Strengths Perspective—Special Considerations

Now I offer narrative data procured with the questions from my interview guide about special considerations, ranging from empowerment in practice, barriers to strengths as well as empowerment, and issues of what may limit, or weaken, clients in their own healing work. Information on what *dis-empowers* clients—what I call issues of power

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and control—was also elicited by these questions. With both questions, *How do you define empowerment?* and *How do you define power and control?,* I found that, across the sample, there was no concerted agreement of definition or explanation through anecdotal experience. It was not long into the actual interview process that I lessened my focus on "barriers."

Still, the data is interesting: The African American social worker describes her work with young Latina women in a large city, in part, as "getting the maximum amount of services that the client really needs." Of course, all participants in this study demonstrated similar values, but this worker was clear that using a strengths perspective and working in a setting where problems are identified as the main focus for treatment, rather than, say, in the client's actual environment, are not contradictory approaches. The questions I asked about agency resources tried to access the social worker's own feelings of efficacy:

> *In the age of managed care, as well as considerations of long term versus short term treatment, do you think there'd be a difference in terms of a strengths perspective?*

> It doesn't, it doesn't, for me . . . I think that, you know, part of it, you know, the managed care, insurance, you know, the people that are paying, don't always appreciate the *language* of a strengths perspective and so you're always, constantly, trying to put what you're [we social workers] doing into a framework that gets the maximum amount of services that the client really needs.

This worker, as others I interviewed, describe a multifaceted approach of balancing strengths with barriers to strengths. Like another participant who works with poor young women, this worker who sees mostly Latina women, takes a pragmatic stance toward presenting problems and what precipitates them:

> . . . Six sessions are ok partly because these people are not long term people; they

have situational problems, when they're really *needing* stuff. I think about what, sort of, the core issues are. And so I have to put it in a language that the client can really use that really embodies strengths and empowerment and, um, engagement with them.

The separate use of strengths-language for clients and problems-language for insurance companies was an emergent theme in the data. However, when a clinician who works in an adult community mental health agency was asked whether evidence-based practice (EBP) is a barrier to strength-based practice, she revealed my own bias by saying that EBP is not a barrier, that EBP is essentially "what has worked before" and that "what has worked before *is* strength-based practice."

I can not say definitively how seriously some of my participants want to apply a true strengths perspective (see Chapter Two) to their work; most, including this community mental health therapist, seem to hold a wide perspective on therapy vis-à-vis strengths and agency constraints to the work. I asked about her setting:

> *Isn't this really a difficult setting to look at people from a strengths perspective?*
>
> People look at this as coming in to talk about problems, and so, um, they're not really prepared to say that much to talk about the things that they like about themselves. And then we easily get drawn into that . . .
>
> *Yes, I know that's the focus. I mean, that's why it's designed, to treat and alleviate symptoms . . . There's not like . . . like there's anything wrong with that, but . . . We're here to provide safety, and, um perspective, um . . .*
>
> Right. Whereas, when I worked in a day treatment setting with adolescents, you know, it was all broken up into different groups, you know, and one day we made masks and one day we did something else, and there you saw a whole different side to these kids.
>
> *. . . Well, what if . . . and developmentally adolescence is a unique social stage . . . but what does that mean being able to see them doing some other things, other than therapy, what does it mean to the treatment . . . ?*

To the treatment? Well, I think that it opened it up. You got to see, mm . . . more of the person . . . you know, because they can be so defended, or symptomatic, but then when you're in a different situation where they're painting or they're, ah, running around, you know, and interacting with other kids, you just see a bigger picture.

Responses to the topic of empowerment (see Chapter Two), while animated, were

less clear than that of strengths perspective. I asked participants what they think

empowerment is, then as a separate question what they think power and control (see

references to Michael White and Michel Foucault in Chapter Two) are in relation to their

work. The participants gave such varied responses that I soon realized, as I said at the

beginning of this section, that I should spend less time on questions on empowerment or

power and control; and that my questions about barriers/enhancements to strength-based

practice are quite biased toward a *political* analysis (which I will not go into).

I would like to present one piece of narrative about power and control that I did

not expect, which speaks to micro-practice rather than expected issues of environment or

policy. In the review of the literature I present ideas inspired by Foucault's work of

power and control that were deconstructed in narrative therapy (White, 1990), primarily

in relation to the therapist-client relationship. While I was thinking macro, this

participant, a DBT team leader in community mental health, brought it back to an

internal level. I would call this a psychodynamic/cognitive behavioral level:

Tell me what you think of the term power and control?

Power and control? Well, it's almost like the client, ah, has this, like, amnesia. They forget what they might have done in the past to help themselves . . . that they did it, ah, in stages maybe. And also when we look at how they might really work through something, be empowered to work on something, they just see an end-point. That . . . that stuck attitude, about seeing the end, not seeing *how* they are going to get there is very, um, ah, disempowering for them.

For this therapist, the concept of mastery motivation and competence partly answered the question about power and control.

This same therapist, who describes herself as a person interested in macro-practice, also offered an explanation of *power and control* as the effects of poverty which is "a huge oppressive force." Poverty, which this and other participants clearly view as a clinical barrier, is seen as, in her words, "a lack of resources such as affordable housing" rather than barriers within their own agency. The general term "poverty" came up as a barrier (on a psychic level as well as a community level) rather than, as I personally expected, the effects of managed care on the effective delivery of social work services. This worker who spoke previously about power and control being her clients' "stuck attitudes" about only seeing an "end-point" rather than a process toward change, emphasized internal forces in the client that are oppressive. Her answer to my question *Tell me what you think of the term empowerment? was:*

> People building confidence . . . and trusting in themselves. It's a place that I think gets developed. We call it *building mastery,* in a way.

This community mental health social worker was animated and positive when making this statement.

Surprises

In my opinion, the most interesting data—because it was data that often evoked client embodied experience—came from questions like, *What surprises have you experienced with your clients?* (Surprises were solicited of client strengths in general, and embodied experience specifically). While questions of this nature stimulated responses

that may not have had direct consequence to the study's questions, they are offered here to illustrate how ". . . flexible methods of research tend to view all information as contextual and to deal with issues of bias and interpretation by "inviting them in' "(Anastas, p. 415). The idea that I view these responses as *some of the most interesting* reveals my own individuality or biases. The relevance of this admission is that the impetus for this study, a study finding few parallels in the social work literature, originates in the researcher's own experience with what is "physical" and what is "lived." As stated in chapter three, the methodology encompasses an inter-subjective process of conversation which allows for the researcher to "come from some place."

I hoped to explore territory I could not explore as the questioner. For the strengths part of the interview, as well as the embodied practice part, I solicited surprising experiences for the participant. This female community mental health therapist offered her experience of certain surprises as welcome events.

Have you ever been surprised by a client's strengths?

People that come in very depressed and, um, feel like they can't do anything and they give a history of just, ah, not being very functional, and . . . and then you get into different things they do and you find out that they, ah, make quilts, or they, ah, paint pictures, and they'll bring in things and show you; write poetry; very *creative* things.

At what point was it a surprise? Surprised, meaning, it didn't make sense . . . Does it ever make you think there's another person out there that you wouldn't have seen if they hadn't shown you something . . . different from their problems?

The way you see them initially, it…you know—and that's *my* impression as much as what they're saying—is that, ah, um, there's not that much to their life, it's very bleak and dark, and . . . and so then to hear that they . . . they, ah, do watercolors, and they're thinking about writing a children's book and illustrating it, and then they bring *in* the thing . . . you know, that can take me aback.

This male social worker, now in private practice but in social work for almost

thirty years said:

> I was talking with a law student who was extremely anxious to the point of being
> tearful, um, and didn't think she could stay in law school . . . and went on
> medication for depression. Well, she came back this semester, um, much better
> and happy to report that she finished in the top 10 of her class—that's like the top
> 1%—and I thought, whoa, what a surprise, you know, she looked like somebody
> who would be struggling to stay off probation.

> Another surprise? I can think of a chronic schizophrenic, who had even been
> homeless, along with having multiple personalities. As I began talking to her, it,
> um, I realized how bright she is, and how interpersonally connected she is, and
> how frank and insightful she is about her condition, and that surprised me.

Another community mental health social worker described a client from a socio-

economically oppressed background. This client had a diagnosis of post traumatic stress

disorder (PTSD). The client was a black woman, and the first woman to do a "man's job"

for a railroad company (I am purposefully vague in order to protect the client's identity).

According to the social worker, the precipitant to the disorder was that she had not been

supported by her boss after a train accident. The social worker was amazed (surprised)

that this woman—also a single mother with young children, and "who, believe me, was

not an easy person to sit with"—managed to earn a law degree to help counter the

practices of male-dominated professions while she was "still experiencing severe

symptoms of PTSD."

Surprises come in many shapes and sizes. Manifests of data that were supported

by the literature on issues of empowerment, strength-perspective, even embodied

practice, often merged or flowed together. The preceding vignette shows how this works.

Rising from the ashes of oppression, people can demonstrate amazing resilience.

