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Lauren Nancarrow Clarke
Putting the Body Back in
Social Work: How Social
Workers Experience and
Differ in Levels of
Personal Body Awareness

ABSTRACT

This study was undertaken to determine whether or not and if so, to what degree social workers are aware of their personal body awareness in sessions with clients. The corollary question was whether or not those with higher reported body awareness would have similar socio-demographic indicators, environmental factors, or clientele to each other. Based on current literature, it was hypothesized that social workers in general would report a low body awareness and those reporting a higher body awareness would have similar correlates of individual factors.

Smith School for Social Work graduates and current students were solicited for participation in an online survey. After data collection, there were 310 participants. These clinicians were required to complete the personal body awareness scale, socio-demographic questions, with the option to complete three qualitative, written responses.

The major findings are as follows: The vast majority of social workers reported both being aware of their bodies and bodily responses in assessment and practice with clients *and* of taking these factors into account in sessions. Also, there were few correlations between body awareness and individual factors, such as years of experience or gender. Only one significant finding emerged: clinicians who reported being non-heterosexual had a higher personal body awareness compared with their heterosexual colleagues. Clinicians also reported specific types of body awareness, such as sleepiness and thirst, more readily than others. Finally, the new

Clinician's Body Awareness Scale had a strong internal reliability with a coefficient alpha of .87, indicating possible future use for this scale.

PUTTING THE BODY BACK IN SOCIAL WORK:
HOW SOCIAL WORKERS EXPERIENCE AND DIFFER IN LEVELS
OF PERSONAL BODY AWARENESS

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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2007

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One must still have chaos in oneself to be able to give birth to a dancing star.
Nietzsche

*At the center of your being you have the answer
you know who you are and you know what you want.*
Lao Tzu

The nature of this flower is to bloom.
Alice Walker

What has gotten me to this point? Was it dancing to Cyndi Lauper in my dad's living room? Walking to the corner with my mom to smell orange blossoms? Arguing with my sister and learning the value of yelling out "Violence! She is doing violence to me!"?

I do know that I have many folks and experiences to thank for the successful completion of this piece of research. First, I would like to thank my teachers – my classmates, my dancing companions, my classroom teachers, my friends and family, and my body.

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CHAPTER I

INTRODUCTION

The body is present in every therapeutic interaction. Two (or more) humans are relating, breathing, sweating, sighing, making eye contact and more. Each of these bodies is also sensing what is happening internally and externally. The psyche could be said, in some ways, to be made visible through these bodies. However, how the client and clinician are aware of their bodies and how this has an impact on the therapeutic alliance and experience is under-examined in the social work literature. Therefore there is a need for further study of how the body is manifested, used, and understood in social work practice. This topic is too large to be examined fully within the context of a Master's Thesis; yet, a beginning may be made. The purpose of this research is to generate information first, of how social workers are aware of their bodies in sessions with clients and second, if there are any personal characteristics of those who report a higher sense of personal body awareness. With this in mind, the research question for this study is as follows: How and to what extent do clinicians experience personal body awareness in sessions and what factors are associated with an increased sense of personal body awareness?

There are no studies in social work theory that focus on this research question specifically. There is clearly a need for further investigation as the therapeutic field in general is moving towards more inclusion of the body in practice (Grand, 1998). For example, there are an increasing number of body-based therapies; there are trauma theory developments related to the importance of the body in treating trauma

(McDougall, 1989); and there is a movement within relational theory to include the body in practice (Aron, 1998). However, no quantitative studies were found that examined how or whether clinicians are aware of their bodies in sessions, how they might use this awareness, and whether or not there are particular correlates to a higher awareness. All of the literature related to this topic was found to be based on anecdotes, case studies, or theoretical examinations (see Ross, 2000; Balamuth, 1998; Stone, 2006). Thus the findings of this study may be beneficial to the social work field and might have an affect on treatment and treatment outcomes for both client and clinician. It may also offer information about why some clinicians are more aware of their bodies than other which may lead to improved training and supervision related to this emerging field of bodily inclusion.

This study was based on a mixed methods design involving quantitative questions along with a qualitative portion to elicit more nuanced responses. An online survey was created and sent to all Smith College School for Social Work graduates and current students throughout the United States. For the graduate sample, the Smith School for Social Work Alumni Office forwarded the survey to their entire email list. The current students received an emailed version of the survey as well through the Registrar's office. The email included an introduction letter with a link to an informed consent for the survey and the survey itself.

The study addressed clinicians' personal body awareness and whether or not there were any relationships between a heightened sense of body awareness and other personal factors, including socio-demographic indicators, environmental factors, or particular clientele. This researcher's interest in this particular topic arises from extensive personal movement based self-exploration. As well, this researcher has had many experiences of being aware of strong 'messages' from her body in sessions and

of being unsure of how to theorize and contextualize these messages due to a lack of research; therefore she has a desire to examine how others within her field are aware and use their bodies' information with clients in sessions. In order to situate these questions, the study will begin with a review of the literature regarding the body in therapeutic practice.

CHAPTER II

LITERATURE REVIEW

The body has been conceptualized in many different ways. It has been seen as a strictly taboo object (Kimble Wrye, 1998), a container for clients' trauma (van der Kolk, 1996), and as an observable object holding clients' latent and manifest material. New therapeutic disciplines have been established, such as body psychotherapy and somatic psychology, to explore the phenomenon of the body in therapeutic encounters. However, the body is still under-utilized by the majority of clinicians practicing today (Aron, 1988). There are also few theorists exploring and researching the body in psychotherapeutic practice (Stone, 2006). Most theorists who do write about the body have placed a greater emphasis on the somatic aspects of the client than on those of the clinician. In particular, little attention has been given to the possible effect of the clinician's body and personal body awareness within the clinical encounter. This study is an initial exploration into clinicians' personal body awareness during sessions with clients. As there has yet to be a systematic, empirical study of this topic, this project is meant to increase the limited amount of empirical data on how clinicians perceive their bodily sensations and responses during psychotherapy sessions. This study will also offer a preliminary examination of possible correlations between clinicians' heightened sense of personal body awareness in sessions with certain personal characteristics and experiences.

The literature review will lay the foundation for this investigation by starting with a brief examination of the dichotomy of the psyche and soma versus the unity of

the psyche-soma within psychodynamic theory. The next section will provide a survey of how the body is seen in three theoretical orientations: psychoanalytic classical thought (Freud), trauma theory work (Scaer and van der Kolk), and the relational perspective beginning from the infant and caretaker interaction (Stern, Beebe, and Lachmann) to intersubjectively-oriented theory (Aron and Harris). Next, will be a discussion of the clinician's use of self in psychotherapy and the argument for the inclusion of the clinician's body in this understanding. This exploration will include an examination of the nature of personal body awareness and its importance to the psychodynamic therapeutic process as a tool for greater understanding of the clinical experience, in particular embodied countertransference. Finally, the chapter will end with some possible correlates to heightened personal body awareness that have been suggested through this literature review.

The Body-Mind Connection

Over four hundred years ago, Descartes postulated that the mind and body were not unified. Following this division, Descartes situated reason with the mind and affect with the body, privileging reason over affect, or the mind over body. This splitting of the human being and favoring of the mind, created a legacy that is still being played out in psychotherapeutic relationships today to the detriment of clients and clinicians.

Humans are not born with this divide but instead learn it through cultural initiation (Seigel, 1984). Forester (2000) states that the terms 'body' and 'mind' are culturally constructed in order to create a dichotomy where false superior objectivity (mind) can be positioned against inferior subjectivity (body). However, the terms 'body' and 'mind' are constructs used to articulate experience and are not distinct identities (Forester, 2000). It is more helpful for integration and healing to see them as

referring to, “interrelated aspects of experience...and experiencing” rather than fixed entities (Forester, 2000, p. 58). By doing so one can view “body states and processes as inseparable from fantasy, interaction, and meaning” (Harris, 1998, p. 43). In other words, the mind and body are one and equally inform each other in both physical and psychological terms. In fact, humans come to know their bodies only in the course of “a series of interactive events with the...social psychic environment” (Harris, 1998, p. 42). Therefore one recognizes oneself through physical-emotional interactions with others, bridging the psyche and soma divide. However, most humans, in the North American context, carry this “ubiquitous split between psyche and soma [which is] often traumatically underscored even in relatively unimpaired people” (Seigel, 1984, p. 34). Integrating this split is the primary concern of several types of therapeutic practice, including body psychotherapy and psychoanalytic dance therapy, however it is not included in most psychotherapeutic contexts.

Winnicott (1949) believed that the “age old gap between mind and body...the antithesis which has baffled all the philosophers will be found to be based on an illusion” (as cited by Aron, 1988, p. xix). A possible outcome from this *gap* is a competition between the body and mind. One possible manifestation of this is the construction of Winnicott’s ‘false self’ and ‘true self’ dichotomy, where:

Mind becomes the location of False Self, and the development of False Self is based on a dissociation between intellectual activity and psychosomatic existence. True Self, by way of contrast, is rooted in the body, both in the mother’s holding the otherwise unintegrated baby (physically and imaginatively) and in the mother’s recognition of the baby’s spontaneous gestures. (Aron, 1988, p. 21)

In this interpretation both mind and body are connected and at play continually throughout the human life span. Aron (1988) seems to poignantly suggest that the ‘false self’ is engendered in part through the mind and body split. Under this

interpretation it would seem irrational to address issues of the ‘false self’ without including attention to the whole human being, including his or her body. Through integration of the body/mind may come an integration of the ‘false self’ and ‘true self.’ Therefore, one possible task of the therapeutic encounter is to help ground the relationship in the body, as this split has left the body a silent player for many clients and clinicians (Aron, 1988).

In later discussion, this understanding of the body and how the relational experience in therapy might aid both client and clinician will be assessed. The following section will begin to look at the mind and body continuum and the need for inclusion of the body in therapeutic discussion through different theoretical frameworks. The first discussion centers on Freudian psychoanalysis.

Psychoanalysis and the Body

At its roots, psychoanalysis, and therefore psychodynamic treatment, is founded on the body (Ross, 2000). However, it has been postulated, that most current practitioners do not utilize their own bodies or that of the clients’ in therapeutic sessions (Aron, 1988). Perhaps this can be traced back to Freud’s ambivalence about incorporating his own body in treatment discussions and of privileging the psyche over the soma. Yet, throughout his theoretical life, Freud did include the body, at a certain distance, to develop his understandings of humans’ inner beings. Below is a discussion of four different ways in which the body was critical to Freud’s theory and treatment, including 1) his personal career history, 2) his use of his patient’s bodies in descriptions of their ‘illnesses’, 3) his use of touch in treatment, and 3) his incorporation of the body into his theoretical conceptualizations.

First, Freud was grounded in the body as he began his career studying the anatomy and physiology of the nervous system. It was through this work and his

contact with Charcot that he shifted his practice into psychology, thus founding psychoanalytic treatment. The structure and workings of human bodies were his passion and it was the body and its symptoms that gave Freud his first clues to developing his drive theory. Originally Freud (2004) hypothesized that at times some physical illnesses, such as paralysis, pain, and fatigue, were in fact conversions of psychical events into somatic reality. These conversions indicated to Freud a hysterical disorder that could be treated using a primarily verbal method. Freud understood the connection between psyche and the soma as critical to both psychopathology and cure. Yet, he highlighted the importance of the psychical meanings limiting the physical implications in his work (Aron, 1988).

Second, when Freud described his patients, he emphasized his awareness and attention to their physical selves. Readers of his case studies gain a sense of his patients as bodily beings (Jacobs, 1973; 1994). In the case of Fraulein Elisabeth von R., Freud (2004) offers the following description:

the hyperalgesic skin and musculature of the legs was pinched or pressed, her face took on a peculiar expression, more that of pleasure than pain, she cried aloud – I couldn't help thinking that it was as if she were being tickled voluptuously – her face became flushed, she threw back her head and closed her eyes, her trunk bent backwards. (p. 141)

In this portrayal, Freud creates a sensual image of sound, touch, and sight so that that reader can almost feel a connection to the patient, as Freud must have. He intimately shares his impressions of his patients' bodily selves; yet shares little to nothing of his own felt-experience. Even when a description, such as the one above, is stated in somewhat erotic terms – the voluptuous tickle, for example – he gives away nothing of his own bodily experience. He emphasizes his patients' bodies against his own blank screen. By choosing evocative words and images it must be questioned how Freud's own body was moved. Was there underlying erotic countertransference to

Fraulein Elisabeth and others through his choice of descriptors? This is an unanswerable question, yet valuable to attend to while addressing Freud's use of touch in his practice.

Third, Freud used physical, body-to-body touch as one of his therapeutic tools. Freud (2004) describes how he created a "small technical trick" (p. 272) where he applied a limited amount of pressure onto a patient's forehead, telling the patient this would help in the recalling of an event. Freud (2004) literally was trying to 'push' an idea or image out of his patient for analysis. Freud, in several recorded case studies, performed the necessary leg massage and rolling for his hysterical patients to help alleviate their symptoms (see Fraulein Elisabeth von R.'s case, for example).

Although touch is not the primary focus of this study, Freud's use of touch raises interesting thoughts about the 'touch taboo' in psychotherapy (Kimble Wrye, 1998). Additionally, while this practice has been lost, the creator of psychoanalysis thought that touch was an important part of the healing process. If one of the patients' main modes of communication is through the bodily symptoms, why is this no longer an area of focus for all clinicians working today? These questions are too broad to be explored adequately in this study however they point to the dearth in literature on the body, to the ensuing mind and body duality, and the resulting necessity of this study.

Finally, Freud grounded his theory of the ego in the body, such that he conceptualized it as a "body-ego" (Freud, 1961, p. 27). In Freud's seminal work, *The Ego and the Id* (1961), he states that, "the ego is first and foremost a bodily ego" (p. 26). To insure that the reader grasps this emphasis, less than a page later, Freud states that the "conscious ego...is first and foremost a body-ego" (p. 27). This body-ego is comprised of and created by the experiences and sensations it feels. It is the "part of the id which has been modified by the direct influence of the external world through

the medium of perception” (p. 25). Simply put, Freud suggests that it is humans’ perceptions and sensations that shape and mould the ego into the force that it is. It is through the body that the ego is formed. Freud theorizes that perceptions are critical, equating the influence of perceptions on the ego to the drives on the id. These sensations and in particular the non-pleasurable sensations are those which, “impel towards change, towards discharge” (p. 22). By defining the ego in terms of physical sensations and perceptions, Freud creates a binding connection between the psyche and the soma. Therefore, although the body has been lost from most psychodynamic work today, the founder thought it was critical to treatment and development. The importance of the body in psychoanalysis itself has only recently been recovered (Aron, 1988).

Another controversial aspect of Freud’s work is his changing theories regarding the origin of hysterical and physical symptoms in his patients. At one point Freud believed that these symptoms were a real by-product of abuse; however, seemingly due to societal pressure, Freud repositioned himself as believing that these symptoms were created by the patients’ own repressed sexual fantasies (Scaer, 2001). This view has since been dismissed, yet, it has still taken much research and discussion to give legitimacy to trauma being caused by external stressors that can lead to somatization, dissociation and more (Scaer, 2001). This next section will focus on current trauma theory in order to highlight the mind body connection in treatment and health.

Trauma: ‘Mind from body’

Bessel van der Kolk’s (1996) famous saying, “the body keeps the score” (p. 214), has come to symbolize current trauma theory thinking. His (1996) research into

the biological causes of trauma states that it is the bypassing of the mental apparatus through the enactment of hormonal changes organized by the limbic system, amygdale, and hippocampus that allow for individuals, in some cases, to survive life-threatening experiences and then sustain trauma. van der Kolk (1996) reports that this circumventing of the psyche may lead to long-term physical, emotional, and mental consequences. Seigel (1986) agrees, writing that there is a, “‘Body Memory,’ i.e. that all experiences are stored in the body, specifically in muscle systems” (p. 65). van der Kolk (1996) explains further:

Almost all persons who have been exposed to extreme stress develop intrusive symptoms; [it is] the persistence of intrusive and repetitious thoughts [that] sets up a chronically disordered pattern of arousal. [D]issociation at the moment of the trauma has been shown to be an important concomitant for the development of full-blown PTSD. (p. 218)

One of the primary effects of trauma is dissociation. It is hypothesized that this dissociation creates a gap between the ability of the individual to verbally describe their experience and the experience that is being held in the body.