Resistance makes people seek mastery—not necessarily according to Hartmann's idea of

doing that in conflict-free spheres of life, but due to oppression, and sometimes under

tremendous stress. Often women and men, white or of color, press so hard against the problem system, the medical model, as to shatter it, revealing a strengths perspective in the context of "problems." The "problem system" exists; clients come in for treatment, and still they surprise us. For this reason, I have not always divided data in this findings chapter into distinct categories of responses to questions.

In fact, as will be evident to the reader, I have allowed answers to float in a context of other questions. Yet another purpose of this "style" of presenting the findings is to show that, while a number of significant themes emerged from the data, none are *statistically* significant due to the small sample size. I was also conscious that no method of coding would be useful in determining what themes may have emerged over the course of the eight weeks in which data was collected and analyzed. Coding narrative data that was elicited with questions that were occasionally reformulated and re-generated along the way would prove extremely complicated and probably would not yield useful results.

As I transition to the next section of this chapter, *Lived Experience,* I allow the "logic" of the narrative data to facilitate this transition. What I mean by this is that clinicians (and their perspectives or narrative) who *wish* to increasingly regard their clients using a strengths perspective—who see the potential of a strength-based approach—have expressed the difficulties in doing that in settings, or facilities, that treat only problems or symptoms of problems. Further, the transition to ideas of seeing clients in their environment, as evidenced by narrative data, demonstrates a strong connection between data and the literature on embodied practice.

Transition to the Life-Space

This participant who is a child therapist in community mental health speaks to the

barriers of using a strengths perspective, and she also echoes the theme of reducing the

barriers in the consultation room by visiting them in their home environment:

> *. . . where would you like to spend a little more time with that strength? What keeps you from . . . ?*
>
> Managed care, lack of sessions, um, and for the client, personally, their stage of readiness. And combining that with limited sessions . . . if I have twelve sessions a year, and I see these strengths in a client, um, but we don't have the time to address the concerns that are obstacles that are keeping them from accessing their strengths more fully—then it doesn't happen.
>
> *So, if you have twenty-four sessions, or unlimited sessions, would that affect . . . ?*
>
> Or if we could access them in other ways, in other services . . . you know, I have clients who it would be best for me to see them at school, and to work with them at school, or work with them in their home, but the insurance company won't, um, cover it . . . (pause) and this is such an artificial setting . . . we're seeing a fragment of this person . . . I always believe, in almost every circumstance, that it's prudent and more effective to work with a person in their environment.

The questions about embodied practice (EP), embodied experience/strengths, and

client strengths in general were often in the context of both macro-barriers, as well as

clinical barriers, to regarding these areas. One participant who works with the chronically

mentally ill expresses frustration when I queried her about whether or not using EP or

any strength-based practice is difficult to do:

> In this particular program, it sort of depends on where people are at. We have to be talking about safety issues, for instance.
>
> There's a structure to the treatment . . . and boundaries, but . . .
> But these questions [strengths/embodied strengths] are about quality of life kinds of discussions…Because you're talking about strategies for staying alive, and, you know . . . this kind of discussion may not come up for a *very* long time

I felt this DBT team leader was struggling. She talks about how using a client's

strengths/embodied strengths "may not come up for a *very* long time." I felt she was

searching for her answers (at least at that point in the interview). I sensed her frustration,

so I said what I think from my own practice experience:

> *I find it debilitating, that concept that it's about survival . . .*
> *You know what I mean? it's always about survival, particularly if they're poor;*
> *but beyond that, can you say something about . . . the positive, healthy, engaged*
> *human being . . . even in that moment of crisis?*
>
> You know, just in this time that we're talking, you know this idea of, ah, how do
> people get out of crisis if they don't, you know, do this thing of building a life
> worth living, and that, and that, those are the parts of life that, ah, *are* about doing,
> and creating, and having meaning, in a different way . . . not in a thinking way
> necessarily. I mean, it can't always be, you know . . . if you have somebody who's
> chronically in that state . . . then eventually discussions do have to come in about
> quality of life, I mean, so that eventually it just gets brought in . . . because if
> people aren't taking suicide off the table, your energy isn't going to go into these
> other things in your life . . . we can't just keep doing a chain analysis, and talking
> about it endlessly, talking about how we, you, got here [into treatment].

Lived Experience

Three participants embrace the psychotherapy setting (being in a room with clients), reporting their belief that more "gets done" in this setting than can be effectively accomplished outside of it. One participant said that a client's embodied experience (and lived experience) may not be something she wishes to talk about, that "it's private." Another participant describes the therapy sessions as an "art" of "going back and forth" between strengths and weaknesses to help the person. Another describes the "50-minute hour" as a time like no other when "there's an intensity, and a focus, and a purity to the rapport in the clinical session that is rare on the outside." This participant who is in private practice says, "I think there's something very powerful within the frame of therapy."

Many of my participants (five out of the seven) brought up references to social work practice outside of the "frame of therapy." In this next narrative, a clinician starts by

describing what happens clinically—or could happen—in her agency setting. Then she

begins to talk about the client's environment. As with many of the narratives, an

exploratory process of going back and forth between agency setting, ideal setting,

strengths, weaknesses, and other treatment considerations, was the method of revealing

the data:

> *What do you think would be an ideal program, if you could design it, which*
> *regarded strengths, and embodied experience/strengths?*
>
> I think it would be great if there was more a connection between, um, clients, that
> we had more options to offer people in terms of modalities for experiencing, um,
> different activities, or different, um, treatment approaches . . . you know, I wish
> that, um . . . I think that would be ideal . . .
>
> *You mean more tailored to the clients themselves?*
>
> Yeah . . . and just having, even, more groups that were, like, focused on not just
> imparting information, but allowing them to experience something . . . like,
> whether it be meditation or art therapy, or you know, something that was, um,
> more experiential.
>
> *Ok, so the key word is "experiential"?*
>
> Yeah.

As I often did when I felt the participant was discouraged, or at least circumspect
as to how to better enable strength-based (and embodied practice), I would ask what they
think keeps them and their client from doing that:

> *So, what are the things that make that difficult, ah, to offer? What are the barriers*
> *to that [allowing the client to "experience something"]?*
>
> The barriers to that are time constraints, maybe, um (pause) reimbursement issues
> . . . as for clinical barriers, um, they are the expectation that we can help them in
> their own natural communities, but that's really hard to do, to develop, to do it
> with support, and pursue it on their own.
>
> *Outside, where they belong?*
>
> Exactly.

Because some of the interviews seemed almost too exploratory, and not focused

enough on questions in my research instrument, I asked this next question of the female

outpatient medical social worker a direct question about lived, embodied experience:

> *So what if you went to someone's home and it was an elderly woman, or a middle-*
> *aged woman (or a man) who was knitting, or quilting, and they were sitting there*
> *in their chair and the TV was on, and they were quilting, um, would you see a*
> *different person than you see in your office who* says *they quilt?*
>
> Absolutely.
>
> *And what's the difference between a woman or a man or a person who* says *they*
> *quilt, and you* know *it's important to them, and actually being* with *them while*
> *they're doing it, is there a different person? Or . . . I don't want to lead you . . .*
>
> Right, no. Absolutely, I think there is a different person.
>
> *What's the difference?*
>
> I think the difference is, um, first of all (pause) I, you, as a therapist can interact
> with the activity, with the person involved in the activity. So, obviously, you
> know, you would, I'd, first thing I would do is walk in and make a comment: 'Oh
> god that's beautiful or look at the colors or why did you choose those colors or
> you know, whatever happened to be appropriate to whatever the person was
> working on. Sometimes, again, you know . . .
>
> *Interact? What does that mean? What do you do with that?*
>
> Absolutely. But *while* a person is quilting or knitting or crocheting, and that's
> comfortable for them and relaxing for them, you may also get a lot more
> information that you wouldn't get while somebody was in your office, anxious
> about being in my little, you know, cubby hole with no windows . . .
>
> This conversation was beginning to evolve, methodologically. After following up

with questions of how this social worker uses these client-activities other than to get

"more information," I asked:

> *But what if we could live in an ideal world? As* many *sessions, or wherever, see*
> *the person in the home, etcetera.   What would be an ideal balance . . . if you were*
> *to* invent *the field of social work?*

Truly, I probably would *mostly* like to see people in their homes, because I think when you come to any treatment facility outside of your home it's an artificial environment; I think people are tended . . .tend to, depending on the issue—and not wrongfully—give you the information *you* need . . .

This participant then explained what she meant by the client giving the worker the information the worker needs when working in a problem-focused setting. By working in the home, rather than in the outpatient hospital setting, "the guard gets dropped", while in the treatment facility the patient does not see themselves as the expert, but defers to their doctor, or in this case, social worker. This participant explains that when the guard gets dropped, you can "see what the strengths are." This segment also speaks to the literature about power and control as discussed by Foucault (1980) and White (1990); how, because of the hierarchical relationship between therapist and client, a client's strengths can be obscured, and become, effectively, unimportant.

Embodied Experience/Embodied Strengths

Questions posed to participants about *embodied practice* elicited a rich variety of anecdotal evidence along the lines of their own professional practices. A significant amount of data made connections between strengths and embodied strengths, particularly through the clients' lived experience, or the life that happens "on the outside."

As expected, and as explicated in the literature, there was not much data that addressed the mind/body split (duality). A number of questions that were designed to probe this area (mind/body, as well as the duality of the two) were asked directly as well as in more subtle ways. Indirect, subtle, inquiries, for example, were about what *surprises* therapists experienced of their client's embodied experience/strengths; what, not

including body language (nonverbal cues), did they notice about clients; and if they could

make a general quantification of how much of their sessions were *non-cognitive,* what

would that be? Direct questions about the mind/body topic were ones such as what did

they know of research that links mind, body, and neurology, for example. Also, I asked

did they know of healing practices from other cultures (including their own backgrounds)

that view the person as more than a cognitive construct . . . and rather an "experiential

integration." The question, *Have you ever heard the term body-self?* I did not ask of most

participants—though I had planned to—as I felt an indirect method would be more

effective.

Participants generally expressed confusion about the embodiment questions—or

wanted the questions clarified. There were some specific answers given regarding clients'

embodied experience, one being reference to the work of Bessel van der Kolk and the

neurobiological approach to trauma treatment; another answer was about the "self" in

clients—which the participant elaborated was "more than psychological"—the "self" that

underlies self-harming behaviors. However, generally participants struggled with the

questions. This confusion was thematic—this struggle with embodied experience and

embodied strengths. Conversation (data collection) was even more problematic when

questions—mind/body questions—of their clients' non-cognitive reality were posed.

As the interview progressed from discussion of lived experience to embodied

practice, one or two questions about *body-self* were asked, such as Have you heard the

term body self?; or less direct questions like, When a client comes through the door, what

do you see? Do you see the person in their body? What is also in the room with you? (At

the beginning of each interview I asked each participant to try to make their clients

"present" during the interview.) There were interesting responses that were given—really fascinating responses—but not in direct relationship to the literature on many areas of embodied practice. What Ventling (2002) describes as effective treatment of mind and body together by paying attention to touch, movement, and breathing was minimally alluded to in the interviews. When treatment techniques such as these *were* mentioned it was in reference to practices other than the participants' own, or mindfulness exercises (Kabat-Zinn, 1990, 1994, 2003) they may themselves have used, for example; nor was the idea that a change process for clients that might be facilitated by such phenomena as body-mind repatterning; nor much emphasis on clinical attention to the body (not just the mind, or brain) as being conscious (as presented in the literature).

Implicitly, responses showed that therapists generally (though there were clear exceptions) do not feel a need for more embodied practice in psychotherapy. Rather, they framed their embodied practice used to regard embodied experience and strengths of their clients as, while important, a minimal part of their practice. One therapist responded negatively to embodied practice in psychotherapy: "I can know more about a person by talking about a physical activity with them than by experiencing that activity with them."

Interestingly, while therapists did not mention movement or cellular repatterning strategies such as DMT or BMC as described in the literature, they did contribute experiences from their practices that make clear connections to a majority of the other "practices" offered in the literature review, including physical exercise, residential treatment, adventure-based therapy, and expressive arts therapies. Further, of these embodied practices, an emphasis on mindfulness and psychotherapy—with the exception of one participant—was found as either an integral part of their agency's approach, or as

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a personal practice approach to psychotherapy. All but one of the seven participants interviewed described some physical activity, such as gardening or taking a walk, as being important in their work with clients. On another level, it could be said that principles of "movement repatterning" (DMT and BMC) *do* factor in, perhaps unintentionally or unconsciously for participants. This could be discussed in the next chapter which analyzes the findings.

Below, I report some of the narrative responses to questions about embodiment, and/or body-self.

Body-Self Questions

Three therapists had distinct ways to describe the concept of body self. One participant who works a lot with women with diagnoses of major depression, describes body-self (a person in their body) as in "the here and now" the other what children see.

This therapist who leads a DBT team in community mental health responded to my question:

> *What cannot get transmitted by words? I mean we have a job to do, that is, get the story, agree on the story, agree on the goals . . . But what are we also in the room with?*
>
> Well, it could be that . . . what I was thinking that you were saying is, 'What is there that can't be talked about,' like, it isn't the words . . .
>
> *. . . Wherever you go with that question . . .*
>
> Well, one of the things that I find is that I . . . that because it's a relationship (we do have a job to do) but there's so much more to this person that maybe I never really get to know about, because it's just not, not, you know . . . (pause) what gets done in here, you know.
>
> *What about the person, the self that doesn't think, doesn't know itself even?*

It seems like I don't know a lot about that, you know, 'cause you know, I'm not seeing people in their lives, and, um, ah, yeah, um, so little of that is talked about . . .

The one participant, who is in private practice, was asked a follow up to some of the embodiment question that were asked relative to his own ideas about Buddhist practice, and mind/body issues. In this response, it is apparent that answers to direct questions may instead flow into experience-near data that speaks indirectly to the essence of a question:

Do you think that there's any other mind? We've talked about that, Wise Mind...

Some people say that we're sitting on top of a giant, you know, there a hundred trillion cells in the brain, and there are all these interactions all over your body that get done automatically, not to mention, um, you know sort of the intuitive, more bigger mind spiritual sort of dimensions . . . but you don't even have to go that far, you can just look at your body for much more going on than you're aware of.

So, what's the connection between our mind, and the rest of nature, um, the world . . . ?

The Buddhists will say there's no separation.

Do you intuit that, or do you know that from your experience?

I did not do a scientific study, but by looking at my own mind I have evidence of that.

A Special Case of Embodied Practice

Now, I offer a part of the interview with the participant who regularly uses bioenergetic techniques in the hospital where he is currently an outpatient therapist. This male therapist is the main exception to the others, who use embodied practice minimally. He spoke to the theory of body-self in very practical terms. He is the oldest person I

interviewed (over sixty) and has worked half his career in agencies and half in private

practice. When asked in the interview if he had heard of the term "body self", this social

worker answered simply: "Body-self? Even animals have it, small children have it. It's

easy to see."

The therapist was talking about how "words can be deceptive" in psychotherapy,

and therefore distracting:

> *. . . You were saying verbal can be very distracting. How does the body communicate what it is, what we are?*
>
> In many, many ways. Um, through your eyes, through your breathing, through your muscles. Um, when I talk with clients, I often try to make . . . I ask them how they feel . . . and what I mean is, what do you feel on a body-level, and then I have them explore that sensation . . .
>
> *You do?*
>
> Yes.
>
> *So you focus on a body-sensation?*
>
> Yes, very much so . . . and I may spend a lot of time on that.
>
> *And how often do you do that?*
>
> Well, in this kind of work, here, not as much, maybe only once or twice a week. Um, when I was in private practice, it was multiple times a day. And . . . and I would actually work with that, you know, to try to, ah . . . maybe do some kind of directed exercise where we focus intently on what's happening there; and if you took one step into that part of your body, what would be there? and what are you feeling? . . . So to explore that, and in a way, when you explore it, it helps you to understand what's going on . . . it helps the client understand what's going on . . . but also it teaches them about their body.
>
> You know, when a sensation like, even like, depression or anxiety comes along, that's not the problem, it . . . it speaks to something, and if you can explore what that feeling speaks to, then you can help them out of an impasse.
> You see when they . . . if they can feel it [not being able to concentrate, for example, such as with depression or anxiety] on a body-level, they'll be aware of it themselves; they won't have to have someone else tell me about it, or go ahead

and have the therapist tell them; it will become their reality and then they may even tell *you* as if . . . as if for the first time; because sometimes you . . . someone will say to you, well you know, we, ah, d-d-d, and you say, oh, wow, that's really interesting, and . . . so it's in your head; but then when somebody does that on a body-level to you and you *really* feel it, then it becomes a real "ah ha", and everything that comes along with that, too.

In above narrative, the social worker describes the possibility of, in his words, "getting out of your head," and of the client being able to directly tell the therapist about his or her own in vivo experience in the therapy session. This speaks volumes to the empowerment part of embodied practice (and embodied strengths of our clients), of the concept of self-determination and direct experience.

However, it is often the case that social workers must find a balance between attending to strengths and attending to weaknesses. This same clinician identified a barrier to using embodied practice, at times when the "client's ego is weak":   ". . . because when the client goes home, they may not have the support to handle the new insight. On a Sunday afternoon, the person may not be able to handle it." Personal insight is not necessary for change, of course, or even for drawing on personal strengths. I think what the therapist meant here was that body-work, ala bioenergetic techniques, can cause some people to feel vulnerable and exposed. This idea, that embodied practice may increase client vulnerability, is also a potentially interesting finding which has implications for what clinical barriers there may be to embodied practice.

In the next few pages, I will mix data on embodied practice (EP) by using chart form with narrative form to help contextualize the findings. This may help as well to show how EP has unique "qualities" and "properties" for each participant. Also, displaying some of the data in chart form shows a graphic method for comparing certain

variables, such as use of EP in the present and past from the perspective of the

participants.

The first chart compares the approximate level of embodied practice, past and

present, described by my participants. The finding of interest is that a significantly higher

level of EPs was used in the past (in a single setting) than in the present setting.