Aron (1998) defines dissociation as “a way of organizing information in which there occurs a compartmentalization of experience. Elements of trauma are not integrated into a cohesive sense of self” (p. 15). This affects the person’s ability for self-reflexive functioning that is the cause of much of the long-lasting symptoms. He goes on to state, “All dissociation is rooted in the primal dissociation of body from mind, of subjective awareness from objective awareness, of ‘I’ from ‘me’” (p. 27). It is in these separations that the person experiencing the trauma loses crucial, protective abilities. Without the ability to make perceptions and recognize interconnectivity, humans are unable to self-reflect and heal themselves.

Both clients and clinicians hold their psychological experiences in this way – in their physiology– and some of these experiences are accessible to cognition and

verbalization, while others are not. McDougall (1989), while writing about the importance of the inclusion of the body in psychotherapeutic practice, states:

All of us use action instead of reflection when our usual defences against mental pain are overthrown. Instead of becoming aware that we are guilty, anxious, or angry, we might overeat, overdrink, have a car accident... or, weather permitting, fall victim to the flu. These are simple examples of “expression in action,” through which one disperses emotion rather than thinking about the precipitating event and feelings connected to it. (p. 15)

Through relying on the body to act, it is possible to bypass the verbal, cognitive, emotional system therefore not needing to self-reflect on the experience. People can lose their ability to connect the experience with verbal language because of hormonal changes, dissociation, and “a primitive psychic message of warning [is sent] to the body which bypasses the use of language [in which] the danger cannot be thought about” (McDougall, 1989, p. 28).

van der Kolk (1996) suggests that those who experience trauma may lose their ability to use emotions as signals and therefore the ability to express these emotions. Furthermore, they are unable to use arousal as a cue for behavior. Thus, some people cannot utilize the full fight-flight-freeze spectrum and either freeze when inappropriate or overreact to triggers. There have also been psychobiological abnormalities found in people who have been diagnosed with PTSD. The entire human being may be affected by trauma, from a cellular to perceptive level.

This initial inability to integrate and reflect on emotional experience can cause some people to have “extreme reactivity to the environment without intervening reflection” (Aron, 1996, p. 235). Without this reflection, “traumatic memories tend to be stored in an emotional or somatic context, and the victim simply may not be able to place them in a verbal context” (Scaer, 2001, p. 159). McDougall (1989) describes the concept of *alexithymia*, sometimes caused by trauma, as: “certain people have no

words to describe their emotional states, either because they are unaware of them or because they are incapable of distinguishing one emotion from another” (p. 24).

However, this ability to self-reflect is a primary tool in psychotherapeutic healing, and it may be (temporarily) lost through trauma. The clinician may be able to help the client regain this skill through offering her or his reflexive connection. However, in order to do so, the clinician must be aware of her or his own reflective thoughts. One primary tool to gaining this is self-reflection is personal body awareness.

The clinician, through a connection to his or her somatic self, can be helpful to clients through interpreting the clients’ somatic experience. The clinician’s body posture and messages may also change treatment. Scaer (2001) suggests that, “a trusting environment is extremely important for trauma patients...Even the facial characteristics or behavioral quirks of the therapist may remind patients of...their trauma” (p. 60). The clinician, through use of personal body awareness and self-reflexivity, may be able to better help the client integrate his or her traumatic experiences. These findings highlight the necessity for this study in determining how clinicians are aware of their personal body awareness. In the next section of this literature review, the concepts of nonverbal and preverbal communication and how preverbal communication directly links to an understanding of relational theory will be discussed.

Relational Aspects of the Body in Psychotherapy

Preverbal experience of mutual influence

Humans’ first relational experiences are through the body. In the infant’s preverbal world, communication and connection are achieved primarily through physical means: crying or not crying, gazing or not gazing, eating or not eating and so on (McDougall, 1989; Beebe & Lachmann, 1988). In this stage the gaze interaction

with mother (caretaker) is akin to locomotor behaviors of later childhood– the infant can use his or her gaze to interact with the caretaker and does so with “almost equal facility” to the caretaker, effectively helping to control this social behavior (Stern, 1985, p. 21). Through gaze alone, the child and caretaker are developing relationship, boundaries, awareness of each other and of themselves. The infant is beginning to gain a sense of self, a sense of other, and a sense of self in relation to other. It is indeed these first actions that “construct representations...including looking, attending, vocalizing, grimacing, turning away” (Beebe & Lachmann, 1988, p. 7). Further, what is “represented is not simply interiorized action, but interiorized *interaction...the dynamic mutual influence*” (p. 8).

The infant learns a sense of self through relationship and attunement to the body. And even at this primary, non-mobile level, the infant has some power to create its social reality and connections (Stern, 1985). Beebe and Lachmann’s (1988) research focuses on using mother-infant dyads to track communication interchange. Through their study, they show how body interaction creates mutual influence. They define this as a “communication process in which influence flows in both directions: both mother and infant systematically affect, and are affected by the other” (p. 4). This influence is a complex, subtle, often unaware, system where ideally infant and caretaker become attuned to one another. This mutual regulation is crucial to the healthy development of the child.

Through infant research, Stern (1985), Beebe and Lachmann (1988), and others demonstrate the volition and ability of humans to use their bodies for meaningful social interactions and control. These social interactions include later relationships such as the therapeutic one. In the therapeutic relationship, communication is recognized primarily on the verbal level, neglecting to take into

account the significant preverbal influence on human relationships. How would therapeutic relationships differ if they intentionally included the first, primary means of communication, the body?

Stern's influential work, *The Interpersonal World of the Infant* (1985), outlines how attunement is produced in caretaker-child interactions through the physical experience. Since attunement and therapeutic alliance have been linked in the literature, how does the somatic reality of the therapeutic interchange influence this alliance? If a clinician has higher personal body awareness are they better able to utilize this aspect of relationship? This next section will address these questions through exploring the effect of gesture, movement and other non-verbal practices on the therapeutic relationship (Davis & Hadiks, 1990, 1994).

Nonverbal communication: Gestures, movement, and rapport

A nursing learns very quickly to distinguish between those gestures and movements that bring its mother closer and those which are met with no response or even induce rejection. (McDougall, 1989, p. 40)

Over the past thirty years, one arm of research around body awareness and nonverbal communication has focused on how physical movements and gestures of both subjects in the room change the therapeutic process (see Fretz, Corn, Tuemmler & Bellet, 1979; Davis & Hadiks, 1990, 1994). Before this time, "empirical findings and observations about facial expressions, gaze, gestures, and postures were denigrated by referring to them as 'veterinary psychiatry.' The study of people was the study of words and verbalizations" (Karpf, 1980, p. 478). Recently more theorists are in accord with Norman (1982) who shares that counseling, "as [a] communication process is dependent upon nonverbal communication. Counselors need to be able to send and receive [nonverbal] messages" (353).

Coming from a relational perspective, what the clinician *and* client feel and express are both important parts of the therapeutic encounter. It is possible that which gestures and movements therapists and clients use also influence the relationship. There has been some debate over the usefulness of this gesture and movement research within therapeutic dyads because of the problematic nature of testing for this type of rapport building skills in an artificial, controlled environment (Fretz, Corn, Tuemmler, & Bellet, 1979). Another possible limitation is the need to evaluate a somatic phenomenon through primarily verbal means. However, through video recording, testing, and self-reflecting, studies have shown some indicative responses of the importance of gestures and movements in therapy.

Birdwhistle (1970) states that the “verbal components of a two-person dialogue carry less than 35% of the social meaning of the situation while more than 65% is carried by the nonverbal component” (a cited by Norman, 1982, p. 353). If 65% of communication is through the body than what are some of the common manifestations of this bodily, nonverbal communication? Norman (1982) lists, based on extensive observation, a common understanding of body language from a North American perspective including facial expressions, “a frown—displeasure or confusion...tightened jaw muscles—antagonism...both eyebrows raised—questioning” (354) and gestures, “steeping of fingers...suggests a person quite confident, smug, or proud; women often use a rather subtle steeping, putting their hands in their lap and joining fingers at about belt level...pinching bridge of nose...indicates deepness of thought, evaluation...locked arms...defensive position” (355). These findings have a significant bearing on the usefulness of clinicians’ personal body awareness and the therapeutic relationship.

Tinnin (1990) contributes to this dialogue by describing nonverbal communication from biological research. His theory revolves around the communication of emotion through primarily nonverbal means. He states the, “recipient of nonverbal communication perceives the sender’s state of mind through unconscious mimicry of the sender’s bodily state” (p. 9). This mimicry, he suggests, comes from the human brain’s evolution out of the reptilian brain, which relies on mimicry for information gathering and perception. In mimicry, the receiver is allowed a visceral experience of what it is like to be in the body of the sender. Additionally, Tinnin (1990) adds, in “communication by emotion, the message is conveyed mainly by facial expression” (p. 9). In particular it is through eye contact or lack of eye contact that the quality of the relationship can be discerned in dyads. Therefore both eye contact and other nonverbal communication are extremely important to therapy as communication is the central aspect of therapeutic process. These studies highlight the this significance.

Davis and Hadiks (1990) developed a research project where they recorded and monitored both the client and therapist’s gestures and movements on a second by second scale over sixty-three sessions of treatment. Through this investigation they determined that “as the client shifted from superficial discussion to actively exploring her internal reactions, her bodily positions became increasingly more accessible, open, and oriented toward the therapist” (Davis & Hadiks, 1990, p. 347). Further they found that the session where there was the best ‘fit’ between the therapist’s movements and those of the client, the therapist reflected that it had also been the best session of work (Davis & Hadiks, 1990). These interactions were non-linear where the client and therapist’s movements and gestures were not completely corresponding but rather interwoven to create a pattern of “echoing, mirroring, and posture sharing”

(Davis & Hadiks, 1990, p. 348). Therefore it is not exact matching that is important but rather something else, perhaps the mutual influence of Beebe and Lachmann (1988). Again, the meaning and importance of body language suggests a need for further research with practice implications.

This thinking is in accord with Meekum's (1992) research with mothers and toddlers, where movement attunement in relationships between mother and child had a positive effect on both participants. Furthermore, as Davis & Hadiks (1994) turned their lens more purposefully to the therapist's contribution to the dyadic experience they saw that "body position patterns reflect and possibly facilitate the development of rapport and self-disclosure in psychotherapy" (p. 401). This type of nonverbal, personal body awareness may act as a tool of metacommunication encapsulating the therapeutic process.

Bodies in relation to other bodies are used as part of creating healing in dance-movement therapy. Mills and Daniluk (2002) conducted a study to assess the usefulness of movement in a group for women survivors of sexual abuse. In their study, they monitored and interviewed participants about their experiences before and after group. The women shared that by mirroring each other physically, they were able to better connect to their bodies, have a sense of intimate connection, a sense of freedom, and gain healing. The participants all reported some sort of positive improvement through the mutual moving of the group in relation to each other and each other's bodies. Relational theorists are turning their own thoughts to similar questions of how the *mutual* experience of the body informs psychotherapy. This next section will explore the significance of the body in psychodynamic theory using a relational lens.

My body, your body, and our body: Client and clinician's bodies in relational theory

If our self is first and foremost a bodily self, then our relational experiences are first and foremost bodily experiences as well. (Aron, 1998, p. 24)

Relational theory is one of psychoanalytic thought's newest developments. In this body of work, which focuses on the intersubjective clinical experience, the clinician and client's body is becoming more and more significant. However, even as the "body, bodily sensations, bodily metaphor, and bodily imagery play a central role in the psychoanalytic process" they are under-acknowledged by current clinicians (Aron, 1998, p. 3). Some relational theorists argue that the usefulness of the body in the therapeutic process is manifold, including the clinician's use of body awareness to monitor both the self and client's body. One of the main tools of relational theory is self-reflexivity, as previously discussed in the trauma section. This self-reflexivity is developed, to a certain extent, through personal body awareness. Without self-reflexivity, by both client and clinician, therapy progresses less effectively (Aron, 1998). If clients, as with some who are dealing with trauma, are unable to express their experiences, perhaps due to alexithymia or operator thinking, their self-reflexivity may be limited. In part it is the clinician's role to help the client become aware of this rupture in reflexivity and gain access to verbal expression of the experience (Aron, 1998; McDougall, 1989). If verbal reflection and expression does not occur, it is possible that there will be release of the "un-uttered experience [in the form of] somatic explosions" (McDougall, 1989, p. 11). Because self-reflexivity is key, relationally-oriented psychoanalysts focus on helping clients develop self-awareness and self-reflexivity through body based awareness. It is through the relationship with the clinician that clients can gain these insights and skills. Further, "it is not enough to encourage self-expression, since they know not what to express

[they] need to have their affects recognized [which] take place on a bodily level” (Aron, 1998, p. 29). In this way, clients may need to have their own emotions experienced from their body and re-interpreted back to them by the clinician.

As relational theory rests its basic assumptions on the importance of subjectivity and intersubjectivity it is not the client alone who must come to greater self-awareness and personal body awareness, but also the clinician. Indeed Harris (1998), another relational theorist, states that “[a]nalysts must have access to and be comfortable with their subjective affect states and bodily reactivity if they are to experience and metabolize patients’ communications” (p. 40). It is through the clinician’s own body awareness that clients’ latent meaning may be felt and interpreted. However, being attentive to one’s own body may be difficult for clinicians as they are trained to pay attention to their feelings related to the client’s material and “are less likely to consider the appearance of bodily sensations—tensions, contractions and pains, sudden changes in breathing and posture—as analytic data” (Balamuth, 1998, p. 267). These core ideas promulgate the importance of the clinician’s own body awareness because if they are able to “...bring... unnoticed bodily states into...consciousness, [they] may enable... patients to bring to life deadened or inaccessible aspects of themselves” (Kimble Wrye, 1998, p. 100).

Aron (1998) broadens the concept of intersubjectivity by speaking of the literal physical intersubjective space that is created by the sharing of breath. Aron (1998) suggests that:

Gradually, patient and analyst mutually regulate each other’s behaviors, enactments, and states of consciousness such that each gets under the other’s skin, each reaches in the other’s guts, each is breathed in and absorbed by the other. For a while, patient and analyst share a jointly created skin-ego/breathing-self. (p. 26)

Aron proposes that breath can act as the medium through which the ego can safely move in and out of a person's self, literally being taken in and transforming each person in the dyad. It is also through this mutual 'breath' that clinicians may first become aware of clients' latent meanings and be able to make interpretations *literally* through their inhalation and exhalation (Aron, 1998).

From the relational perspective, clinicians are currently not using their body awareness enough while working with clients to the possible detriment of both clients and clinicians' wellness. Aron (1998) remarks that:

...corollary of findings on self-reflection and the body is that, when self-reflection begins to falter, one of the first signals is often a bodily reaction. This is true for both the patient and the analyst, so that an obstacle to self-reflection may become apparent in a change of posture, facial expression, eye movements, respiration, bodily tension, or, more worrisomely, in psychosomatic explosions and the outbreak of illness or deterioration in physical functioning. (p. 28)

However clinicians, by being able to tune into their own bodies and that of their clients, may be able to better aid their clients. Through the use of self-reflexivity bolstered by personal body awareness, clinicians may be better able to interpret the 'un-uttered experience' of their clients. Personal body awareness, in fact, becomes an important use-of-self in therapy. This crucial therapeutic concept, use-of-self is the focus of this next portion.