Embodied Practices (EP)

Participant	Number of present practices in current setting	Number of past practices in one setting
LICSW-1	0	N/A
LICSW-2	1	3—outpatient medical
LICSW-3	2	TNTM—residential tx
LICSW-4	3	3-5
LICSW-5	3	TNTM— "rec" therapy
LICSW-6	2	TNTM—inpatient groups
LICSW-7	4	20+ / week—private practice

KEY: TNTM stands for "too numerous to mention"; numbers in this chart do not reflect use of the concept of "being present" in a physical way (see Discussion Chapter).

The following chart talks about verbal sharing of embodied experience/embodied

strengths of clients that was elicited from participants. It can be safely assumed there are

probably many more. The chart which follows this one on *what has been verbalized,*

speaks to what is *not necessarily* verbalized. It's purpose is to display clinical data that

has been *physically shared between client and therapist.* But first to the verbal.

Embodied Practice (EP): Over the therapists' career, embodied strengths shared verbally between therapist and client

1. Making children's books and illustrating them

2. Making quilts, clothes, etc.
3. General self-soothing tips (lozenges, herb tea, journaling)
4. Working out
5. Walking
6. Playing basketball
7. Playing music
8. Singing opera
9. Playing on computer (keyboarding)
10. Gardening
11. Farming
12. Household chores
13. Employment activities (factory work, etc.)
14. Parenting
15. Hands-on care of elderly family members

To illustrate this idea of talking about embodied strengths with clients, I give the

narrative of a child therapist during the interview section on embodied practice:

Can you give an example of clients' work and hobbies?

A girl who's very depressed, for example, a teenager, came in the other day, but
she's still interested in basketball, she's still athletic, and, um, even motivating
herself to find opportunities to play basketball; and so I'm going to *fully* (pause)
exploit that, ah, strength.

*Yeah, and so her concept of herself playing basketball, is that a different concept
she has of herself than, say, in the classroom . . . ?*

Yes, she's assertive when she plays basketball, she's empowered when she plays
basketball, she's got control, she can express herself without reservation or
hesitation, she's more authentically herself when she's on the basketball court than
she is in any other place probably in her life.

In the next segment, a therapist in private practice is asked about his clients. I

place the narrative in a wider context to show how embodied experience is known (and as

the researcher elicited), indirectly and directly:

*Do you have any anecdotes to share about embodied strengths, or embodied
experience outside of therapy, of clients you've known . . . strong impressions?*

I don't really know what you're . . .

In other words . . .

Do I know of any such *instances*? Is that what you're asking me?

Yeah, and it might go back to what has surprised you about . . .

For years, I've been seeing a shy, slightly insecure guy, who's got a *tremendous,* almost operatic singing voice.

Well that guy, that's an elaboration of what we're talking about; but of clients who don't have much to say, and it's hard to illicit things from them . . . ?

To go back just a little bit [we had been talking about making early assessments of clients], another example would be, um, men who just can't talk about their feelings very well, but they're firemen, or cops, and when you're having a fire, this guy is . . . he is hot, he is your man, you know, he knows what to do, he knows how to put the fire out, he knows, um, how to be safe about the whole thing, he knows how to get everybody out of there, and yet he can't talk about his feelings very skillfully in the session.

But if somebody is not very verbal, I go to what they *can* talk about . . .
There was a teenage kid who was just doing yup and nope and forced and mandated to be here with me, and um, at *last* I hit on that he was into video games, and, um, playing these networking games and stuff, and we talked about that stuff from one end of the session to the other, and he had this incredible strength of keyboarding, and relating to people on line and stuff . . . And he was really bright, you know. And so he, I, I . . . and he didn't want to talk about his *feelings* about anything, but I could get a lot, kind of working the um, ah, ah, the video game thing as if it was a metaphor for the rest of his life.

Below, I simply list the EPs clinicians identified for use during their sessions with clients, in which embodied strengths were *physically* demonstrated. Number 6—*doing volunteer work in an agency setting*—is described later in the chapter in the *Issues of Gender* section. Other illustrations from this list are scattered throughout this chapter. I place them here because EPs which involved a physical connection between client and therapist *were* emphasized during the interviews, and I just want to show that. What is important here is to understand that an emphasis was placed on eliciting EPs, but positive responses were minimal; this, in my view, is another interesting finding. As I will discuss

in the next chapter, this seeming minimization of EPs may be due to the therapy frame

(and practices of my participants) being in a room, sitting in chairs or couches, and/or it

may be due to the age of many of my participants. Generally, the overall narrative data

collected for this study was *peppered* with information shown in the following list:

Embodied Practice (EP): Over the therapists career, embodied strengths shared <u>physically</u> between therapist and client, or otherwise performed in a psychotherapy session

1. Playing Djenga and other fun games of skill in groups
2. Groups games with yarn (and social interaction)
3. Playing chess
4. Playing basketball
5. Riding adult tricycles with veterans
6. Doing volunteer work in the agency setting
7. Playing on computer (keyboarding)
8. Walking during psychotherapy session
9. Bringing in scented candles, artwork, journals, fabric, poetry
10. Swimming in a girl's group (child treatment)
11. Gardening
12. Walking in flower gardens
13. Bioenergetic practices with individuals and couples
14. Mindfulness exercises (awareness on bodily sensations)

The purpose of the next section (issues of gender) is to help to understand how

embodied experience is physically and psychologically experienced differently by

people. While I choose to address gendered experience of embodied

experience/embodied strengths, this section could be written with any group of people in

mind due to the fact that an appropriate use of embodied practices is determined by who

is the client, and what are a client's priorities.

Issues of Gender and Embodiment

One participant, who works a lot with women with diagnoses of major depression,

describes body-self (a person in their body) as existing in "the here and now." This social worker who works in the community also frequently makes referrals to a battered women's support service. She makes the point that clear and consistent physical boundaries, particularly for male therapists, are essential to work with women who have been abused.

As a male researcher I am not sensitized to the embodied experience of women. I was interested to hear two disparate perspectives of female social workers, one African American, one white. Each perspective is instructive to the issue of gender and embodiment.

First the white clinician, who has spoken earlier about re-mediating trauma after rape in a military setting, challenges limitations of embodied experience (and strengths):

> I took walks, out in nature, you know (around the hospital) with this woman who had been assaulted. I wanted her to know that, ah, she could be . . . feel safe, really safe . . . and do that again. I think it's . . . um … there's a lot of things . . . some of the physical memory of being assaulted. But if you get someone out into the physical body they can . . . um, ah, re-mediate that event. Now, I'm talking about a woman who never said a peep for almost a year, who would, ah, curl up on her, um . . . this kind of couch thing I had . . . in a fetal position . . . and now, I see her and can't shut her up!

More about women's embodied experience from the same participant:

> Part of it is upbringing, you know . . . what are you comfortable with, your ability to challenge and be who you want to be . . .
> When I was a girl, I couldn't go out . . . I had to sneak out, you know . . . my parents thought anything that could potentially be dangerous . . . it could "put your eye out", as my parents used to *always* say.

An African American social worker who grew up in the period of the civil rights as well as the second wave of the women's movement responds to my question about body-self:

It's like, it's like for me…you know, most of the clients that I have are working class, um… are either of some visible racial or ethnic group and have some issue that they're working on that impacts on their ability to survive on a day to day level, so *race, hhh, gender?* That's *all* their body stuff.

So, it sounds like they're really stressed.

No, they're not *really* stressed. But that's a value judgment that everybody has time to participate in regular physical activities…
Those are really privileged, middle-class, things… Those are really privileged hobbies and habits that people can develop.

After this, I said to the participant that I appreciated this information on what it's like for her clients, but that I needed to persist with the questions about embodied experience/embodied strengths. This therapist then offered more about her clients and their capacity to feel satisfaction with daily activities, even leisure-time activities (see mastery and competence section of this chapter). She explained, more than anything else, parenting and employment were the domains in which her clients experienced a feeling of efficacy.

To end, I would like to move toward some of the positive responses to questions about embodied experience/embodied strengths given in some of the preceding sections. These responses seemed more the average, over the sample. They are, I feel, the marvelous, idiosyncratic, and simple kinds of responses that one would probably hear from most social workers at any point in time (and that I recorded on my digital tape recorder). One response is from a clinician who does psychotherapy with adults; while this clinician did not always demonstrate a clear sense of what I was asking in terms of the language of embodied practice or strengths, she did demonstrate a strong sense of embodied practice, for her own practice. She seems to "take in" the embodied person in an essential way; when asked about a body-self, her response was, "you can see by the

way they sit, by the way they laugh . . . " This clinician also said: "I take it in, but I don't

write it down… it's just an observation." I took this, along with responses from other

participants, as non-scripted strengths perspective practice, performed but not

documented; by regarding the physical selves of the client, and a basic way to do

embodied practice.

This next clinical social worker, and also a teacher of Buddhism for many years,

was asked: *What percentage of the time you see clients is verbal versus non verbal?* The

answer was, "I think each one is a hundred-percent." This clinician who is in private

practice now, but has taught family therapy to psychiatry students, brought forth the

"other selves" of clients in this pedestrian response to the question: *Have you ever been*

surprised at what a client said about what they do?

> Well, I've been surprised that some people have been musicians…and I had no
> idea… and they're part of a band that plays every Saturday night, and they're very
> successful . . . that sort of thing . . .

> Or . . . um, um . . . I've been surprised at somebody who says they're a factory
> worker, and think, yeah, it's sort of an assembly line thing, you know, but then I
> find out as they're talking about it that they're very sophisticated machine tool
> operators, or something like that, and that they're . . . and I can imagine them "in
> command" of their profession.

Summary of the Findings

There was agreement across the sample about the importance of a strengths

perspective. Most participants offered vivid scenarios or vignettes from their own

practices to support these assertions, assertions that demonstrate a genuine interest in a

strengths perspective. In terms of *embodied practice,* most could not identify more than a

few embodied practices they use currently. Interestingly, most participants identified a

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decreased use of embodied practice over the course of their careers. No direct analyses were offered about this decrease. This finding will be further analyzed in the discussion chapter to follow. The narratives elicited about embodied experience and embodied strengths were generally inconclusive. This is not to say that participants were not interested or engaged in the conversations; all participants had very interesting data to contribute.

One theme which clearly emerged from the data was the idea (practice?) of "being present" and "being mindful" when with clients. One participant even said that "intuition" for clinician as well as client is a "strength." Frequently, participants used terms such as "grounded," "experiential," and "being present." Participants also described their strategies for using embodied practice as "weaving it in" to their work, or "finding a balance" in their work. These types of comments were expressed frequently.

Lastly, questions exploring the idea of working with clients in their home or work environments produced valuable data about client strengths and client embodied strengths, as well as creating opportunities to help build mastery and competence. Over half of the clinicians interviewed expressed views that seeing the client in her or his environment helps focus positively on their lived, embodied experience.

CHAPTER V

DISCUSSION

Is there a poem that never reaches words?
Wallace Stevens (1942)

It is not easy to know about a person's lived experience. We do not see our clients in their life space. As part of social work assessment phases, might we try to make an account of our clients' positive embodied narratives and experiential integration that is their embodied selves? Do we even know what our clients *do* in their life space*?* Do we know what they do that exhibits competency and resourcefulness? A review of the literature reveals that current writings on social work clients' lived experience are lacking in comparison to literature on client deficits. Not surprisingly, the literature is also lacking in the area of our clients' *embodied* strengths. This study's purpose, therefore, was simply to explore what social work therapists know about client strengths as expressed in the lived experience of the body; and to look at what aspects of their own practice is embodied (embodied practice). I also discussed with social workers the subject of barriers to embodied practice, and the possible lack of regard for our clients' embodied experience. The purpose of this side-discussion on *barriers* was designed to explore why, as Parviainen (1998) says, "The social body is rarely reflected on" (p. 27).

Points of entry into a person's embodied experience and embodied strengths were taken by this study to be a person's work, hobbies, and other areas in their life space where competency and resourcefulness may be experienced. This study intentionally

focused away from pathology and toward windows of hope. In this vein, this study assumed that a person's strengths as expressed in the lived experience of the body can be explored through social work assessment and ongoing treatment. Using a methodology that solicits meaningful data, questions were asked of participants that illuminated some of the areas where social work therapists do and do not regard embodied experience and strengths in assessment and treatment phases.

This chapter begins with a discussion of the major findings, then a discussion of a few less significant, though interesting, findings. The results of this study will be compared to insights drawn from the literature. After this comparison, some of the strengths and limitations of the study itself will be examined. To conclude, I will state some of the implications for clinical practice and opportunities for future research.

Key Findings

Participants responded to this study with a feeling of interest and engagement, with each participant uniquely rooted in her or his own professional experience. In narrative form, clinicians offered a wide range of specific practices and anecdotal evidence of how they do and do not regard embodied strengths. Across the sample, interest in this area of practice was high.

Incontestable findings show, however, that therapists in the settings in which they currently practice (in the consultation room) believe that they under-use embodied practice. Participants revealed this theme both manifestly and latently: they know that they appreciate client embodied strengths, but also know that they do not and can not

solicit these strengths as much as they would like to; and latently, participants reveal that

embodied practice has *decreased* over the course of their careers.

It was also a possible important implication of this study that to help counter a

decrease in attention to client embodied experience, participants describe intensified use

of being more "present" in sessions. This is perhaps the most interesting positive finding,

in my opinion. It was not clear how deliberately my participants use this counter-practice,

but it emerged as a theme across the whole sample; a theme of "being present" and "being

mindful" when with clients. One participant even said that "intuition" for clinicians as

well as clients is "a strength." Other participants used terms such as "grounded,"

"experiential," and "being present." Participants also described their strategies for using

embodied practice as "weaving it in" to their work, or "finding a balance" in their work.

These types of comments were expressed frequently.

As I will discuss in the section on implications for practice, the finding that a

counter-practice has emerged due to decreased attention to embodied experience over

time may deserve further study to enhance this practice.

As expected, this study found that participants generally were able to describe the

essential tenets and practices of a strengths perspective in social work as described in the

literature (Cowger, 1997; De Jong & Miller, 1995; Early & GlenMaye, 2000; GlenMaye,

1998; Poertner & Ronnau, 1992; Saleebey, 1992; 1997; 2001; Weick, 1992; Weick,

Rapp, Sullivan, & Kisthardt, 1989; White, 1990). They also felt that they embrace these

ideas in practice, viewing the client-as-expert and helping them to externalize their

problems by exploring alternative self-narratives. One participant who works in

community mental health typifies this sample's view of client strengths: "There's so

much more to the person than what you see [in therapy sessions]." No matter the setting

or population, six of seven participants described a personal desire to clinically attend to

client strengths—and to a lesser degree embodied strengths—*more* than they do

currently.

It was also found that participants felt that the important concepts of competence

and motivation (White, 1959), as well as the "feeling of efficacy", or experiencing

oneself as a cause, as well as ways to operationalize these concepts, were essential in

their own practices. I will present the concept of competency as this chapter progresses.

In a positive way, participants were able to identify numerous *potential* clinical

applications *could they act* on their desire to regard client strengths in general, as well as

embodied strengths in particular. While this was not a quantitative study and exactitude

was not possible, this study did show that more than half of the sample more than half of

the time feel constrained by various factors that mitigate against focusing on client

strengths, as well as constraints to regarding strengths as expressed in the lived

experience of the body. Due to the nature of a social work therapist's environment (for

my participants, anyway), this finding was expected.

Another major theme regards working with clients in their life space. Valuable

data was produced by inquiry of participants on working outside of the consultation

room, and what that means. One participant, an outpatient medical social worker, said:

> Truly, I probably would *mostly* like to see people in their homes, because I think
> when you come to any treatment facility outside of your home it's an artificial
> environment; I think people are tended . . .tend to, depending on the issue—and
> not wrongfully—give you the information *you* need.

As I will continually emphasize in this chapter, seeing clients in their life space helps facilitate a process in which social workers can focus on what things people are good at, and ways they are socially and physically resourceful.

A few minor themes that emerged help show that regarding client strengths (and competencies) as expressed in the lived experience of the body is a complex problem. For example, some participants said that working with a person's physical reality can be perceived as invasive, and cause a client to feel vulnerable and exposed. However, all participants did indicate that even those clients who are severely and chronically ill can benefit from clinical attention to embodied experience and embodied strengths. This finding was also supported in the literature (Payne, 1994; Vendling, 2002). The following section compares my findings to the literaure.

Findings and the Literature

Much of the literature cited in Chapter Two draws from a number of sources, including social work theory and practice. Psychological, physiological, expressive arts and movement theories make vital contributions to my study's problem. The reason for including research and scholarship from other helping professions helps to create what I will call a matrix of inquiry. The elements of this inquiry are client strengths, lived experience of the body, and embodied practice (EP).

In the review of the literature I state that no research study has been found in the social work literature that directly addresses my research question. Two areas that intersect the most with my study are residential treatment (Gilligan, 1999) and adventure-based therapy (McDowell, 1999; Moga, 2004; Shaw, 2005). Client embodiment is seen

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as just as important as cognition and other domains of experience, and sometimes at the center of practice in these two treatment settings. However, the inclusion of body self concept (sense of self) (Krueger, 2001) is not usually addressed in these settings. While competency is valued (physically and psychologically) these two treatment modes do not necessarily operate from a strengths perspective.

Results of my study that are clearly consistent with the literature are those related to *the strengths perspective* and *client lived experience.* These results help to make a concrete focus for my research. This research as I will discuss in the strengths and limitations section was problematic for socio-linguistic reasons as well as it's large scope. Additional research would be necessary to more adequately explore some of the questions posed by this study. For example, If I had done a study on client embodied strengths and feelings of efficacy (competence), my findings would more simply reflect literature from residential treatment and adventure-based therapy. As it is, a comprehensive process of comparison between my findings and the literature would be too complex. I hope to adequately modify this process as I will show in the sections on implications and opportunities for future research at the end of this chapter.