Use-of-Self: Use of Body

The concept of 'use-of-self' includes clinicians' ability to effectively use their personal experiences, intellect, emotions, and corporeality to better aid clients. It is an encompassing term, suggesting that clinicians' selves are their primary tools.

However, as Balamuth (1988) relates, in psychoanalysis, "we often look far and wide for subtle and hidden meanings. We often miss an experiential center in ourselves from which to perceive the intersubjective field in which we are immersed [that of

the] body as a container...” (p. 283). Balamuth suggests that clinicians’ understanding of their body awareness is crucial to full use-of-self.

Silvia (2003) supports these basic use-of-self statements through his qualitative research project investigating the use-of-self of social work students. In this study, participants outlined five primary meanings of ‘use-of-self’, including “(1) “being real” or taking a relational approach, (2) responding differentially to each unique client, (3) the use of self-disclosure, (4) the use of countertransference, and (5) the use of one’s physical self” (p. 70-71). One participant stated that use-of-self included:

the way you make eye contact with someone or the way your body language talks to someone, how you sit...crossed arms, sitting back, very distant, or able to sit forward, reach out, hear them. I think all of those things are you using...your physical self: smiling, frowning, looking concerned. (Silvia, 2003, p. 53)

These findings concur with other writers who suggest that use of the physical self is an important part of use-of-self techniques that are essential in the therapeutic relationship (see Kimble Wrye, 1998; Aron, 1998).

Balamuth (1998) uses a case example of a client named Jim to explore the usefulness of his own body awareness in therapy. With Jim, Balamuth (1998) became “aware of my rigid routinized interactions with Jim, the presence of my body—tense and unfree to breathe and to be—was the first clue to how strapped we both had become” (p. 280). Using this awareness, Balamuth was able to correctly interpret Jim’s latent emotions around his father and help Jim through a corrective emotional experience. Balamuth (1998) states that the clinician “needs to be able to ‘free associate’ to his own body, to take his own body as an object” (p. 280) in order to fully engage in the therapeutic process with the client. Being able to use the body in therapy begins with being aware of one’s own body (Aron, 1998). Some of the uses

include acknowledgment of countertransference and a possibly clearer recognition of enactments and projective identification. In the next section, an examination of how use-of-self in the form of personal body awareness affects clinical experience will be addressed. It will begin with an exploration of personal body awareness itself.

Personal Body Awareness

Clinicians' personal awareness, including perceptions and sensations of clients, guides treatment. Having a fuller access to awareness may contribute to more understanding and interpretations. One part of this awareness is of the body. But what is personal body awareness? Philosopher Thomas Hanna (1988) suggests that it is the "living, self-sensing, internalized perception of oneself" (as cited in Forester, 2000, p. 5). Forester (2000), like Hanna, does not include interpretation in his definition, in fact states that personal body awareness requires a "crucial...delay of, or disinterest in, 'interpretation'" (p. 72). This disinterest, he suggests, creates a natural container to allow awareness to arise, be observed, and noted without trying to effect change, reminiscent of a meditative approach. Through this process of awareness "clinicians are able to refine their sense of their own and other people's boundaries" (p. 73). By leaving space for awareness, crucial interpretation may be available to clinicians, who may be able to better reflect on what is their countertransference and what is the client's transference, and gain clarity about the interaction. Thus personal body awareness can be critical to both gaining important information about the therapeutic relationship and maintaining clear boundaries. For the course of this study, personal body awareness is defined as the *perception of the living self experienced from within the self* (Hanna, 1995). Body awareness can be thus understood on multiple levels: emotionally, physically, and intellectually. Within this study, the crucial element in

the definition is the ‘experience’ perspective in that it is the action and corporal element that creates the experience that is perceived.

As has been stated previously, the body and personal body awareness, in therapy has been undervalued and understudied (Grand, 1998). However, there are researchers who are trying to share their experiences of their personal body awareness through case studies in order to highlight its possible contribution to practice. For example, Ross (2000) playfully writes of her experience of body awareness by stating:

without so much as a ‘by your leave or it you please’, Simon/Simone enters my nose, possessing me with the effluvia of wickedness. Bertice/Bert forcefully penetrates my ears with the ring of a doorbell. Jo lies curled on the couch, wraps herself in the blanket and my eyes in tears. (p. 452)

In this description, she highlights how her awareness of the impact of her client on her physical self helps her ‘do’ therapy in a different way with a deeper understanding of herself. She shares that this awareness allows her to listen better and provide better treatment. Another writer, Burnstein (1998), suggests that her “use of the body in therapy sessions involved not so much a change in technique or working style, but rather a change in myself that permeated my participation in all aspects of the therapeutic relationship” (p. 119). Thus, a simple shift of awareness, onto the body, can have a significant result on the clinical experience.

Some theorists, such as Burnstein (1998) and Epstein (2000), suggest a personal body awareness practice, such as meditation, in order for clinicians to have fuller access to their experiences in sessions with clients. Through enhanced body awareness and shifting consciousness, it may be possible for clinicians to utilize the body’s messages more effectively in treatment. Some of the ways in which this shift can effect change include a deeper understanding of countertransference through

personal body awareness. This next section will explore a particular type of countertransference, embodied countertransference.

Embodied Countertransference

One of the most useful aspects of personal body awareness is its possible impact on the therapeutic relationship. Personal body awareness has the potential to allow the therapist to gain a greater attunement to what is happening in the room, including her or his responses to the client. As Kimble Wrye (1998) describes of her relationship with one client, these responses are complex:

I became aware that my body would tighten warily [with the client], as if sensing danger. At times I imagined unpleasant smells emanating from him; at others I wondered how his girlfriend could tolerate sex with him. I felt invaded and repelled. I felt tense, provoked, and worn out after sessions; often, I would get a stiff neck. (p.100)

In most types of psychotherapy, clinicians use an awareness of their reactions to the client in order to gain countertransferential meaning. They use this meaning to formulate hypotheses about the client and how to proceed in working with the client. This awareness or reaction may be on various levels including the intellectual, emotional, spiritual, physical, or some type of combination (Hayes & Gelso, 2001). It is the latter aspect of awareness that is the focus of this study as an emerging significant component of effective use-of-self in therapy: the clinicians' personal body awareness. This section will outline first a definition of countertransference, then a definition of embodied countertransference, followed by the history of embodied countertransference, then the three postulated primary types of embodied countertransference, and, finally, the importance of embodied countertransference in therapeutic practice.

Countertransference

Freud initially hypothesized that countertransference was the analyst's defensive, unconscious response to client's transference (Hayes & Gelso, 2001). Indeed, Freud wrote "the doctor should be opaque to his patient and, like a mirror, should show nothing but what is shown to him" (Freud, as cited in Davis, 2002, p. 437). Freud believed that the analyst's countertransference was as a result of unanalyzed pieces of him or herself that had yet to be analyzed sufficiently. In fact, if the analyst was not able to sustain the "ideal [of] absolutely objective observer whose attention hovered evenly over the associations of the client...the therapy suffered" (Kahn, 2001, p. 128). However, current theorists and practitioners have developed a broader understanding of countertransference acknowledging that often the knowledge from the therapist's reactions to the client could teach the therapist and client new, helpful information (Kahn, 2001). Indeed today, countertransference has become known in some therapies, in particular the relational school, as broadly as encompassing *all* the therapist's reactions to his or her client (Kahn, 2001). 'All of these reactions' may include the therapist's physical reaction to the client and the latent content in the room. Because of its unique application to therapy, this type of physical countertransference has been assigned its own name, embodied countertransference (Field, 1988).

Defining Embodied Countertransference

Somatic countertransference- soma meaning body- extends [the] definition to include the physical as well as the emotional responses aroused in the therapist. (Ross, 2000, p. 453)

Countertransference can be seen as any of the clinician's reactions to the client, including physical reactions. Embodied countertransference was originally referred to as somatic countertransference. In some ways the terms are

interchangeable as they both evoke the body. Yet the definitions have different understandings. The word somatic is an adjective meaning “of, relating to, or affecting the body, especially as distinguished from a body part, the mind, or the environment; corporeal or physical” (Somatic, n.d.). Embodied, however is a verb meaning “to give a bodily form to; incarnate” (Embody, n.d.). For the purpose of this study, the term “embodied” as opposed to “soma” was selected because of its more active meaning.

Embodied countertransference has been further defined as a “physical reaction, evoked in the therapist apparently without connection to the manifest material or even in direct contradiction to it” (Field, 1988, p. 513). It is generally assumed to be the clinician’s physical reactions to the client whereby it “extends [the] definition [of countertransference] to include the physical as well as the emotional responses aroused in the therapist” (Ross, 2000, p. 453). This extension can potentially provide a more holistic understanding of the client. It is possible, as Iannoco (2000) suggests, that this “silent dialogue between therapist and patient...has much to do with the pre-reflective and preverbal communication based on the mother-child model” (p. 534) thus accessing and responding to buried material that is not otherwise accessible or perceived.

There is little written in the literature regarding embodied countertransference. Those who do write of bodily experiences suggest these types of sensations: “...aches, pains, rumblings, coughing, nausea and suffocation... tightness in my chest...strange sensations” (Stone, 2006, p. 109-112). Still more perceptions were reported by Field (1988) as “surges of physical hunger, tears, fits of coughing or sneezing in an inappropriate moment, stabs of pain in the head or body, the sudden sensitivity to noises from the street or the deafeningly loud ticking of the clock” (p.

513). Yet what is the history of the term embodied countertransference? This upcoming section is a brief look at the history of this term and its uses.

History of Embodied Countertransference

It is a paradox that although the study of transference has been elevated to a fine art, rarely in courses on technique are students taught to observe those small, barely perceptible, and often fleeting [embodied] interactions between patient and analyst that can be of the greatest significance. (Jacobs, 1994, p. 749)

Embodied countertransference as a particular part of countertransference was a term first used in the past twenty-five years to describe a phenomenon that was a previously unnamed part of psychodynamic theory (Field, 1988). Embodied countertransference as a concept has perhaps been little explored since, “the role of nonverbal communication in both the theory and practice...has been an uncertain one [as] Freud was a keen observer of nonverbal behavior in his patients [but] did not elaborate on or develop this aspect of analytic work” (Jacobs, 1994, p.743). As previously discussed, Freud described and utilized the body’s workings but did not verbalize his own feelings or thoughts about the inclusion of the body theoretically in practice or of his own body or bodily reactions. Accordingly, his followers have needed to find new ways of introducing and arguing for its presence in theoretical thought.

Some of these theorists have examined their patients’ bodies’ movements and meaning during sessions and how this corresponded to their interpretations of both latent and manifest content. Wilhelm Reich, a Freud contemporary, focused on “defensive processes and character traits [which] were revealed in muscular tension, body posture, voice, and movement” in the analytic situation (cited in Jacobs, 1994, p. 743). As early as 1952, Deutsch wrote of how the body could be used as a diagnostic tool to see thematic shifts in analysis (as cited in Jacobs, 1994). Merleau-Ponty (1959)

discussed first how posture shifting and holding could be signs of regression (as cited in Jacobs, 1994). Finally, Sharp (1979) wrote of the way a dissonance between the body and verbal presentation could change interpretation (as cited in Jacobs, 1994).

As the theory of the patient's body and its importance developed, so did hints at the significance of the clinician's attunement. MacDougall (1979) writes of working with trauma survivors who are often unable to communicate verbally. In these cases, he suggests that the trauma can sometimes be understood through "the analyst's countertransference reactions, and particularly by his tuning in to his affective and bodily responses" (cited in Jacobs, 1994, p. 746). Here, MacDougall suggests, perhaps for the first time in the literature, that analysts can gain insight and interpretation through use of their own bodily responses to their patients. Other writers speak of the danger analyst's own regression due to the pull of the patient's *body* and the risk to the analyst of taking on the bodily symptoms of the patient through interpretation (Ross, 2000). These theorists suggest that clinicians' awareness of their bodies affects their ability to treat their clients. They seem also to be suggesting that whether clinicians are aware of it or not, they are being affected somatically, and affecting the other as in mutual influence research (see Beebe & Lachmann, 1988; Stern, 1985). By gaining awareness into this physical process, clinicians have the potential to increase insight of what their clients are telling them through their internal reactions.

In this larger constellation of embodied countertransferential reactions and meanings, three primary groupings have been established (Ross, 2000; Field 1988). These include sleepiness, erotic or sexual arousal, and trembling from fear. This chapter will continue with an examination of these three subcategories.

Primary Types of Embodied Countertransference

Over the years I have developed a familiarity with some of my own body communications, particularly my belly which has a varied repertoire. Terror grips it like a vice. At times like that it is silent with pain. Fear produces feelings of nausea. Anxiety makes me sweat with a particular smell. A sexualized environment can excite my vagina. (Ross, 2000, p. 462)

Above Ross alludes to a general consensus among theorists that embodied countertransference can be divided into three major categories, with some exceptions, including sleepiness, erotic or sexual arousal, and trembling or fear (see Stone, 2006; Field, 1988; McLaughlin, 1972). In order for any of these sensations and perceptions to be experienced, clinicians must have a certain amount of body awareness. Each of these groupings has a particular *raison d'être*, which is explored in the following section.

First, McLaughlin (1972) suggests that sleep and sleepiness “constitute the most striking examples of a true countertransference response” (p. 369). This sleepiness or sleep is not caused by physical fatigue. Rather therapists, at times, use sleep as a primary defense to ward off possible hostile or erotic feelings directed at them by the client. From the relational perspective, sleep could be the clinician’s defense against his or her own feelings of hostility or eroticism towards the client or from the clients’ projections. If the clinician has personal body and self-awareness, he or she may interpret and intervene with this new knowledge at hand. However, without awareness the clinician may just feel sleepy, missing a chance to engage more fully with the client.

Second, sexual and erotic arousal is often cited however there is little or brief exploration beyond the reporting of this type of physical reaction (see Jacobs, 1994; Stone, 2006). It is likely that there is little exploration of the erotic reaction due to the taboo surrounding it (Miller, 2000). However, based on psychoanalytic theory, the

erotic/libidinal drive is a constant companion in the intimate therapeutic setting. As Field (1988) asks why would there be such condemnation against sensuality, if it were not naturally present? He goes on to state that it “must be presumed that nearly every therapist, at some time in his or her practice, has been disturbed by erotic responses to patients” (p. 516). The lack of exploration of this topic is also understandable due to the possible (and actual) boundary violations that may (have) come from this type of erotic reaction. Yet, in not exploring, and therefore not normalizing this type of embodied countertransference, the field may be missing something that needs to be addressed for the greater health of the client and clinician.

Third, the final type of embodied countertransference most often reported is trembling in association with fear and anxiety. Field (1998) graphically describes his experience with fear as it:

...can arise the moment the patient enters the room and before a word has been spoken. Equally often I can begin to be aware of it during the session, although the talk may have no apparent connection with the feelings that have been aroused. These feelings may range from a slightly increased heartbeat to intense internal trembling, so that I have to hold myself together with my arms tightly clasped and I can barely speak. (p. 518)

This trembling fear again comes more from the reaction to the latent content of the client than the clinician’s own sense of anxiety due to external or internal stressors. It may also be related to anxiety related to the clinician’s own sense of self and ability. For example, this trembling can at times signify a type of power struggle as it is shared back and forth between the client and clinician due to latent (and sometimes manifest) material in the room (Field, 1998). It is only with careful analysis that the therapist is able to discover that the perceptions she or he is feeling are related to the power dynamic and not another cause.

Embodied countertransference is an area of psychodynamic practice with much potential to add to effective work with clients. Thus far, theorists have only touched the surface. As McLaughlin (1972) shares “I think we stand to learn much more about the way we work and the vicissitudes of the analyzing instrument if we can become freer to talk about and study the full range of our reactions” (p. 381). Without honestly addressing all countertransferential experiences, including sleepiness, erotic arousal, and trembling fear, clinicians are not using their full ability to work with clients.