Another complication in terms of connecting the literature with my findings is that embodied practices as presented in Chapter Two are very different from those practiced by my sample. They are different in theory and technique in some cases, but also philosophically and/or culturally. There are problems and inconsistencies with language, such as in the areas of mind/body (Kabat-Zinn, 2003; Scranton, 2007), body-mind (Aposhyan, 2004; Cohen, 2003 revised), and culture (use of therapeutic touch (Betta de Boer-van der Kolk, 2007; Sakiyama & Koch, 2003) in westernized society, for

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example). This problem of finding the relevant connections between the field of social work and those that rely heavily on embodied theory and practice is not just a challenge in this study; it is a more comprehensive issue. One important theme concerns social workers heavy reliance on the medical model which tends to undermine attention to client strengths and lived experience. I will also treat these areas later in this chapter.

As noted above, results that are most noteworthy and consistent with the literature were my participants' positive views on the importance of building on client strengths even though they often feel constrained or limited by the forces directing practice. Cowger (1992) characterizes attention to client strengths as a recurring philosophical and theoretical construct in social work literature. My participants' perspectives on using client strengths clearly reflect that. While some clinicians would like to use a strengths perspective more in their work, most describe a practice of "weaving in" clinical attention to client strengths with the delivery of social work services (in the case of psychotherapy, stabilizing and making appropriate referrals).

In the general area of strengths, this study will continue to highlight the concept of *competence*, and from the area of lived experience a clinical practice that regards a client's *environment* (Germain & Gitterman, 1980; Saleebey, 2001). Reflected in both the literature and in my sample's narratives, competencies are best accounted for outside of the psychotherapeutic frame ("50-minute hour"). From this comparison it is easy to see that the domains of individual competence and the life space are the strongest, and perhaps most relevant, intersections between literature and results of this study. This study also indicates that even for poor clients who social workers see so often, competency in the life space does not fall lower on scale of Maslow's (1943) hierarchy of

needs than with those who might have more resources. While this study did not access

the literature on how and where embodied practice might be prioritized, my data revealed

an even playing field. One participant who works with young Latina women (who are

also poor) said embodied experience

> all revolves around employment and *parenting* issues . . . and, um, you know,
> trying to, sort of develop a sense of competency and proficiency

Where some inconsistencies show up between findings and literature are places

where a "medical model" and an empowerment model clash. Participants were unable to

identify institutional barriers. Participants were also unable to identify a mind/body

duality (Scranton, 2007) as shown in the literature. My participants work in hospitals and

clinics and they readily identified a number of barriers to ways they might foster client

empowerment. As described in the literature, narrative and collaborative approaches help

empower our clients. Creating alternative stories or narratives (White, 1990) for clients

may be accomplished in a cognitive way, but may be harder to do experientially. Body-

mind repatterning (Aposhyan, 2004; Cohen, 2003 revised) was not a concept (or

approach) my sample identified. Clinicians largely rely on a medical model that

compartmentalizes aspects of the lived-experience of persons in psychotherapy (Hartman

& Laird, 1983; Saleebey, 2001). This reliance on the medical model prioritizes

psychological issues and medical necessity over all else, minimizes the body self and

separates mind from body (Saleebey, 2001; Scranton, 2007). Saying this, body self (sense

of self) concepts (Krueger, 2001; Parvanainen, 1998) were minimally addressed by my

participants. This was not a surprise. Yet latent content was heartening; the words of

participants ("There's so much more to the person than what you see [in therapy

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sessions]") point toward the structures in which windows of hope do exist; windows this study as well as the literature attempt to open.

Strengths and Limitations of this Study

According to Steinberg (2004), analysis of qualitative research begins with clarity about words and ends with interpretation. Many "words" and phrases were left unclear by this research. The scope of this study was likely too large to accomplish adequately by only having one hour per interview to explore the questions. This may have been the major limitation of this study: lack of interview time; and/or questions from too many areas of theory and practice. Seeking to probe clinicians' experience about topics ranging from mind/body issues to barriers to embodied practice in the context of strengths perspective made it difficult to interpret data, partly due to "words" and "terms" being used differently from the literature (of which there were disparate fields with different terminology) and among my sample. Future studies would need to keep the problems of terminology in mind.

I would like to emphasize this lack of clarity (too many questions) experienced within the narrative data. While my sample was expert and diverse in the field of clinical social work (psychotherapy), participants could not operationalize (nor could I) some of the language and concepts treated in this study's literature. Examples of this are data solicited on embodied practice and empowerment. Concepts I asked about did not directly relate to current settings in which participants practice.

By calling attention here to this study's problem with its focus, and with the participants' occasional lack of connection to the problems I posited, a positive

"methodological" claim can also be made: participants were behooved to explore difficult terrain, new terrain. Participants still produced data that was rich and experience-near; narratives were replete with values that support strength-based practice, embodied practice; and values that resist the way we can pathologize people who seek our help. Because much of the data was rich, I can say the limitation of the study's approach to data collection was also a strength. By allowing room for a lot of interpretation (a possible limitation), a space was created for grounding fluid theory-building in reality or empirical data (Anastas, 1999). Answers were not expected: researcher and participant maintained a reflexive stance; unknown quantities were shaped and interpreted by the seat of our proverbial pants. While clinicians were asked to explore ideas of embodiment that they may not consider much in their daily medium, an understanding of mind/body issues that are usually so complex (yet popularized these days) could be co-constructed; questions about how a clinician attunes to a client's embodied self could be exchanged; and a change process for the client that is felt and experiential rather than a cognitive construction, could be storied.

Reliability for this research seems at a high level. The flexible methodology and research instrument (interview guide) employed were centered on being curious and solicitous. While, participants did sometimes seem to be reaching for answers that they may have felt I was trying to get them to say (as I have suggested in the preceding chapter on the findings), they predominantly explored their own experience (as well as the questions) in their own way. When participants did not always understand a question they still offered interesting interpretations—or asked for clarification. This fluid process required me to re-formulate some of the questions after two or three of the interviews.

Further, case vignettes that I brought to interviews and planned to utilize should participants have difficulty coming up with their own were not necessary. Participants offered plenty of their own cases and examples.

As for the research instrument, the ways in which I needed to refocus, or re-formulate, the interview guide were simple—and only was a matter of emphasis. For example, I spent less time exploring questions of strengths and empowerment in general, and more on embodied experience, embodied strengths, and actual activities of my participants' clients. I also emphasized questions put to participants asking how they might envision a practice that was more inclusive of our client's embodied experience. To get at our clients' physical sense of self (body self), I began to ask more about what surprises my participants have experienced with clients. I would characterize this flexible methodology, the facile quality of conversation, as a strength of the study.

Going back to the reliability of this study's data, skepticism of this researcher's assumptions (Anastas, 1999) was invited in to the conversations with participants. This spirit of skepticism invited participants to disagree with my biases. One participant, for example, felt strongly that using a strengths perspective, and particularly attending to client embodied experience, is not that important in the frame of psychotherapy. In fact, most participants identified areas where such attention (to strengths and embodiment) is not warranted and areas when it is probably counter-productive, even unethical. The research instrument was designed to seek the negative case; the negative case was solicited. The implications that challenge this study's assumptions stand in the narrative data and can not be ignored.

Regarding issues of validity, or how accurately the data was collected and analyzed, the reflexive quality of the interviews (a two-way participation in producing narrative) provided data that was experience-near and particular. This data was valuable because the small sample—seven participants—provided such "thick" descriptions. However, the subjective nature of the data as well as the small size of the sample means that my findings can not be generalized to other populations or practices.

Another limitation of the study is that the sample was comprised of older clinicians (average age 45) who may not be "up on" current "embodied" social work and other modalities. (Literature is not presently extant on innovative embodied practices in social work. I assume, however, that some are out there that have not been scientifically supported (controlled studies)). Further, seven of the seven participants are white and all practice in New England. This is a factor that may be limiting because cultural and local expertise in embodied practice probably exist outside of my sample's demographics. My sample's clinical practices also employ cognitive behavioral approaches in tandem with psychopharmacology. While one can assume that the participants have developed their practice over their professional lives, and that they are essentially content with professional choices, the CBT/drug approach within their settings is a significantly limiting factor to an approach to embodied practice. This study implicitly assumes the CBT/drug approach has this effect. Data generally supported the idea that these clinicians experience numerous barriers to embodied practice. Interestingly, one participant, the one with the most connection in his practice to embodied techniques (bioenergetics), said he had "made a pact with the devil" by working in a setting in which he can not regard client embodied experience or strengths. All of these issues about limitations to coming up with

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the best data infer a need for additional research. If, for example, a study were done which asks similar questions of practitioners in different settings, such as residential treatment or adventure-based therapy, very different content (and data) would probably be revealed.