The Importance of Embodied Countertransference

Embodiment...invites us to awaken our senses and our own sensual responses to our patients' material, to help us attune as well to the rich data within the realm of body talk. (Kimble Wrye, 1998, p. 97)

Stone (2000) has eloquently suggested that a clinician's body is like a tuning fork and when working well a “[r]esonance occurs [that] vibrates with the patient's psychic material through the unconscious” (p. 115). It may not be necessary for verbal expression to occur for the clinician to gain insight into the client's psyche. From a relational perspective, the client is also possibly resonating with the clinician's body and making interpretations from this for his or herself. Imagine a client who has repressed an event in her or his body who then experiences his or her clinician through body awareness gently, recognizing the bodily experience of that repression and working it through on the level of bodily affect. This may signify a way of working with certain clients whose physical messages are stronger than their verbal. As Field (1988) suggests, “these responses may be seen as a kind of internalized body language that offers an additional means of access to primitive levels of communication [which] may prove a vital part of the therapeutic process” (p. 513).

Further, this internalized body language may be extremely important to client's perspective of the therapeutic experience. Bedi (2006) researched clients' perceptions of counseling alliance formation. In this study, a research team interviewed forty counseling clients who all reported having a good connection to their therapist. Clients first talked about their therapeutic experience and then once this information had been transcribed and categorized, formed groupings of the answers into distinct categories to represent factors contributing to therapeutic alliance. From these groupings, the participants picked the top eleven factors that contribute to alliance formation. Included in the top three factors were two body-related elements: 1) body language and nonverbal gestures and 2) self-presentation of the clinician. This introductory study demonstrates from the client's viewpoint the importance of the clinician's physical self, presentation, and gestures. It also highlights the necessity for further research to gain more insight into clients' perceptions of clinicians' use of body in treatment.

Possible Critiques of Using Embodied Countertransference

The optimum analytic stance is one free from neurotic countertransference. At first glance such gross physical reactions in the therapist may appear massively inappropriate. (Field, 1988, p. 519)

Although the literature clearly suggests that having a more holistic, body-aware approach is helpful, there are also possible limitations. These possible cautions parallel any caution around the use of all types of countertransference. One area of possible conflict is if a clinician is overwhelmed by a physical response, say a racing heartbeat, and instead of attending to other countertransferential responses, only attends to this aspect, missing other important dynamics. Upon examining a conference's proceedings on the body, Iannaco (2000) raises this question, stating: "[s]omatic feelings are more pressing than psychic feelings, but are they necessarily

more truthful? If one feels sexually aroused, or breathless for instance, there is little else one can think about” (p. 537). If clinicians allow their bodies to become the primary tool by which they are aware of themselves and the other in the room, what is lost? How does a clinician discern which information is important or not? One part of this study is an attempt to address this question through exploring potential factors influencing clinicians’ personal body awareness. Further, Iannaco (2000) wonders if “in stressful situations [using the body’s signs] may become an easy way out of the uncomfortable state of not knowing” (p. 537). Could it be that rather than stay in the ‘hard place’ that is ‘not knowing’, a clinician would choose an easier way out by following the body? And if this is the case, it is possible that the state of ‘not knowing’, which many have argued is an important and necessary part of the therapeutic process, might be lost at times (Stone, 2006)?

Iannaco (2000) continues by asking, “what does one do with these feelings if they are not to be acted out? Not all somatic feelings can be translated into language...and they may have to remain silent. This may be the limit of psychoanalysis” (p. 537). By acknowledging another variable in the room, do social workers deepen the ability to engage with clients and possibly confront the boundaries of understanding? If clinicians act from physical perceptions and sensations, without allowing for ‘not knowing’ and space for repetition, what impact will this have on practice? Stone (2006) suggests that when working with the body, a clinician must be even more comfortable working with confusion and ‘not knowing’ than in strictly verbal interpretation. Clearly, this is another part of the complex nature of a holistic approach to working with clients.

Possible Factors Effecting Personal Body Awareness

It appears that there are many potential aspects involved in a clinical experience that may lead to varying levels in the clinician's personal body awareness in sessions. Everything from the clinician's past to the client's is included in this spectrum (Ross, 2000). A clinician's somatic awareness outside of the sessions is possibly important to their awareness inside the session (Ross, 2000). The clinician's relationship to his or her body and past experiences also may play an influential role. Further, the sameness and difference in body between the clinician and client may also affect the use of personal body awareness by clinicians (Stone, 2006). Finally, the diagnosis of the client may change the clinician's sense of their own body and its responses (Field, 1988; Jacobs, 1973).

Summary

Since the development of psychodynamic thought there have been numerous additions, refinements, and omissions that have formed the practice of social work and counseling. One thread throughout these decades has been the changing nature of the body in psychodynamic thought. The general trend has been towards more and more inclusion of the usefulness of awareness of the client's body in therapeutic treatment; however, the use of the therapist's body has lagged behind. It is only in more recent years that the therapist's body has become a site of examination and importance.

Throughout the literature there appears to be a tension between the usefulness of including the body and the possibility that the body will divert attention from the psychological realm. This conflict reflects Descartes original separation and reification of the mind over body. Many current theorists believe that this divide is primarily useful as a cultural construct, where objectivity and subjectivity are

polarized. One group of researchers, trauma theorists, who tend not to separate the psyche from the soma, see the affect of life-threatening experiences on the whole individual with both somatic and psychiatric complaints being reticulated as one. Trauma theory postulates that one of the main causes *and* outcomes of serious trauma is the inability to verbally express the experience and the unexpressed experience becomes held in the body.

As the literature shows, it has taken many years for the therapist's body to become accepted as an important exploratory site, particularly in psychoanalytic thought. At its start, psychoanalytic practice was highly connected to the physical-psychical connection as Freud incorporated both components into treatment and interpretation. However, this connection was lost, as it seems Freud distanced himself and his work from the corporal concerns, never articulating his own physical awareness in sessions. Currently, body-based psychotherapy, dance-movement therapy and some relational theorists are positing this different view. These clinicians offer that the body not only keeps the score but also can give important, otherwise inaccessible, information to the clinician about both the client and the clinician. This review suggests that further dynamics in the therapeutic dyad may be addressed through body awareness as a part of clinicians' use-of-self. This body awareness can allow clinicians to use embodied countertransference, which may be particularly helpful where verbal expression by the client is not possible for numerous reasons. The literature has suggested that clinicians at varied times have diverse levels of body awareness and therefore perhaps different ability to access embodied countertransference.

The study issue, then, is first, addressing clinicians' personal body awareness in therapeutic sessions and second, beginning to assess any possible relationships

between those clinicians with a higher sense of personal body awareness with certain characteristics, such as years of experience, gender, and type of clientele with whom they practice. This study is meant to shed light on how clinicians experience their bodies during sessions and possibly how awareness of the body is being used in therapy by clinicians. In the next chapter, the methodology used for this study is outlined and explained. Quantitative methods have been used as a way to reach a sizeable amount of people in an effort to gain information from a diverse group of participants. A qualitative component is included in order to gain fuller access to more nuanced responses. Through a mix of closed and open-ended questions, a large sample of participants were encouraged to express their understanding of body awareness, its place in their practice, and demographic questions that may contextualize differing awareness levels.

CHAPTER III

METHODOLOGY

Formulation

The primary purpose of this study is to examine how social workers report on and differ in their level of personal body awareness in sessions with clients. A secondary focus is to determine if there are any possible relationships between those clinicians who have a higher sense of personal body awareness with other factors, such as theoretical orientation, years of practice, personal bodily experiences and so on. With this dual purpose in mind, the research question is: How and to what extent do clinicians experience personal body awareness in sessions and what factors are associated with an increased sense of personal body awareness? Underlying this research question are two hypotheses. The first is that different social workers report differing levels of personal body awareness but in general they have a low awareness. The second is that there are factors, such as gender and population served, which influence this awareness.

Research Design

To date, the literature surrounding this topic is made up of case study and theoretical writings. There has never been a systematic, multi-case, empirical study to address differing levels of social workers' personal body awareness. Therefore this study was designed to begin to fill this gap by choosing primarily a quantitative, relational research design founded on descriptive data to gather as broad a sample as possible. The survey also includes a qualitative portion to allow for further

exploration of the question. Descriptive data offers the possibility of “a better understanding of a phenomenon in detail [and] the results can be perhaps among the most unambiguous” (Anastas, 1999, p. 123-124). However, it is this detail and clarity that can be its greatest limitation as it presents a limited, static portrait of the data (Anastas, 1999). Second, the relational aspect of the data was addressed by examining promising correlates to higher personal body awareness. By making relational comparisons, the research addressed the possible “dynamics, that is, changing or interacting, relationships among phenomena” (Anastas, 1999, p. 149). Through addressing both the underlying descriptive data and possible dynamic issues of the data from a large sample, potential new insights have been created regarding the role of body awareness in clinicians’ work along with possible correlations to a heightened sense of this body awareness. The qualitative portion allowed participants to enrich their survey responses by answering open-ended questions. Due to time limitations, a longitudinal study was not feasible even as it would better offer a non-static view of the sample.

Prior to the survey being placed online, the Smith College School of Social Work Human Subjects’ Review Board Committee (HSR) gave permission for its use. The survey was conducted online as: 1) it was convenient for participants as they had easy and private access to the survey, 2) it could gather a large sample, and 3) it was inexpensive and practical to manage. However, there were some possible disadvantages of using an online survey. These included: 1) the sample had to be computer literate, 2) the survey tool lacked the ability for interaction and mutual reflexivity, and 3) the results remain static as they were responded to at one time, in one manner.

Sample

The sample included 338 respondents recruited from current Smith College School for Social Work (SCSSW) students and graduates of the Smith program. Twenty-eight participants were eliminated from the sample because they did not answer the primary body awareness questions, the Clinicians' Body Awareness Scale. This left a sample of 310 (N=310). As broad a sample as possible was drawn from this group, which was chosen both for its convenience and relatedness to this researcher's own educational experience. As the study is both descriptive and exploratory, an attempt was made to gather multiple sociocultural variables such as ethnicity, gender, age, level of experience and so on. However, as the sample population was recruited from the entire graduate and current SCSSW community, participants were not specifically recruited for sociocultural factors. Therefore, one limitation of the sample was the lack of diversity presented within the SCSSW community itself. Specific inclusion criteria were simply having been or currently being a SCSSW student. Within this group, there were no exclusion criteria beyond those students and graduates who were not accessible via email addresses through the school. One participant mailed her response to the researcher; however, this data was not included because it was not verifiable without multiple readers and this system was not in place. Another limitation of the sample is that it is not generalizable as it only involved social workers from Smith College and not a diverse sample from all colleges in the United States, or the globe. Specific socio-demographic information is reported in the Findings chapter.

Data Collection

The recruitment process involved contacting both the Registrar and Alumni Officer for the SCSSW to gain access via email to those students and graduates whose

email addresses were open to public access after gaining SCSSW HSR Committee approval. Potential participants were sent an email (see Appendix A and B) describing the context and purpose of the study and asking for their participation. Graduates and current students received slightly modified versions addressed to each group as 'graduate' and 'student.' Potential participants were then directed to connect to the measure at [surveymonkey.com](https://www.surveymonkey.com). Surveymonkey is an online software program that manages anonymous gathering of information at a low cost to the researcher. It is also recognized by SCSSW HSR Committee as a reliable and confidential tool. By agreeing to take the survey, participants gave their consent for inclusion in the survey, unless they decided at any point during completing the survey to withdraw. It was stated clearly to participants that once the survey was submitted, they would not be able to remove their data. There was no individual screening of participants, as only current students or graduates of SCSSW received the survey. All recruitment took place online. Although several other reminder emails were composed for further recruitment, the response rate was higher than expected from the initial email, and therefore no follow up letters were needed. The survey took participants between ten and fifteen minutes to complete online at their own convenience. Participants were able to reach the survey on the website until the desired sample size (N=80) was surpassed (N=338). Once the anticipated sample size was exceeded, participants attempting to take the survey reached an online note stating that the survey was no longer accessible. Once the survey closed, this researcher sent the results, with no personal identification attached, to Marjorie Postal, at SCSSW, for further statistical analysis based on a created codebook with requests for specific analyses.

There were few risks for participants in this research project as it was anonymous, the participants were not a vulnerable population, and the survey was

comprised of fairly non-intrusive questions. However, there was a possibility that some participants may have discerned from the questions' contents a certain bias towards inclusion of the body in psychotherapy that may have led them to alter their practice without proper support of this change. It is also possible that a participant may have had painful or shameful memories evoked from experiences of personal body awareness in sessions (Miller, 2000). Further, because this was an online survey, participants may have felt some sort of regret after submitting the survey with no recourse for expunging their data from the research because of the limitations of the instrument. To help mitigate these concerns, participants were aware that their participation was anonymous, as the submitted data was not linked to their email addresses. The Human Subjects Review Board did not find it necessary for the inclusion of referral resources in the informed consent procedure.

Just as a possibly heightened sensitivity to the body in sessions following the survey might cause limited harm, it also may indeed have helped clinicians in their work. It is also possible that participants may have found this opportunity to describe their personal body awareness in sessions relieving or supportive, as it is rarely discussed in supervision yet is an integral part of any therapeutic interaction (see Jacobs, 1994). Further, some may have experienced a certain normalization of their otherwise under-acknowledged bodily experiences and sensations in therapeutic sessions and in this way have been validated. Finally, participants would have the awareness that their responses contributed to social work research and literature for the possible betterment of both client and clinician.

Ethics and Safeguards

Ethics and safeguards were given the highest priority in this study. As this survey was conducted entirely through an online resource, the informed consent

procedure was linked to the online survey itself. The participants were not minors, so no special consent procedures were applicable. Participants did not sign a traditional informed consent as their submission of the survey online was their consent. The researcher highlighted this before they entered the survey and then once again after they entered the survey itself. Participants received an introductory email letter stating the nature of the survey, the reason they were being asked to participate, the possible risks and benefits of completing the survey, the length of time the survey would take, information stating that their submission of the survey was their consent, and the researcher's contact information (see Appendix A and B). This letter was also posted on surveymonkey.com for participants review before they moved on to the rest of the survey. As this survey was anonymous, there was no link between who answered the survey and who did not. Participants' returned surveys were their de facto consent.

The individual, non-identifiable survey results were received and downloaded onto an Excel spreadsheet on the researcher's computer and sent online to the statistical analyst. After the data was entered, the printed results were placed in a folder that was locked in the researcher's cabinet. After the data analysis was complete, all computer files were destroyed, and the researcher only retained the hard copies, which will be destroyed after three years according to Federal regulations. All results from this study are non-identifiable and are presented in aggregate form in this thesis and will be in any future presentations or publications.

Instrument Design

The survey was newly created for the purposes of this research project. The survey is comprised of five sections: 1) standard demographic questions; 2) the population served by the social worker; 3) personal body awareness; 4) personal bodily experiences; and, 5) qualitative responses (see Appendix C). Questions were

limited to a total number of sixteen in order to minimize imposition on participants' time and to streamline the data gathered. First, the survey began by asking eight demographic questions in order to ease the participant into the survey. These questions are being used for descriptive purposes and to document possible correlations between heightened personal body awareness with particular characteristics of participants (see Field, 1988; McLaughlin, 1972). Second, the survey continued with two questions addressing the population served for descriptive purposes and to examine the hypothesis that a clinician's personal body awareness is heightened by interactions with certain types of clients (see Stone, 2006). Third, a multi-variant, lickert-type scale was created to address the question of social workers' personal experience of body awareness based on the hypothesis of the reality of embodied countertransference (see Stone, 2006; Ross, 2000). Fourth, two questions were based on clinicians' past and current bodily experiences in order to determine, again, any relationship between these experiences and their bodily awareness (see van der Kolk, 1996). Last, the survey ended with three qualitative questions, which focused on clinicians' awareness of the body in their therapeutic work, allowing participants to elaborate fully in their own words. These questions were reserved until the end in the hope that participants would have had maximum time to be immersed in the study and respond from this possibly more reflective place.