Implications for Clinical Practice and Policy

The narratives of this study's clinicians speak to a need for more writing and research in the area of regarding our clients' embodied strengths. All but one of the seven participants identified important gaps in the ways they approach their clients in terms of their embodied experience. While participants did identify a number of ways they regard embodied experience (by being more "present", by crediting experiential learning over cognitive learning, and even giving credit to human "intuition" as a strength), a sense of frustration overall—even disappointment—was revealed in the data. Further, according to the data, agency policies that put too much emphasis on the cognitive understanding reached between clinician and client fail to attend to the lived and embodied experience of people. This study implies that future study may reveal that the emphasis on a cognitive approach fails egregiously in ways that undervalues a person's lived, embodied experience. By undervaluing a person's embodied experience, their sense of self (body self) is inadequately regarded in a setting which does not really view the client as the expert. Our clients, like all persons, have a sense of self that is not just a cognitive construct but is an experiential integration.

Recommendations for Future Research

      This study helped to identify certain elements for social work embodied practice, as well as future study: client strengths, client embodiment, client life space, and clinical "embodied" theory and practice. For social work, these elements together form a matrix of inquiry, if you will. Some of the questions that may require more study as a result of this study's findings are:

1. If embodied practices have been in decline over recent years, why? (My study suggests that there is a decrease in social work practice in the clients' life space and community.)

2. Does a decline in embodied practice signal a shift in clinical practice toward a more intense level of attunement (being "present") between social worker and client, as this study suggests? What implications does this have for clinicians being "physically" more present over psychologically more present? What are practices that social workers could utilize? What theories can be explored that might bring this practice into wider use? The literature supports further inquiry: Germer, et al (2005) describes techniques of "being present" as "easily experienced by anyone" "but cannot adequately be described. Mindful awareness is mostly experiential and nonverbal (i.e., sensory, somatic, intuitive, emotional)" (xii). A study like this could yield useful results, as well as important implications for social work practice and policy.

3. How do we regard client "embodied" stories? What are daily activities of clients? Do we regard them? If not, why, and what effect does this potential neglect have on treatment of social work clients?

4. How do social work clinicians from non traditional psychotherapeutic settings— notably residential treatment and adventure-based therapy—attend to their clients' body selves in the areas where they experience a feeling of efficacy, a la Robert White (1959)? Looking beyond "western" psychotherapy, what healing traditions attend to a person's body self? What healing traditions attend to a person's life in their authentic life space, and how can this influence social work practice and policy? Further, are there significant cultural proscriptions to using a strengths perspective that need to be considered when using embodied practice?

5. This study suggests there may be patterns based on gender, ethnicity, or other group identities that oppress our clients' embodied experience. What factors are significant when studying a person's embodied self? Further, what are the best approaches to working with clients who may perceive embodied practice or inquiry into embodied experience as privileged and/or invasive?

6. Do people with severe mental illness develop hobbies and interests the same way people without these challenges do as this study suggests?

7. White (1959) used the phrase "a pleasure of enjoying one's abilities" when he borrowed from Heinz Hartmann's (1956) Notes on the Reality Principle the idea that "adaptive skills developing in the conflict-free sphere may have a decisive influence on the handling of conflicts" (White, 1959, p. 308). Does this important aspect of White's theory of competence motivation also hold true when a person is re-mediating a traumatic event, or doing exposure therapy? (Some clinicians in this study see competence motivation as working in pleasureful as well as anxiety-provoking situations.) Further, how can social workers develop more creative modalities that access the different channels of learning that are more pleasureful?

8. How do social workers experience their clients as bodies?

Conclusion

In their classic work, *The Life Model of Social Work,* Germain and Gitterman (1980) talk about how human beings need effective interaction with the environment. (This idea goes back to Robert White's (1959) classic paper on mastery and competence as described earlier in chapter two). This study, "embodied practice," seeks to identify opportunities for when our clients feel efficacy. In *The Life Model,* the authors write:

> Repeated experiences in which this need [effective interaction with the environment] is satisfied leads to feelings of competence. While competence motivation may be covered over or dampened by harsh environments, it can be mobilized and supported by imaginative provisions of opportunities for action. And finally, effective coping requires willingness and ability to turn to the environment for information, resources, and support. (p. 101)

Social workers spend time with people of all classes and cultures. No matter what the problem, what the oppressive forces, people have embodied experience that is masterful, effective, and satisfying—and regularly beautiful. In the section on embodied practices in chapter two, many ways of seeing, and working with, people as creative participants in their environment are presented. Some are more comprehensible than others; but most mix the concrete and practical with the spiritual. A social worker who I interviewed in this study wants to expand her clinical practice to include a person's physical activity in the home. She describes this client as a quilter:

> As a therapist [you] can interact with the activity, with the person involved in the activity [. . .] The first thing I would do is walk in and make a comment: 'Oh god that's beautiful or look at the colors or why did you choose those colors or you know, whatever happened to be appropriate to whatever the person was working on.

Is this anecdote banal? Is it commonplace? Or does this social work clinician describe a crucial nexus of competence, personhood, and the life space? As Dennis Saleebey (2001) has said:

> To be able to do, to be able to make things happen, to develop the resources and knowledge to live as well as possible given the challenges and constraints, the possibilities or foreclosures of your life space is one of the vehicles that drives people to the farthest reaches of possibility. (p. 489)

To this, we add what a person does physically, from climbing a cliff to buttoning a sweater.

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Appendix A

<u>Human Subjects Review Approval Letter</u>

SMITH COLLEGE
School for
Social Work

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

March 22, 2008

Duncan Nichols

Dear Duncan,

Your revised materials have been reviewed and all is now in order. You have done a good job of clarifying your purpose and defining your terms. We are happy to give final approval to your interesting study.

Please note the following requirements:

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

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

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

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

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

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Joan Laird, Research Advisor

Appendix B

Informed Consent Form

Dear Potential Research Participant:

My name is Duncan Nichols and I am a graduate student at Smith College School for Social Work. I am conducting a study of assessment and treatment issues that arise when working from a strengths perspective with clients, and particularly the strengths inherent in our clients' physical selves, physical activities, and physical lived-experience both within and outside of the therapy room. This study assumes that a strengths perspective of a client, first of all, asks the therapist to look for the values and resources employed by the client; to learn from the client his or her strengths, who, according to strengths-based practice, is the regarded as the expert; and to co-construct with the client (or family), a narrative that informs treatment. Body-based strengths include the storied use of the client's body within the client's own narrative of their life; examples of these strengths—strengths that are viewed by the client as healthy and adaptive—are hobbies, work, play, and sports

This study is being conducted for my thesis in partial fulfillment of the Master's of Social Work degree at Smith College School for Social Work and for future presentation and publication on the topic. I have received permission from the Human Subjects Review Board of the Smith College School for Social Work to conduct this study.

You are being asked to participate in this study because of your experience as a social worker who has likely been trained to make biopsychosocial assessments and may

have special knowledge of strengths-based assessment and interventions. You must also speak English, as no translation services are available for this study.

If you choose to participate in this study, you will be asked to sit for an interview lasting approximately 45-60 minutes. Interviews will be audiotape- recorded. You are asked not to use names or identifying information of your clients when you talk about examples of your work.

The interview will cover the following topics: Demographic information; Strength-based (Strengths perspective) assessments and interventions used presently or in the past in your practice or otherwise known to you, with an emphasis on how your clients' physical (embodied) lived experience affects your practice. Simply put, questions you will be asked will explore the awareness in treatment that the therapist and client bring to body-based strengths, such as hobbies, work, play, and sports. You will be asked to briefly describe the general scope of your practice, as well as identify any demographic information that contributes to the diversity of the sample.

This is a low-risk study, and this researcher anticipates no risks to participation. You can choose not to answer any question and/or to stop the interview at any time. There will be no financial benefit to you for participating in this study. However, participation will allow you to share your experience(s) working with your clients over the course of your careers, as well as hopefully make a contribution to the practice of social workers and other health professionals.

Assigning interview tapes a number and removing any identifying names and locations from transcripts will keep confidentiality. Your name or identifying information will not be discussed with anyone in connection with this study. Some illustrative quotes

may be used for publication but will be changed to eliminate identifying information, thereby protecting your privacy. I will be the handler of all data including tapes and transcripts. However, my thesis advisor(s) will also have access to this information after all identifying information has been removed. I will do all the transcriptions myself. I will keep the tapes and transcripts for three years, in compliance with federal regulations. During this time, tapes, transcripts, and consent forms will be kept in a locked cabinet. After the three-year period has expired, all material will be destroyed. If at any time during the interview you do not want to answer a question or you wish to discontinue the interview, that is your right and I will honor your request without any repercussions to you. You have the right to withdraw from this study at any time (before, during or after the interview) up to April 15, 2005, when the report will be written. Should you choose to withdraw, all information pertaining to you will be destroyed.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; 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

If you have any questions, or wish to withdraw form the study, please contact me at:

Duncan Nichols
West Central Behavioral Health
140 North Street
Claremont, New Hampshire 03743
Tel. (603) 542-2578

You may also contact the chair of the Human Subjects Review Committee, should have any questions or concerns at 413-585-7974

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS. I HAVE
INCLUDED AN ADDITIONAL COPY FOR THIS PURPOSE.