Data Analysis

Descriptive statistics were used to describe the demographic characteristics of the sample. In order to determine the internal reliability of the question in section four based on social workers' personal body awareness, a Cronbach's Alpha test was run. As well, the responses to this question were categorized into two groups, higher and lower personal body awareness, based on those who answered 'never/I haven't

noticed' and 'sometimes/frequently'. In order to determine possible correlates between those determined to have a higher versus. lower sense of personal body awareness with other variants, t-tests and Chi-square tests were utilized. For one question addressing gender demographics, a random sample of the higher response was taken in order to run a valid Chi-square test. In order to allow re-examination of context, questions related to age, years of experience practicing, past and current personal bodily experiences were not categorized prior to analysis. Further, Pearson Correlations were used in three cases to determine the relationship between social workers level of body awareness with client and personal factors. A one-way analysis of variance test was used to determine difference in personal body awareness of social workers based on years of experience.

Discussion

As with any research project, there were methodological and personal biases inherent in the study. First, some possible methodological biases may have included the choice of using an online survey as the data-gathering tool. As outlined above, there are disadvantages to this method including but not limited to an exclusion of those without computer access, an assumption of computer literacy, and the limiting of flexibility in terms of response options. In order to best address this last question of bias, space was included for "Other" options where appropriate and three qualitative questions for participants were added in which they could express their experiences in their own words. Another methodological bias may be using a written tool to assess a physical/emotional experience in a retrospective manner as opposed to an in vivo experiment.

In terms of self-disclosure, this researcher's personal bias and reason for the research is a strong belief in the importance of inclusion of the body in therapy.

Coming from a relational perspective, this researcher considers that both “bodies” in the room are equally significant and engaged in the interaction and therapeutic experience. Therefore, there is a probability that some of the questions reflect this bias. In certain questions, there may be underlying assumptions based on personal past experience and interests that are not the same as the participants. However, four proofreaders critiqued the survey in order to attempt to minimize bias.

In the next chapter, the findings will be presented beginning with socio-demographic factors, followed by responses to the body awareness scale questions, and concluded with an overview of the common themes from the open-ended questions of the scale.

CHAPTER IV

FINDINGS

The purpose of this study is two-fold. First, this research was conducted to examine how social workers report on and differ in perception of their personal body awareness in sessions with clients. Second, it was created to determine the possible relationships between those clinicians who have a higher sense of personal body awareness with other factors, such as their personal experience with trauma, the client population with whom they work, years of experience and so on. The first hypothesis was that different clinicians report differing levels of personal body awareness and that this reporting of awareness would be low. The second hypothesis was that there are factors, such as the social worker's gender and population served, which affect this awareness. There were several major findings for both hypotheses.

In regards to the first hypothesis, it was found that social workers reported wide levels of personal body awareness. This was shown through the variations in participants' responses on the newly created personal body awareness scale, Clinicians' Body Awareness Scale, and through respondents' answers to the open ended questions. There were also significant findings associated with the second hypothesis. Major findings included: a higher rate of body awareness by non-heterosexual social workers than their heterosexual colleagues; a higher awareness of crying by social workers with more years of experience than their colleagues; a higher awareness of 'tearing' eyes by social workers with more years of experience, who are

older, and who practice from a psychodynamic theoretical orientation; and, finally, a reported higher awareness of sexual/erotic arousal by those with more years experience, those who were older, males, and non-heterosexual respondents. Another significant methodological finding was the robustness of the newly created body awareness scale, which was found, through a Cronbach's alpha test, to have a strong internal reliability (alpha= .87, N=310, number of items= 27).

There were 338 (N= 338) respondents to the online survey within the time period using survey monkey. Of these 338 respondents, 28 individual respondents' answers were eliminated before any frequencies or tests were run because they did not respond to the central question regarding personal body awareness, Clinicians Body Awareness Scale. Therefore the sample size that was used to calculate all statistics was 310. One participant sent in a survey through the mail. This survey was not used as it fell outside the parameters for collection via the Internet. Although the responses to both the quantitative and qualitative questions have commonalities, and the same sample, for the sake of clarity they will be presented separately. Therefore this chapter will contain two parts: 1) Quantitative Data Analysis, and 2) Qualitative Data Analysis.

Part One: Quantitative Data Analysis

Socio-Demographic and Practice Related Results: Independent Variables

Gender

The vast majority of the 310 respondents were female (87.7%, N=271). Twelve point three percent (N=38) of respondents reported being male. Two other gender choices were offered in the survey, intersex and transgender; however, no one from the sample selected these options.

Age

The median age of the sample was 36 years old with a range of the youngest respondent being 23 years old and the oldest reporting 88 years of age. Respondents' individual ages were grouped into five categories. Below is a table indicating the ages by category of participants in the survey. The largest group of participants were in the 31-40 year old range.

Table 1

Age Category Frequencies

Age Category	Frequency (N)	Valid Percent (%)
20-30	88	29.6
31-40	94	31.6
41-50	40	13.5
51-60	56	18.9
61+	19	6.4

Racial Identity

Racial identity categories were chosen in accord with the majority of the United States racial composition. The majority of the sample reported being White/Caucasian (84.5%, N=262). The next highest group reporting was a combination of those who stated they were either African American or Black (3.8%, N=12). This statistic was closely followed by Hispanic/Latino/Latina respondents with 3.2% (N=10), trailed by those stating they were 'Multiracial' at 2.9% (N=9), followed by Asian participants with 1.6% (N=5). Three point nine per cent (N=12) of respondents identified as being in the 'other' category. No one responded to the Pacific Islander possibility.

Sexual Orientation

Sexual orientation options were presented with an attention to inclusive language in order to elicit as much specific information as possible. The majority of

respondents reported being heterosexual (69.7%, N=216). Those reporting a bisexual orientation (11.6%, N=36) and lesbian orientation (11.0%, N=34) nearly equalled each other. The same number of individuals (2.6%, N=8) stated that they were gay, queer, or ‘other.’ The table below demonstrates the re-coding of the gay, bisexual, lesbian, queer, and ‘other’ into one category, ‘non-heterosexual’, compared with heterosexual orientation respondents.

Table 2

Heterosexual Versus Non-Heterosexual Frequencies

Sexual Orientation	Frequency (N)	Valid Percent (%)
Heterosexual	216	69.7
Non-Heterosexual	94	30.3

Years of experience

The median years of experience as a practicing social worker were reported by participants as 6 years. The mean however was higher with 10.7 years of experience in practice. In order to get a more complete description of the breakdown of participants’ experience, three categories were created, grouping individual answers. The table below outlines these categories.

Table 3

Years of Experience Frequencies

Years of Experience	Frequency (N)	Valid Percent (%)
5 or less	139	46.2
6-14	72	23.9
15 or more	90	29.9

Theoretical orientation

Participants were given five choices for specifying their theoretical orientation, including ‘other.’ Of these categories, the vast majority reported having a

psychodynamic orientation (69.1%, N=212). The next highest percentage were those stating that they had an ‘other’ orientation (13.2%, N=41); a sample of their written in answers includes: ‘all of the above’, ‘body psychotherapist’, ‘shamanic and energy’, and, ‘eclectic.’ Those who practice from a behavioural orientation and those from a systems perspective reported with the same frequency (8.4%, N=26). The smallest group were those reporting a 12-Step orientation (0.6%, N=2).

Primary Practice Setting

Eight practice settings were chosen to enable grouping of respondents into appropriate categories, including ‘other.’ The highest number of participants chose outpatient clinic as their primary practice setting (31.1%, N=96). This was closely followed by those participants who reported being in private practice (23%, N=71). The next highest group reporting were those who responded in the ‘other’ category (15.5%, N=48). Some of their individual responses include: ‘college counselling’; ‘forensic setting’; and ‘hospice.’ The next highest category was comprised of those who reported working in a school setting (11.3%, N=35). Far fewer individuals stated working in residential programs (5.5%, N=17), day treatment facilities (4.2%, N=13), and on inpatient units (4.2%, N=13).

Client Population

Participants identified the percentage of their caseload by various mental health issues. They were not limited to a total of one hundred percent as many clients present with multiple mental health issues. Below is a table that outlines the results of these responses.

Table 4

Total Percentage of Clinicians' Caseloads as Represented by Clients' Diagnoses

Mental Health Issue	Mean (%)
Anxiety Disorder	31.45
Developmental Disability	5.74
Mood Disorder	40.26
Personality Disorder	14.07
Psychotic Disorder	7.33
Substance Abuse	19.47
Trauma	37.99

Age Groups of Client Population

Similarly, clinicians reported on the composition of their caseload based on their clients' ages. Five age groups were created for respondents to differentiate between, including: 1) children (0-12 years); 2) adolescents (13-18 years); 3) young adults (19-30 years); 4) adult (31-64); 5) seniors (65 and above). Below is a table that demonstrates the mean of client age groups with whom the sample works.

Table 5

Total Percentage of Clinicians' Caseloads as Represented by Clients' Age

Age Group	Mean (%)
Children (0-12 years)	16.69
Adolescents (13-18 years)	20.08
Young adults (19-30 years)	18.78
Adult (31-64 years)	34.18
Seniors (65 and over)	4.03

Past and Current Personal Life Experiences

Participants answered a variety of questions addressing their past and current personal life experiences related to their physical wellbeing. Respondents were asked if they had experienced a serious or life-threatening physical illness in the past or currently; whether or not they had a debilitating or chronic physical illness; if they

had in the past or present experienced a physical disability; and whether or nor they had in the past or currently experienced some type of other trauma. The overall results show a higher level of respondents reporting past experiences with these issues as opposed to those who are currently facing these occurrences. The highest percentage of respondents reporting on the past identified having a personal experience with trauma. The highest percentage of those reporting some current personal experience reported having a chronic physical illness. Below is a chart outlining these results.

Table 6

Past and Current Personal Experiences of Respondents

Type of Personal Experience	Past		Current	
	Experienced % (N)	Did Not Experience % (N)	Experience % (N)	Do Not Experience % (N)
Serious or life-threatening physical illness	24.7 (76)	75.3 (232)	2.6 (8)	97.4 (295)
Debilitating or Chronic physical illness	12.1 (37)	87.9 (286)	13 (40)	87 (267)
Physical disability	14.3 (44)	85.7 (263)	4.6 (14)	95.4 (289)
Other trauma	44.0 (133)	56.0 (169)	8 (24)	92 (277)

The Clinician’s Body Awareness Scale: Dependent Variable

There were two steps in the development of the dependent variable. A series of questions was created to measure social workers’ level of personal body awareness. These questions were drawn from an extensive literature review, as presented in Chapter II. The questions addressing personal body awareness had four possible response categories including ‘never’, ‘sometimes’, ‘frequently’, and ‘I haven’t noticed.’ The answers to these questions were then analyzed in two ways: 1) The four categories were collapsed into two categories to enhance interpretability; ‘never’ and

‘I haven’t noticed’ recoded as ‘lower awareness’ and ‘sometimes’ and ‘frequently’ recoded as ‘higher awareness’; and, 2) These questions were also combined into a scale, called “Clinicians’ Body Awareness Scale.” This was created by taking a mean of all responses to the body awareness questions, after first testing the internal reliability using Cronbach’s Alpha. The questions were found to have a strong internal reliability (alpha=.87, N=310, number of items=33). The chart below demonstrates social workers different awareness of physical sensations in sessions. The following table presents a description of the respondents’ answers to all individual questions after the categories have been collapsed.

Table 7

Clinicians Body Awareness Scale: Higher and Lower Personal Body Awareness as Reported by Respondents

Physical Sensation	Percentage Reporting Higher Awareness (%)	Percentage Reporting Lower Awareness (%)
Coughing	73.1	26.9
Constricted throat	36.6	63.4
Dry throat	60.5	39.5
Increased heart rate	73.1	26.9
Decreased heart rate	16.1	83.9
Trembling	23.8	76.2
Sweating	50.3	49.7
Sweaty palms	38.2	61.8
Crying	22.5	77.5
Tearing eyes	85.8	14.2
Yawning	88.7	11.3
Sleepiness	94.1	5.9
Falling Asleep	12.1	87.9
Headache	65.8	34.2
Tension in jaw	49.5	50.5
Tension in back	65.7	34.3
Tension in neck	71.6	28.4
Tension in arms	27.6	72.4
Pain in jaw	14.1	85.9
Pain in back	42.2	57.8
Pain in neck	37.4	62.6
Pain in arms	12.4	87.6
Rigidity in body position	58.7	41.3

Uncomfortable body position	85.2	14.8
Abnormal body position	35.9	64.1
Sexual/erotic arousal	45.1	54.9
Erection	4.3	95.7
Thirst	90.0	10.0
Hunger	87.3	12.7
Need to defecate	35.9	64.1
Need to urinate	81.4	18.6
Feeling of being 'outside of your skin'	19.7	80.3
Feeling of being disconnected from your body	29.7	70.3

The clinicians' responses of physical awareness can be divided into three groups by percentage levels in a virtually equal manner. Twelve physical sensation fall between 64% and 100%; eleven sensations are within 34% to 63%; and the remaining ten are between 0% and 33%. This wide spread demonstrates the variability of responses between each question. Below is a chart that denotes the top ten percentages of higher awareness factors of which social workers reported.

Table 8

The Top Ten Higher Awareness Factors

Number	Physical Sensation	Percentage Reporting Higher Awareness (%)
1	Sleepiness	94.1
2	Thirst	90.0
3	Yawning	88.7
4	Hunger	87.3
5	Tearing eyes	85.8
6	Uncomfortable body position	85.2
7	Need to Urinate	81.4
8	Coughing	73.1
	Increased heart rate	73.1
9	Tension in neck	71.6

Erection Question

As the majority of the sample reported being female, the results for the erection question were skewed. A separate frequency test was run on the male respondents' answers to the erection question. Of this sub-sample, 70.3% (N=26) reported never being aware of having an erection during sessions while 29.7% (N=11) reported sometimes having an erection.

First Hypothesis Analysis

The first hypothesis suggested that different social workers would have differing levels of personal body awareness and that overall reporting would be low. Through examining the responses to the Clinicians' Body Awareness scale and participants' written answers to the open-ended questions it is evident that not only do social workers pay attention in different ways to their bodies, they do so in a significant manner. Therefore, the first hypothesis has both been supported and refuted by the data.

Second Hypothesis Analysis

In order to examine the second hypothesis, that there are relationships between those clinicians who have a higher sense of personal body awareness with other factors, such as their personal experience with disability, gender, sexual orientation and so on, a series of inferential statistical tests were run. Two sets of analysis were run because of the lack of results from the first set where the overall scale was tested against all of the socio-demographic and practice related results. In this set, only one significant finding was determined. Therefore, a second set of tests was utilized, where specific physical sensations and socio-demographic factors were chosen for theoretical reasons. Below is a description of these two sets of analysis.

Clinician's Body Awareness Scale Correlations with Independent Variables

To determine if difference exists in level of personal body awareness between respondents who work with children (recoded children and adolescents categories as 'children') versus adults (recoded young adults, adults, and seniors categories as 'adults'), a t-test was utilized. There was no significant difference. Similarly, a t-test was run to determine difference in body awareness of respondents by gender, no significance was found. No significance was determined through the use of a t-test in comparing the level of personal body awareness for practitioners who had more or less years of experience. There was no significant difference determined when a t-test was run to determine the difference in personal body awareness for practitioners with a primarily psychodynamic orientation versus a combination of the combined other categories (recoded behavioral, systems, 12-Step, and other). Again, when looking at the different diagnoses of the primary client population with whom social workers practiced and higher or lower personal body awareness, there were no significant findings. Finally, through running separate t-tests, no significant findings were found when determining difference between social workers' personal body awareness as related to past or current personal experiences, such as disability, trauma, and life-threatening illness.

The one significant finding from this series of t-tests was between social workers who reported being heterosexual as compared to those who reported being non-heterosexual. It should be noted that this group of non-heterosexual is a recoding of the groups including gay, lesbian, bisexual, other, and queer respondents into one category. The t-test showed that the non-heterosexual group had a mean body awareness score of 1.53 whereas the heterosexual group had a lower mean body awareness score of 1.44. This difference is significant showing that the non-

heterosexual group has a reported higher body awareness than the heterosexual group ($t(145.37)=-2.251$, two-tailed $p=.026$).

In order to further explore the hypothesis, a Pearson Correlation was used to determine the relationship between level of personal body awareness of the social workers and the different diagnoses of clients. No significant correlation was found. A second Pearson Correlation was used to determine a relationship between the different age groups of clients and social workers personal body awareness; no significant correlation was elicited. Finally, no significant correlation was found when a Pearson Correlation was run to determine the relationship between a social workers' personal body awareness and the years of experience they had been practicing. A one-way analysis of variance was utilized to determine if there was a difference in the mean body awareness score between the three years of experience groups (5 years or less, 6-14 years, and 15 years and more). No difference in mean was found.

Correlations Between Specific Independent Variables and Specific Dependent Variables

After utilizing the overall Clinicians' Body Awareness Scale in a variety of tests to determine correlations, only one was found of significance. In order to gather a fuller picture of the second hypothesis, which suggests that social workers' personal body awareness levels vary with difference in personal experiences and socio-demographic variables, specific physical sensations and socio-demographic characteristics were chosen to test as correlations. The five socio-demographic characteristics were chosen for methodological simplicity's sake: these factors were gender, age of social worker, years of experience practicing, sexual and theoretical orientation. Six physical sensations were chosen from Clinicians' Body Awareness Scale for theoretical reasons. Sleepiness, yawning, and falling asleep were chosen

because of the findings from the literature, which suggest that sleep is the strongest form of countertransference (McLaughlin, 1972). Sexual/erotic arousal was chosen because of its repetition in the literature as clear signal of embodied countertransference (Stone, 2006). Tearing eyes and crying were chosen due to their theorized nature as an exhibit of visible embodied countertransference by this researcher. These six physical sensation categories were divided into those reporting higher versus lower body awareness, as explored in the collapsed Clinicians' Body Awareness Scale above. These higher and lower awareness categories were used in a series of Chi-square tests to determine difference by each of the five particular chosen socio-demographic factors as noted above. The results of these tests are presented below.

Crying

In an effort to assess whether there are differences in the extent that male and female social workers report having a higher or lower awareness of crying in sessions, a Chi-square test of differences was utilized, and no significant difference was found. The same test was run to determine difference in regards to higher or lower awareness of crying in sessions by age categories, sexual orientation, and theoretical orientation. No significant differences were found for any of these variables. However, in assessing the difference between social workers with different years of experience practicing, there was a significant difference (Chi square (2,298)=10.74, $p=.005$). As the years of experience for social workers increased so did their reporting of crying during sessions. Clinicians with 15 years or more of experience reported the highest awareness of crying (34.1%). A smaller percentage of social workers with 6-14 years of experience reported higher awareness of crying during sessions (19.7%). In

contrast, those with 5 years experience or less reported the lowest percentage of a higher awareness of crying (15.8%).

Tearing Eyes

Again, in an attempt to determine the differences in ‘tearing eyes’ by social workers in relation to various personal qualities, a series of Chi-square tests were run. There were no significant differences found in the awareness of tearing eyes by gender or sexual orientation. However, the three other personal quality variables did present with significant differences. First, there was a difference by years of experience (Chi square (2,300)=8.59, $p=.014$). A smaller percentage of those with 5 years experience or less reported a higher awareness of tearing eyes (80.6%) than those with 6-14 years (86.1%). Those with 15 or more years of experience reported the highest percentage of higher awareness (94.4%). Second, as people aged they reported a greater awareness of tearing eyes in sessions (Chi square (4,296)=13.65, $p=.008$). These differences are shown in the chart below.

Table 9

Age Category and Higher Awareness of Tearing Eyes

Age Category	Percentage Reporting Higher Awareness of Tearing Eyes
20-30	76.1
31-40	85.1
41-50	90
51-60	96.4
61+	94.7

Third, those with a psychodynamic orientation reported a higher awareness of tearing eyes (89.1%) as compared to those in the non-psychodynamic category (78.9%) (a recoding of behavioural, systems, 12-step, and other) (Chi square(1,306)=4.781, $p=.029$, continuity corrected).

Yawning, Sleepiness, and Falling Asleep

As a way of determining whether there were significant differences between those who reported a higher awareness of yawning in sessions and particular personal qualities, a series of Chi-square tests were utilized. These tests measured all five personal qualities above in relation to yawning. There were no significant differences found. Similarly, in an effort to assess whether there are any significant differences between those social workers with a higher awareness of sleepiness in sessions and personal characteristics, a series of Chi-square tests were run. In these tests, which measured all five personal qualities, no significant differences were found. Finally, in an attempt to determine whether there are differences between personal qualities of social workers and those who report a higher level of sleep during sessions, a series of Chi-square tests were run with no significant differences found.

Sexual/Erotic Arousal

The final series of Chi-square tests addressed the question of higher awareness of sexual arousal by various socio-demographic variables. The first of these variables was gender where a significant difference was found (Chi square(1, N=305)=15.876, $p=.000$, continuity corrected.) Males had a much higher reporting of awareness of sexual arousal at 76.3% compared with females at 40.6%. There was also a significant difference found by the number of years of experience of social workers reporting awareness of sexual arousal (Chi square(2, N=297)=25.18, $p=.000$). As social workers gained more years of experience, they were more likely to report having a higher level of awareness of sexual/erotic arousal. Clinicians who had been practicing for the longest (15 years or more) reported sometimes or frequently being aware of sexual/erotic arousal 61.8% of the time. Those who had a mid-range of experience (6-14 years) also reported having a higher awareness (55.1%) than those with the least

experience (30.2%). There was also a significant difference in those reporting higher levels of sexual arousal by age categories (Chi square (4, N=293)=23.02, p=.000).

These rates rose consistently until the last category of participants over sixty-one years old. Below is a chart that summarizes these findings.

Table 9

Age Category and Higher Awareness of Sexual Arousal

Age Category	Higher Awareness of Sexual Arousal
20-30	26.1
31-40	45.1
41-50	60
51-60	61.8
61+	52.6

In order to determine whether there were significant differences of higher body awareness of sexual arousal as defined by sexual orientation, a Chi-square test was utilized, which found a significant difference (Chi square(1, N=306)=5.701, p=.017). Those who reported being heterosexual stated having lower awareness of sexual arousal (40.4%) than their non-heterosexual colleagues (55.9%). There was no significant difference found when using a Chi-square test to determine higher awareness of sexual arousal compared with differing theoretical orientations.

Part Two: Qualitative Data Analysis

In order to elicit a fuller and broader picture of social workers' personal body awareness, three open-ended questions were devised. The majority of the sample answered all three of the questions, seeming to indicate an interest and engagement with the material (1st question: N=280; 2nd question: N=279; 3rd question: N=231). Below are the results obtained from the participants' answers to these questions.

First Question

The first open-ended question asked participants to share whether or not they view their bodies or bodily responses as factors in their assessment and practice with clients. (Is your body or are your bodily responses in sessions a factor in your assessment and practice with clients? Please describe.) Two hundred and eighty respondents (N=280) completed this question. The results below are based on multiple readings looking for common themes and outlier comments. Based upon these readings, seven common themes were identified with several outlier comments. These common themes are outlined below.

1) Most social workers reported using their body and bodily responses as important pieces of information to inform their assessment and practice.

This was the most frequently reported theme by participants. The large majority of participants elaborated (N=241/280) on how they use their body and bodily responses in their work. One participant explained:

I use my body as a barometer for what is presenting with my client. My body is telling me what is going on, so when I notice any of those sensations presenting, I work with the client as to what is presenting for them right in that moment and where in their body it is presenting. From there I would incorporate some guided imagery into what their body is holding...

Another respondent answered emphatically, stating, “Absolutely. Sometimes my own body sensations are the most honest reactions I have.” Further, another clinician shared:

Yes- I often use what is happening in my body to consider what is happening for the client, what it might feel like to be with the client, and what might be hapening [sic] in the relationship. What happens in my body in response to a client also helps me think about developmental and diagnostic category.

2) *Fewer social workers reported that they do not take their body into consideration while doing assessment or practice.*

Several clinicians shared that they were not “aware” of the body in sessions, not elaborating further. A few others simply stated “no” as their answer. One respondent shared:

I would say that my own bodily responses in sessions have a limited impact on my assessment with clients. I do take note of them but have usually found that they are related more to my own stress, lack of sleep--- generally [sic] speaking, my personal wellness. I don [sic] think those responses play a larger role in practice. I have to question whether my responses may be similar to what others experience when I am in the company of the client.

Another participant shared, “the less aware of myself, the firmer the treatment alliance.” A different social worker stated, “No they are not. I am aware of them however I do not notice any patterns with particular clients.”

3) *Some social workers believe their bodies mirror their clients’ bodies, giving them insight into their clients’ experiences.*

Several participants shared how their bodies own reactions mirror what they think their clients’ bodies are experiencing thus giving them possible interpretations of clients’ material. One clinician wrote that:

I definitely feel that when I am sitting with an anxious client that my body tenses up and I may even get a head ach [sic]. If I feel very connected to my client I may tear up as I talk about intimate information. This often happens when my clients are not expressing any emotions. I sometimes feel spaced out when my clients are confused or perhaps somewhat dissociated.

Another respondent shared:

Yes. I pay attention to my breathing, anxiety levels, tiredness. Often these things mirror what the client is experiencing. I have asked in the past about a client’s breathing, and he acknowledged that he had stopped---mine had also stopped. I tend to feel teary eyed when a client is feeling intense emotion even if their affect is restricted.

Finally, a different social worker reported, “I like to think that they [sic] way I am feeling is often the way the client feels. So I try and pay attention. If I am bored, chances are they are too.”

- 4) *Some social workers are only aware of their bodies’ responses when they are particularly strong and, or reacting to particular types of clients.*

Another group of clinicians reported instances where they became aware of their bodies because of the nature of the material their clients were presenting. A number reported that their bodies would often attune them to the potential for danger from their client in sessions, seeming to “shout” at them to stop the work. One social worker stated:

Yes, if during the first session I get a sensation of ‘the hair on the back of my neck raising’...and my gut churning I have learned that my body is telling me that the client is at least ‘putting me on’ in a deceitful way. But more often that the clint [sic] has a violent history.

Several clinicians spoke of their strong reactions to clients’ presenting with personality disorders. One stated, “I frequently feel fatigued or bored with clients with narcissistic personality features.” Another shared:

...A new client walked into my office and I had this sudden sensation of ‘Uh-oh, I’d better fasten my seat belt’ before I realized that I was not in my car! Boy, could I have trusted that bodily sensation! The client turned out to have a personality disorder that had messed up her life and the lives of several others, including threatening previous therapists. That was many years ago and since then I especially pay attention to how I feel when I first sit down with my client.

Other clinicians spoke of their strong reactions, “when working with clts [sic] who have a trauma hx [sic].”

- 5) *Some social workers experience tearing up, sleepiness, anxiety, and arousal from their clients and use this as countertransferential material.*

Numerous clinicians stated that they not only used their bodies and bodily responses as tools in assessment but that they did this through understanding these responses as countertransference. One respondent reflected:

With one client in particular I am quite aware of how I hold my body and the sweatiness of my palms. I am acutely aware of transference and countertransference in this relationship and believe these bodily responses to be directly connected to these issues. I use awareness of these bodily responses to heighten awareness of transference and countertransference.

Another clinician stated simply, “I always try to be aware of any bodily reactions when seeing clients, as they are often clues to countertransference.” An additional social worker responded to this question, sharing:

While sometimes a bodily response may be completely unique to me (e.g., needing to urinate when I’ve had a busy day and haven’t allowed myself time to get to the restroom), often when I feel tired/sleepy or slump in my chair...I believe that this is related to something in the patient—either anger, or a defence against engagement or some other affect. If I feel tension it is sometimes either anger in me at the client, or anger in the patient (either observable or not). So, in some cases I use my own responses to understand what is going on between myself and the client, and/or what is going on in the client.

6) *Some social workers use body language, spatial dynamics, and their own body as tools of communication.*

Another common thread throughout some clinicians’ responses was the significance of the way they used and positioned their bodies to communicate with their clients. A respondent shared, “I try to pay close attention to body language – mind [sic] and the client’s.” A different participant reported that spatial dynamics were important with her clients, noting when she feels clients are, “invasive of my space or when they seem to want me to be farther away from them or nearer to them. For example, I have one client who will ask me to sit in a chair closer to her.” Several other social workers shared ideas around how changing posture was a way to engage

or change the therapeutic dynamic. One stated, “At times, I purposefully change position to ‘block or unblock’, to present a more formal or informal stance.” Another noticed, “sitting forward, leaning back, levels of calm relaxation, tension etc and use this information in my understanding.” A different clinician added, “I...will intentionally move forward to demonstrate greater interest, as a way of giving feedback to patients.” Finally, another group of clinicians shared how they literally express themselves through their body language. One stated, “I sometimes use my hands when expressing myself.” Another wrote, “I...consciously try to maintain a relaxed body position realizing that clients do pick up on body language.”

7) *Some social workers see their body as distracting from assessment and practice.*

Several clinicians expressed caution about the usefulness of the body as they feel that at times it can be a distraction to deeper meanings or nuances. One respondent shared, “It is important to be aware of your body’s processes because they may be detracting you from paying complete attention to the client, therefore, hindering a complete assessment and possibly preventing genuine and complete empathy.” Another participant stated, “I suppose if I am not feeling well, that might affect my assessment and practice with clients, in that I may not be focused on their issues, distracted by my own bodily situation.” A different respondent seemed to share the same hesitation, writing, “Usually, I cannot help but be aware of my anxiety because of my bodily responses (sweaty palms, redness in my face, racing heart) and the fact that this anxiety is potentially inhibiting rather than informing my practice with clients.”

8) *Other Outlier Comments*

Some of the outlier comments included several clinicians who spoke of using ‘gut reactions’ to inform their practice, another who feels as though she literally holds the client’s material in her own body, a different practitioner who spoke of having her personal illness inform her work with clients, and, several social workers who wrote about how they use what they feel in their bodies to gather information about how the client makes other people ‘feel’ in their bodies. Another small group of respondents reported that they felt like they were too new to therapy to be able to incorporate their bodies into it while other clinicians stated that after doing this survey they would begin looking more to their bodies for information.

Second Question

Participants were asked in the second open-ended question to share times when their clients’ bodies or bodily responses have been a factor in assessment or practice. (Are your clients’ bodies and bodily responses a factor in your assessment and practice with clients? Please describe.) Two hundred and seventy nine respondents (N=279) answered this question. Again these answers were read in order to draw out common themes and any outlier comments. From these multiple readings, seven common themes and several outlier comments were elicited. The respondents noted that their clients’ bodies and bodily responses affected their practice in these ways listed below.

- 1) *Most social workers reported clients’ bodies and body language is an essential component to practice and assessment.*

More social workers reported being aware of their clients than their own. The vast majority of respondents reported that they took their clients’ bodies into account when working with and assessing clients (N=271/279). Of these, a large number

stated that body language itself was a significant variable in their practice. One clinician reported, “Yes, body language is a powerful signal of communication.” Another stated emphatically, “...definitely...that is why I believe that in person sessions are better 99 per cent of the cases...than phone, email, letters, etc. bodies ‘speak’ of tension, sadness, trauma, anger...” A further respondent spoke about not always being able to rely on reading body language, as “It can be difficult to read some of the clients based on their bodily responses and difficult to gauge their emotional reactions based on their body language.” However, this social worker still took body language into account.