Appendix C

Letter of Inquiry

Dear _____,

I was given your name by _____ or through_____. I am a

candidate for the degree of Masters in Social Work at Smith College School for Social

Work, and I am currently doing my second internship, which is at West Central

Behavioral Health in Claremont, New Hampshire. I am conducting a qualitative,

exploratory research study that explores strength-based practice and how therapists

regard their clients' physical lived experience (hobbies, work, sports, etc.). The intent of

this study is to help inform other health care professionals about our clients' strengths,

whatever they might be.

Participation in this study is completely voluntary and anonymous and would

entail your involvement by being interviewed for 45 to 60-minutes. During this study,

you will not be asked to disclose any identifiable information. The data collected during

this study will be used for my MSW thesis and in any resulting publications or

presentations.

If you are interested, please get back to me at my place of work, 603-542-2578, or

at my email address, dnichols@email.smith.edu, and I will send you the Informed

Consent Form.

Sincerely,

Duncan Nichols

Appendix D

The Interview Guide

1. How do you identify yourself as a therapist now?

2. What approach(es) to doing therapy do you use/ have you used?

DEMOGRAPHIC INFORMATION

1. What is your age?

2. What is your race/ethnicity/other cultural identification?

3. What may be some other socio-cultural characteristics that you feel may be relevant to this study?

STRENGTHS

1. Have you heard the term in social work, "a strengths perspective?" Is that something you use in your work with people?

2. Whether or not you use that term, how do you bring that idea into your work? Do you support your clients' achievements, for example? How?

3. Do you use a *family's* strengths in your work? If so, how?

4. Do you use a *community's* strengths in your work? If so, how?

5. What does empowerment/power mean to you, and how do you bring it into your practice?

6. If you do not regard or credit clients' strengths much clinically, why?

7. What do you think prevents you from paying more attention to client strengths?

8. Have you ever been surprised by a client's strengths?

EMBODIED STRENGTHS/ EMBODIED EXPERIENCE

Before going into these questions with participants, I will briefly define "embodied

experience." As is consistent with the intention of this study, the experience of the clinician's clients will also be connected to a strength, rather than the focus being solely on the client's problem or weakness. The "embodied experience" (primarily activities that are within our awareness such as hobbies, work, play, or sports) will be defined as an embodied strength; another way of defining this is a strength experienced as healthy, adaptive and a positive experience from the client's perspective.

(If the interview feels stuck in this part of the interview, use the case vignettes (Please see Attachment 4) to illustrate people's embodied strengths and to stimulate ideas—this will be the only time that case vignettes may be referred to.)

1. What have you noticed about the nonverbal, non-cognitive aspects of your clients?

2. What percentage, would you say, of the cognitive versus the non-cognitive do you see in your practice with people? Including "body language"; not including "body language."

3. Do have any anecdotes to share about embodied strengths/ experience regarding clients you have known? (This could be in therapy or outside the therapy room.)

4. What percentage, would you say, of the cognitive versus the non-cognitive do you see in your own life, in your practice, or in your private life?

5. Can you give some examples from your practice? (Work, hobbies, pastimes, artistic endeavors, household chores, jogging).

6. Do you bring the concept of embodied experience into the therapy room? Do you bring *actual* embodied experience into the therapy room? (For example, what people like to do, hobbies, etc.).

7. What, if any, embodied experiences are brought into the therapy room?

8. If you don't bring embodied experience in, how would you? Or would you? If not, why?

9. Have you ever been surprised by a client's embodied experience?

10. Do you know of other therapies, disciplines (particularly healing traditions) outside of your own that incorporate the body in a different way than you do, or have?

11. Have you heard the term "body self?" Have you heard the term "embodiment?"

12. Shall we create our own—or would you share your own—definitions of these concepts?

13. When is it relevant, or purposeful, to pay clinical attention to these embodied strengths /experience/ and or what you/ we have just defined?

14. Have you ever been surprised by a client's embodied self?

15. Have you ever been surprised by anything a client *expressed* regarding their embodied self or experience?

ADDITIONAL QUESTIONS and SPECIAL CONSIDERATIONS

(These questions may be asked as an alternative and/or a stimulant to the interview where appropriate.)

1. Is it ever ethically necessary to pay clinical attention to embodied strengths? If so, when?

2. Is it ever ethically proscribed? If so, when?

3. What do you think of the medical model as it affects the strengths perspective; as it affects embodied strengths?

4. Within your agency, what do you see as a good balance between strengths based practice and the standard biopsychosocial assessment/treatment.

5. Does the setting in which you work, private practice or within an agency, or the method of reimbursement, out of pocket or third party payer, affect your practice in terms of how you regard the clients' strengths/ embodied strengths/ embodied experience?

6. Of those clients you have had who are difficult to engage verbally, are there any who you have (might) engage in some embodied treatment/practice? Or is there a distinction between verbal and nonverbal clients?

7. Is there any meaning behind a clients' long-term silence, or lack of engagement?

8. Are you aware of new research (last 15-20 years) linking mind, body, and neurology?

9. Except breathing, what aspects, if any, of your practice have included the use of the body? (i.e. taking walks, stretching, leaving the office with the client)

10. What about yours—or other therapists'—cultural background? Are there differences specific to cultural background that matter in this discussion about embodied experience/ embodied strengths?

11. Regarding yours, or others, professional affiliations and training, stances and lenses, do you have thoughts/ experience about how diverse practice or theoretical perspectives affect strengths/ embodied strengths/ embodied experience?

Appendix E

Case Vignettes

Carl, a 52-year-old man, an inpatient in a psychiatric ward of a hospital, was admitted to the emergency room for detox. Carl is a veteran who has been previously diagnosed with PTSD. One night during his stay, 3 A.M., he is making a puzzle in the lounge. A nurse on his ward tells Carl to stop working on the puzzle. He must go to his room, she says, sleep, and show up for group and individual sessions the following morning. Carl protests, but does what he's told. The next day, Carl sees the psychiatrist for med management, and then attends a group. Later, he complains to the social worker that he was not allowed to do one of the only things he enjoys and which, he reports, truly relaxes him.

Theresa, a 21-year-old woman who works part time in sales, is also a painter. She is in private therapy because of severe social stressors and for help managing her bipolar disorder. Theresa is home in her studio hard at work on several paintings for a small group show at a gallery. The days she works, her fingers, and occasionally her hair, have paint on them. She often wipes paint on her pants. The process of painting for the day ends with her pushing brushes into the tins with turpentine in them to get them clean. She stretches her own canvas for large pictures. When she is at the gallery opening, will her therapist, whom she really likes and trusts, take her up on her invitation and be there to witness the client in an environment outside the therapy room?

Sandra, a 55-year-old woman with diabetes who stays in bed at home most of the time, is depressed. It is difficult for her husband to care for her; she argues with everything he tries to do. He reports to the social worker that he loves her, but she has changed for the worse. Sandra enjoys only one thing, he reports. She finds a way to drag herself down to the bingo parlor each week where she enjoys playing with her friends. Her husband describes her there as an imposing figure at the table, as though a queen, with not a hint of depression. In fact, he reports, Sandra's friends don't know what her life—or his life— is like at home. Why is Sandra being treated only for her diabetes? Neither the social worker nor other clinicians involved in their care explore the meaning or reality of this embodied, lived experience in which Sandra exists among her bingo buddies. One might ask, who is the Sandra outside of her depression and her medical problems? One might also ask, what is it about Bingo that fully engages, even transforms, Sandra?

Michael, a boy of 14, is very disruptive at school. He is being reprimanded with a school suspension. The school psychologist is about to code Michael with a learning disability, lining him up for special ed. Michael's mother is upset about this process. She is confused and angry and feels that the school does not know some important things about her son. For example, she knows that Michael makes braided hemp necklaces in front of the TV at home—a hobby he enjoys and engages in for hours at a time. His mother is aware that at these times Michael is amiable, cooperative, and focused in ways that she feels the school does not see. Further complicating the situation, Michael's mother needs further education herself about the

clinical practice of engaging kids with wandering thoughts like Michael in a sensorial, tactile activity to help them better focus. Additionally, Michael's music teacher has special knowledge about Michael's performance in his class, and has a similar take on him as his mother does. Unfortunately, the music teacher, the parent, the school psychologist, and special ed teachers do not meet with one another at the same time. In fact, special ed teachers often do not attend special ed team meetings. How can they learn of Michael's self-integrating interests? Is there an awareness that they all should meet and share different perspectives and work as a team?

Joseph, a 71-year-old retired attorney, experienced a significant decline in his health when he stopped playing golf. He had played all his life, and worked his way to having a minus-two handicap. After his doctor told him to stop, he became atypically sedentary. He began to drink heavily. His life became punctuated by triple bypass operations and moody outbursts at his family. Was there anything about a lifetime of playing golf, beside the obvious benefits, that went unnoticed by Joseph or his caregivers? Has anyone explored the meaning this longstanding activity had in his life by what its loss has meant; or explored the psychoanalytic area of the body self? Why did Joseph not consciously experience the loss of golf, which he had played nearly every week of his adult life, as an intrapsychic event, not just of mind, but also of body? According to one of his children, Joseph never seemed aware of his loss. How was it that Joseph could not verbalize/ articulate/be conscious of the importance of this loss? How would awareness, if at all, have affected Joseph's quality of life?