2) *Many social workers noted that discrepancies between a client’s words and body language are important for interpretations.*

Another factor that multiple respondents identified as being helpful to their work was being able to notice and acknowledge when clients’ words did not support their body language or physical presentation. One clinician shared, “Sometimes...I notice...the patient’s bodily actions are out of synch with what he/she is saying.” Another explained, “I pay attention to my cts [sic] postures and facial expressions when I am working with them. In particular, I pay attention to whether their body language and affect reflects the content of what they are taling [sic] about.” Finally, a different respondent stated:

Observing the nonverbal cues and/or client’s reported somatic feelings provide a wealth of information about what may be going on in the client. Also, the difference between what a patient says he/she is feeling and their body/nonverbal messages can be useful. The discrepancy may be revealing in and of itself, or it may lead to exploration with the client about the meaning of the disparity.

3) *Many social workers feel that clients’ emotions are held in the body and that asking clients to verbalize these physical experiences can be helpful.*

Many participants addressed the issue of their clients' bodies holding emotions and that an effective intervention was to ask clients about this. Two clinicians had slightly different takes on this process. One stated that the way clients are, "holding their emotions in their bodies seems to be reflected in our sessions and so I sometimes ask clients what they are feeling in the moment in the room in their bodies (breath, tightness, rigidity, etc.)" The other shared, "I often ask clients when they are describing feelings to tell me where in the body they are feeling the feelings and what those feelings are like." Another clinician explained:

I am aware of clients' responses and work with them to become aware of their bodies and to use their responses to inform them of their own processes. I also encourage them to work with me to inhabit their bodies more fully and to heal from the experiences they have had.

One participant shared her whole process of observing and intervention:

Yes, I try to practice in a contemplative, aware state, noticing changes in posture, breathing, eye contact, movements, and reflecting these changes back to the patient and asking them about the[m]. Sometimes I say: Your body is doing _____. Why do you suppose that is? Or: What does the feeling of anger feel like in your body?

A different social worker shared how she coaches clients' to better understand their bodies and reflect their feelings, stating:

When clients are having trouble identifying emotions, I often ask where they feel something in their body. I sometimes will suggest grounding in the body through breathing or noticing sensation, particularly when a client has a strong emotional reaction.

4) *Some social workers find interpreting and verbalizing for clients what they see in their clients' bodies helpful.*

Other participants shared how they themselves put into words what they were seeing in their clients' bodies in order to offer insight. One such respondent stated, "Yes, I am always reading the client's body. I comment [on] it a lot to guess if what they are showing me is how they are feeling." Another social worker wrote:

Yes. I pay close attention to such client responses as blushing, teariness/near-crying, eye contact, physically leaning/moving closer or farther away from me during session...and I often utilize these observations in session—helping client to identify hidden feelings or to state feelings with words rather than actions, etc.

A different participant shared how she thought both teaching clients about feelings in the body and also inquiring verbally about what she is seeing are helpful to the process. She shared, “I definitely notice my clients’ nonverbal clues, and inquire about them – ‘You look very tense. I’m wondering if that is how you are feeling.’

5) *Some social workers reported that clients’ bodies present material just as effectively as their verbal presentation.*

Again, many respondents shared that they see the body presenting material just as fruitfully as the clients’ words. One participant shared that body language is “a language that conveys just as readily and accurately as words.” Another clinician wrote that the body’s messages are in fact more important, noting, “you can often tell much more about anxiety, depression, and psychosis through body language than you can through verbal interaction.” A different clinician commented on how sometimes verbal language is not enough and that the body gives a truer impression, sharing that clients’ “bodies tell me things that they cannot usually describe in words. The past is housed in the body and where energy is blocked.” Another social worker agreed, stating, “I believe that our bodies speak what we can not say in words.”

6) *Some social workers believe that how the client uses spatial dynamics is an important factor to consider when working therapeutically.*

Another group of clinicians wrote about their understanding of their clients use of their bodies in space. One social worker wrote:

Very much so- I look at how they place themselves in relation to me (space-wise), their pose, their gestures, and how the client carries him/herself as cues to assess their current state. I may discuss a

patient's body posture or gestures with him if it seems changed from the norm.

One clinician shared how power dynamics can be evoked through spatial factors, sharing this example:

I find it interesting that new clients debate about where to sit in my office. I have several choices for them (comfy chair, formal chair, loveseat) but MY seat is obvious and it is interesting to me when they consider sitting in my seat or ask me where I will be sitting. In my opinion, it's a statement about who is going to be in charge of the session, in some ways.

Another social worker related that a particular counselling space, her car, was, "very unthreatening way for especially teenage kids to freely express what's going on with them ('Car therapy')." Finally, one respondent noted how some clients will, "adopt the same positions as I do, how close or far they choose to sit from me, and will pay attention to [this]."

7) Some social workers commented on noticing and taking into account more readily their clients' bodies when clients presented with a trauma history.

There were many respondents who observed that they were especially attentive to the body when working with clients with a trauma history. One clinician wrote, "Their body responses can tell me a lot about my clients – especially those who have trauma histories." Another shared that specific sensations may be related to trauma such as, "When a client reports that she is disconnecting from her body." Several other social workers spoke of the importance of physically 'grounding' when working with clients with trauma histories. One reported, "Working with trauma survivors, I do a lot of grounding and relaxation work." Another shared, "I use the body as way to ground clients in [the] moment when they are being overwhelmed in recounting their trauma histories." Finally, another clinician wrote:

Because I work almost exclusively with trauma survivors, I do a lot of work with clients to help them identify their emotions by how they experience them in their body. This helps them be aware of what they may be feeling at other times, and then allows them to take steps to manage these affects.

8) *Other Outlier Comments*

There were several other themes mentioned that vary slightly from the common themes explored above. These include several respondents stating that as therapists they only address the body when the client first brings the topic into verbal interplay, another clinician wrote of assessing her clients' bodies to help them maintain their physical well-being, another participant shared that she is only aware of her clients' bodies and not her own. A few respondents reported that they think their clients' bodies and bodily responses are important but do not know what to do with this information. Another small group wrote of the importance of using clients' use or lack of use of eye contact in assessment.

Third Question

The third open-ended question asked participants to share stories of times that clinicians had become very aware of their own bodies in sessions with clients. (Do you have a story of a time when you became very aware of your body in a session with a client? Please describe. For example: falling asleep or feeling aroused.) Two hundred and thirty-one respondents (N=231) answered this question with responses ranging from 'no' to lengthy stories of personal awareness. For the purposes of this study these answers will be used only for discussion purposes to highlight findings from the non-open-ended questions above. The themes of these stories ranged from times when clinicians felt extremely uncomfortable in their bodies due to the danger that they perceived from their clients to the usefulness of being able to make a

meaningful interpretation because of allowing the sensations of their bodies to inform their practice.

The following chapter will explore the theoretical meaning of these findings. It begins with an exploration of the implications of social workers reporting high and varied awareness of their bodies and bodily sensations. This will be followed by a brief discussion of why non-heterosexuals report higher body awareness than their heterosexual colleagues. It will also examine possible reasons for limited correlations between heightened awareness with certain personal and professional qualities of the participants. The chapter will conclude with heuristic questions, the study's research limitations, and implications for future social work practice and research.

CHAPTER V

DISCUSSION

Introduction

The original impetus for this study was this researcher's belief in the importance of inclusion of the body, both the clinician's and the client's, in social work practice. In order to create a study area, this researcher chose to examine how social workers are aware or not aware of their body in sessions with clients. Second to this inquiry was a question regarding whether or not those social workers who report a higher body awareness are more likely to be correlated with any particular socio-demographic, personal experience, or client population. The discussion below addresses four major findings from this study: 1) The majority of social workers report having a high personal body awareness *and* using their bodily responses in practice; 2) There are specific types of body awareness that are more readily identified by social workers; 3) There is a lack of correlations between those with a heightened sense of body awareness and specific personal factors; 4) The newly-created scale is statistically robust and there are important implications for its future use. This chapter will also outline further questions for study and limitations of this research project.

Social Workers and Personal Body Awareness

It was expected at the beginning of the research that social workers in general would report low personal body awareness. This assumption was based on literature that suggests that in therapy today, the body, *and the therapist's body and personal*

body awareness specifically, is not discussed, acknowledged, or taught as a site of inquiry or practice (Aron, 1998). Therefore, the overwhelming response of the sample stating high levels of personal body awareness *and* using this awareness came as a surprise. Within the written responses of the qualitative portion, the vast majority, eighty-six percent of respondents, shared that they use their own body and bodily responses in their assessment and practice with clients. These social workers reported a wide and varied use of their bodily awareness, sharing a breadth of possibility for inclusion of the body in practice. For example, a large group of social workers reported using their bodily responses as countertransference material in sessions with clients. These clinicians are noticing not only their bodies but are *addressing* why they are feeling how they are feeling in the context of the relationship. It seems as though they are using their bodies as sites of inquiry and guidance.

Similarly, within the quantitative scale, the overwhelming majority of participants reported having awareness of particular physical sensations as compared to those who reported 'not noticing.' Further, forty-five percent of social workers reported having a higher awareness of particular physical sensations as opposed to those with a lower awareness (55%). Additionally, ten physical sensations were reported as being experienced sometimes or frequently by over seventy percent of the sample. Ninety percent of participants reported experiencing thirst and 94.1% sleepiness.

These results have crucial implications for the continued understanding, research and teaching of social work as they highlight the importance of the social worker's body and bodily responses in practice. They demonstrate that even though the body and bodily responses are very rarely addressed in mainstream social work training and supervision, they are essential (Jacobs, 1994). When these aspects of

therapy are not acknowledged it is as though there is an elephant in the room, a large, breathing, moving, sensate being whose presence is not addressed. Yet, outside of mainstream social work practice and teaching, there are multiple disciplines addressing the body. (Some examples include psychotherapy, dance-movement therapy, bio-energetics and so on.) These theories and practices remain on the fringe and not within the typical training. However, the results of this study demonstrate that for social workers the body is not on the periphery but is a critical instrument and site of knowledge in their work.

What then are some of the specific implications of these findings? If the majority of social workers are including body awareness in their practice, what does this mean to the field that in many ways has excluded the body, and certainly the practitioner's body, from theory and practice since its inception? One factor is that the type of research that this study addresses needs to be continued and broadened. If social workers are using their bodies, but do not have a theoretical or practical undergirding, there may be hazards to both the client and clinician. It is possible that without further training, both parties in the therapeutic dyad may experience (or continue to experience) preventable physical and/or psychological effects from the practitioners use of the body in treatment. Further, the sample reported using body awareness mostly in a constructive manner; however, it is possible that it might also have a harmful effect. Both the literature and the sample suggested that the body and its reactions may interfere with other types of responses – thus important projections or countertransference may be overwhelmed by the body's response and therefore be neglected (Iannaco, 2000).

As well, it is likely that just as the unconscious psyche of all participants plays its part in therapy, so too may the unconscious bodily responses of both parties. This

unconscious part may have both negative and positive consequences. This interplay may lead to unforeseen consequences in therapy. It is possible that the unconscious may create blind spots in the relationship where client and clinician cannot discern their next steps. At the same time perhaps the interchange between unconscious may contribute to a new kind of dynamic (Suchet, 2004).

Next, perhaps it would be possible, with greater awareness of the body, that burn out, which is often manifested physically (Maslach & Jackson, 1981), could be eased or avoided. A greater understanding of the body in social work, may lead to more effective self-care for social workers leading to greater longevity and productivity while practicing. Social workers with greater awareness might be better able to predict, for instance, their own tiredness and work within sessions to actively refine this feeling to understand it as either the effect of embodied countertransference or not getting enough sleep the night before, or possibly both.

A further implication to these findings is the possibility that greater awareness might lead to a more effective treatment with certain clients, such as those who would benefit from a more intentional inclusion of the body as it applies to the preverbal level, through the nonverbal interchange. Those experiencing alexythymia, for example, who are unable to put into words their emotions, may benefit more from a therapist who is able to attune to their bodily responses through his or her own sense of body awareness (McDougall, 1989; Aron, 1998). Many clinicians reported using techniques of interpretation of their clients' bodily clues to aide their clients in self-expression. Therefore including the body, as the majority of social workers do, seems to be a helpful step in addressing the needs of this particular type of client.

Additionally, intentionally using the body with the general population may also be helpful as humans first learn to communicate and interact socially though preverbal

experiences (Beebe & Lachmann, 1988). By acknowledging and accessing this part of the whole human there is perhaps a greater possibility of working therapeutically.

Fourteen percent of respondents report that they do *not* take into account their own body. Who are these persons? One participant suggested, that she is unaware of her body because she has never been exposed to it as a possible site of information or exploration. Another participant shared that she finds the body to be distracting from the process and thus unhelpful. Further research into why this minority of social workers do not address their own bodies in practice is needed to better understand this phenomenon.

Levels of Specific Sensations

Another important contribution of this research is identifying what specific areas of physical sensation social workers are most aware. Included in the top ten sensations, listed in descending order, are: sleepiness, thirst, yawning, hunger, tearing eyes, uncomfortable body position, need to urinate, coughing, increased heart rate, and tension in neck (see Table 8). However, this list is complicated by the fact that it is hard to determine the causality of each of these factors. Was the social worker tired before entering the session, or did the social worker become tired during the session through countertransference response? Was the social worker hungry and thirsty because she skipped lunch or because of the client's projection of oral needs onto the clinician?

Out of this list, three appear to likely be more often caused from *within* the session: tearing eyes, uncomfortable body position, and increased heart rate. Other physical sensations may be determined by countertransference within the session, but without further investigation it is difficult to make this theoretical leap. Tearing eyes seem to be a physical sensation that social workers are aware of frequently as a

countertransference response, barring some external event that has caused the social worker great sadness and an inability to contain her emotions. This supports literature that suggests counsellors believe that crying in sessions is appropriate at times in order to form genuine relationships with clients (Curtis, Matise, & Glass, 2003). Through sharing this genuine expression of emotion it is possible that both the client and clinician experience a sense of healing in the dyad.

Additionally, both the high reporting of *uncomfortable* body position and *increased* heart rate could indicate that a majority of social workers are also frequently or sometimes feeling discomfort and, or anxiety within the therapeutic session. Their bodies may be alerting them to their own reactivity and possible countertransferential experience of their clients. Some social workers within the qualitative responses wrote of using feelings of discomfort as ways of recognizing particularly problematic clients, such as those with a later corroborated history of violence.

Further, although sexual/erotic arousal was not included in the top ten responses, it is interesting that almost half of the sample reported frequently or sometimes experiencing this sensation (45.1% and 54.9%). Again, it is possible that this feeling was lingering from an external event; however, it seems more likely that it was evoked from within the session itself. As there is a strong sexual taboo in the therapeutic setting, this high rate of reporting is unexpected. This high rate of response also reflects the need to address more openly, both in training and in the research, the issue of sexual arousal to better support both parties in the dyad (Field, 1988). As the body in practice merits further research, so too does this particular type of physical and emotional reaction.

A further question raised by these varying levels of awareness of physical sensation, is why do clinicians report differing levels of each sensation? Why was the sample more aware of sleepiness as opposed to tension in their arms? Why are social workers more aware of the feeling of being disconnected from their bodies versus feelings of being ‘outside of their skin’? Perhaps different societal or cultural training, physical illness or health or idiosyncratic reasons influence why people attend to certain body sensations and not others. It is also possible that certain physical sensations are more relevant to the psychic process and to the therapeutic process compared with other sensations. If a social worker is more aware of sleepiness as opposed to thirst, perhaps the therapeutic interaction may be different. Again, this lack of understanding leads to a need for more research.

Correlates to Social Workers’ Personal Body Awareness

The second research question of this study was to explore possible relationships between body awareness and various factors, including socio-demographic, personal experiences, and client population with whom they work. The literature suggests that all of these areas might increase the clinician’s body awareness (Stone, 2000; Field, 1988). However, with the exception of one socio-demographic factor, that of sexual orientation (which will be further addressed below), there were no significant differences between those reporting higher or lower personal body awareness and any of the above mentioned factors.

Social workers who reported being non-heterosexual have an overall higher personal body awareness than those who reported being heterosexual. (It should be noted that the non-heterosexual category is a recoding of those who replied as gay, lesbian, bisexual, and queer.) None of the literature reviewed suggested this result; therefore, this is a new finding that perhaps offers more questions than answers. In

theorizing why this is the case, one hypothesis may be that because of non-heterosexuals definition as an ‘other’ in society, and therefore marginal, non-heterosexuals have had to examine more closely all aspects of themselves, including, and perhaps especially, their bodies. Perhaps in becoming aware of being oriented differently from mainstream society, where this ‘otherness’ is defined by the *sexual, physical act*, a person must become more aware of the body to understand this positioning. Another possible reason for this difference may be that non-heterosexuals have a greater comfort in disclosing, in particular, sexual/erotic information as they have possibly had more practice of this type of discussion due to the need for personal evaluation and disclosure due to their ‘marginal’ status. Further research is needed to target these questions as there are no known previous studies related to this.

The finding of no other significant associations may be explored theoretically in several ways. First, it is possible that since the majority of clinicians reported being aware of and using their bodies and bodily responses in sessions (86%), body awareness itself may supersede other factors, such as age, years of experience, and client symptom picture. Second, another explanation may be that the study does not address other potentially significant predictors of body awareness. Perhaps what creates the difference in social workers’ personal body awareness is something that this survey did not elicit. One such possibility is highlighted in the literature, as Jacobs (1973) states, “the nature of the [clinician’s] own bodily experience in childhood plays an important role in fostering [embodied] responses” (p. 91). Third, it is possible that as personal body awareness is not a subject that is taught or emphasized in primary training institutes for social workers, it is not a skill that social workers consider perfecting or developing through continued education. Without further refinement, perhaps levels of personal body awareness remain much the same

for social workers over years of practice. Fourth, it is possible that there are methodological reasons why these suggested results were not found, primarily that the tool itself does not offer space for nuanced answers or test in a way that can measure body awareness accurately as it is a written, retrospective tool. (These methodological limitations will be further discussed below.)

Despite the lack of significant findings in the quantitative portion of the study, social workers did write of many self-perceived associations between a heightened sense of body awareness and other factors they identified. These responses could be primarily divided into two categories: 1) clinician's theoretical inclusion of the body in practice, and 2) their client type. First, some of the respondents stated that they worked from a primarily body-centered approach, where their main interpretation came from their own and their clients' bodily responses within sessions. These clinicians spoke emphatically of the "necessity" and "importance" of the body's information, both of client and clinician. These social workers report that the body, their own and their client's, gives them the most essential information about treatment. For them, it appears, the primary 'language' of therapy is the bodies', not verbal.

Second, another group of clinicians reported on having a higher awareness of their bodies because of clients' presenting material. These particular client types included: 1) when working with a client with a personality disorder; 2) when working with a client with a trauma history; and, 3) when working with a client with a history of violence. How can this be understood theoretically? Clinicians who work with clients with personality disorders are often challenged by the intensity of the client's emotions (Horwitz, Gabbard, Allen, Frieswyk, Colson, Newsom, & Coyne, 1996). These emotions are not neutral and may lead the clinician to question herself or

himself more deeply than with other clients. Clients with certain personality disorders may also report being in crisis more often and may use splitting with their clinicians to both distance and embrace them (Horwitz, 1996). Therefore, perhaps it is this quality of intensity of clients with personality disorders which elicits strong psychological and physiological responses, including sleepiness, anxiety, uncomfortable body positions and more.

Further, it is clear from current trauma theory that trauma effects both the physiology and psychology of those who have experienced it (van der Kolk, 1996; Scaer, 2001). It seems likely that if there is a “body memory” (Siegal, 1986), then those who have experienced trauma would carry the trauma within their bodies to a certain degree. Perhaps attuned and aware clinicians are better able to identify and work with these bodily aspects of the trauma experienced. There may be a different quality or intensity to a body’s presentation or sensation if it has experienced trauma and certain clinicians may be able to better recognize this through intentional use of their bodies.

Lastly, clinicians working with people who they know to be or later determine to have a violent history reported having a heightened sense of bodily awareness. Here, there seems to be a direct correlation – actual physical fear and discomfort. However, even those clinicians who do not know the client’s history of violent interactions have reported in this study feeling unsafe physically. In these cases their body awareness alerted them to a potential danger in the room. In this way, it seems that part of body awareness may be related to the instinctual fight or flight mechanism in humans. These clinicians were perhaps ‘warned’ by their bodies about these clients before they had any other information.

There were several significant findings when addressing specific physical sensations from the scale with specific socio-demographic characteristics. As these findings do not speak to the larger sense of overall body awareness, they will not be discussed further (please refer back to Findings chapter for results). However, these specific sensations are worthy of further study in and of themselves for greater illumination of the use of the body in social work.

Robust Scale

Finally, this research has contributed to therapeutic practice through the introduction of a new scale to measure body awareness of social workers in sessions. This scale has a strong internal reliability ($\alpha = .87$, $N = 310$, number of items = 27). The scale's robustness suggests that it represents what social workers' pay attention to in terms of their physical sensations while sitting in sessions. This scale has created a foundation for new lines of inquiry. It may be used in the future, with modifications, for further research with different samples in order to broaden the field's understanding of clinicians' body awareness and its affect on therapeutic practice.

Heuristic Questions

As this study is an initial investigation into empirical research on social workers' personal body awareness, there are many avenues of discovery yet to be explored. One of the main questions that this researcher is left with, is how is personal body awareness developed? It has been suggested through the literature that childhood experiences influence the development of body awareness (Stone, 2006). However, if it is something, as this researcher postulates, that is worthy of cultivation by social workers for deeper and more holistic work with clients it is imperative that further research be undertaken. It may also be important to include learning from this future research in the education and future training of social workers. Another

question for additional research is why do non-heterosexual social workers report a higher overall body awareness? As this has been thus far unexplored, it is undetermined why there is this difference. Further research might allow a clearer understanding thus enabling all social workers, of all sexual orientations, to gain more body awareness and insight. Another line of fruitful investigation may be into the atypical respondents who did not take their own bodies and bodily responses into account in practice. What makes these respondents different from the others? Also, are they using their bodies unconsciously and if so how does this affect their work? A possible future project could employ 'pre', 'during', and 'post' testing for physical sensations of the clinician in order to determine a closer link between evoked embodied countertransference and pre-existing and non-related physical sensations.

Research Limitations

The major research limitation of this study revolves around the lack of diversity of socio-demographic characteristics within the sample. The first such limitation is represented by gender, where the overwhelming majority of participants were female (87.7%). However, this is largely reflective of the social work field in general, (females 79% and males 20%) (Demographics, 2003). The second skewed category was racial identity, where 84.5% of social workers reported being White/Caucasian. This number is actually slightly lower than the national average of social workers (87% White versus 13% Clinicians of Colour); yet, it does not address a need for a diverse sample (Demographics, 2003). The third is the lack of representation of participants over the age of forty (61.2% of participants were forty years old and younger versus 38.8% who were forty-one years and older). This sample is not consistent with the national average where only 24% of social workers report being under the age of forty-two years old (Demographics, 2003). Another area

where diversity was not addressed was in the median years of experience as a practicing social worker. For this sample the median was six years, however, the vast number of social workers working in the field have had over fourteen years of experience (Demographics, 2003). This begs the question of how would the research have been different had these socio-demographic issues been more balanced?

Another limitation may be that the sample was drawn from Smith College School for Social Work. It is unclear if and how a different training environment might influence social workers; however, it is possible that it would. Further to this issue, the majority of respondents stated that their theoretical orientation psychodynamic (69.1%), a field characterized by little research in the areas of body awareness or inclusion of the clinician's body and bodily responses in assessment and practice (Jacobs, 1994). Yet as it was found that theoretical orientation did not influence higher body awareness, perhaps this is not a significant factor.

There are two potentially significant methodological limitations. First, this research question is addressing physical awareness and sensations; however, as a written tool was used to address the topic, it is possible that much of the 'physical' was lost. Additionally, it was a retrospective survey, again perhaps limiting some of the nuance of observation of process. It may be that physiological tests of social workers during sessions with clients might gather more nuanced data. Another methodological restriction may be the survey tool's reliance on the Internet for gathering data. It is possible that by using computer and Internet technology the sample was distorted to those who use the Internet, can afford the Internet, have access to a private computer in order to confidentially complete the survey, and have the training to use the Internet, and so on. The use of the Internet may also have limited the shades that verbal interview collection could have elicited.

Conclusion and Implications for Clinical Social Work

Two underlying conclusions have guided this research: 1) that inclusion of the body in social work enriches practice by offering a more holistic view of practice; and, 2) that as the bodies of both the client and clinician in social work have been understudied they are thus underutilized and unacknowledged in practice. The first underlying assumption was firmly supported by the social workers' own responses where the vast *majority* stated that they take their bodies and bodily responses into consideration when assessing and practicing with clients and *all* who responded stated that they take their clients' bodies into account. This first finding disproves the second assumption, that the body is underutilized and unacknowledged in practice; however, the reality of it being understudied remains true. Thus this study is significant as it begins to address this lack of research. It is clear through this research that the body is being used in social work practice. It is essential that further research on the body, including how it is being used and with what theoretical under-girding, be conducted for the betterment of treatment outcomes for both client and clinician.

References

- Aron, L. (1998). Introduction. In L. Aron & S.F. Anderson (Eds.), *Relational perspectives on the body* (Vol. 12, pp. xix-xxviii). New Jersey: Analytic Press.
- Aron, L. (1998). The clinical body and the reflexive mind. In L. Aron, & S.F. Anderson (Eds.), *Relational perspectives on the body* (Vol. 12, pp. 3-38). New Jersey: Analytic Press.
- Balamuth, R. (1998). Re-membering the body: A psychoanalytic study of presence and absence of the lived body. In L. Aron & S.F. Anderson (Eds.), *Relational perspectives on the body* (Vol. 12, pp. 263-286). New Jersey: Analytic Press.
- Bebi, R. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology*, 53(1), 26-35.
- Beebe, B., & Lachmann, F. M. (1988). Mother-infant mutual influence and precursors of psychic structure. In A. Goldberg (Ed.), *Frontiers in self psychology: progress in self psychology* (Vol. 3, pp. 3-25). Hillsdale, NU: Analytic Press.
- Burstein, C. (1998). Living Inquiry. In D.H. Johnson & I.J. Grand (Eds.), *The body in psychotherapy: Inquiries in somatic psychology* (Issue 58, pp. 107-124). Berkeley, CA: North Atlantic Books.
- Curtis, R., Matisse, M., & Glass, J. (2003). Counselling students' views and concerns about weeping with clients: A pilot study. *Counselling and Psychotherapy Research*, 3(4), 1473-3145. Retrieved June 08, 2007, from <http://www.informaworld.com/10.1080/14733140312331384303>
- Davis, J. T. (2002). Countertransference temptation and the use of self-disclosure by psychotherapists in training. *Psychoanalytic Psychology*, 19(3), 435-454.
- Davis, M., & Hadiks, D. (1994). Nonverbal aspects of therapist attunement. *Journal of Clinical Psychology*, 50(3), 393-405.
- Davis, M., & Hadiks, D. (1990). Nonverbal behavior and client state changes during psychotherapy. *Journal of Clinical Psychology*, 46, 340-351.
- Demographics. (2003). *Practice Research Network*, 2(2). Retrieved May 7, 2007, from <http://careerplanning.about.com/gi/dynamic/offsite.htm?zi=1/XJ/Ya&sdn=careerplanning&cdn=careers&tm=4&f=10&tt=14&bt=1&bts=1&zu=http%3A//jobstar.org/tools/salary/sal-surv.php>

- Embody. (n.d.). Retrieved October 28, 2006 from, www.answers.com/embody
- Field, N. (1988). 'Listening with the body: an exploration in the countertransference'. *British Journal of Psychotherapy*, 5(4), 512-522.
- Forester, C. A. (2000). Body awareness: an aspect of countertransference management that moderates vicarious traumatization. *Dissertation Abstracts International*, (UMI No. 9992388).
- Fretz, B. R., Corn, R., Tuemmler, J.M., & Bellet, W. (1979). Counselor nonverbal behaviors and client evaluations. *Journal of Counseling Psychology*, 26(4), 304-311.
- Freud, S. & Breuer, J. (2004). *Studies in Hysteria*. (N. Luckhurst, Trans.). New York: Penguin Classics. (Original work published 1893, 1895, 1908).
- Freud, S. (1961). The ego and the id. In J. Strachey (Ed. & Trans.). *The standard edition of the complete psychological works of Sigmund Freud*. (Vol. 19, pp. 3-66). London: Hogarth Press. (Original work published 1923).
- Grand, I. J. (1998). Psyche's body: Towards a somatic psychodynamics. In D.H. Johnson & I.J. Grand (Eds.), *The body in psychotherapy: Inquiries in somatic psychology* (Issue 58, pp. 171-194). Berkeley, CA: North Atlantic Books.
- Harris, A. (1998). Psychic envelopes and sonorous baths: sitting the body in relational theory and clinical practice. In L. Aron & S.F. Anderson (Eds.), *Relational perspectives on the body* (Vol. 12, pp. 39-64). New Jersey: Analytic Press.
- Hayes, J. A. & Gelso, C.J. (2001). Clinical implications of research on countertransference: science informing practice. *In Session: Psychotherapy in Practice*, 57(8), 1041-1051.
- Horwitz, L., Gabbard, G., Allen, J., Frieswyk, S., Colson, D., Newsom, G., & Coyne, L. (1996) Borderline Personality Disorder: Tailoring the Psychotherapy to the Patient. *American Psychological Publication*. Washington, DC. Retrieved June 8, 2007, from, http://books.google.com/books?id=mR8eXrqeI5EC&pg=PR3&dq=borderline+personality+disorder+splitting+crisis&sig=Vjp17Jj3hW04kvK3wm7_eK9qHxY#PPA36,M1
- Iannaco, G. (2000). Open space: the therapist's body. *Psychodynamic Counselling*, 6(4), 533-537.
- Jacobs, T. J. (1973). Posture, gesture and movement in the analysis. *Journal of American Psychoanalytic Association*, 21, 77-92.
- Jacobs, T.J. (1994). Nonverbal communications: some reflections on their role in the psychoanalytic process and psychoanalytic education. *Journal of American Psychoanalytic Association*, 42, 741-762.

- Kahn, M. (2001). *Between therapist and client: The new relationship*. (revised edition). New York: Henry Holt and Co.
- Kimble Wrye, H. (1998). The embodiment of desire: Rethinking the bodymind within the analytic dyad. In L. Aron & S.F. Anderson (Eds.), *Relational perspectives on the body* (Vol. 12, pp. 39-64). New Jersey: Analytic Press.
- Maslach, C. & Jackson, S. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour*, 2(2), 99-113. Retrieved June 8 2007, from, <http://links.jstor.org/sici?sici=0142-2774%28198104%292%3A2%3C99%3ATMOEB%3E2.0.CO%3B2-X>
- McDougall, J. (1989). *Theaters of the body*. NY: Norton & Company.
- McLaughlin, J.T. (1972). The sleepy analyst: some observations on states of consciousness in the analyst at work. *Journal of American Psychoanalytic Association*, 23, 363-382.
- Miller, J. A. (2000). The fear of the body in psychotherapy. *Psychodynamic Counselling*, 6(4), 437-450.
- Norman, S.L. (1982). Nonverbal communication: implications for and use by counselors. *Individual Psychology*, 38(4), 353-359.
- Ross, M. (2000). Body talk: somatic countertransference. *Psychodynamic Counselling*, 6(4), 451-467.
- Scaer, C. R. (2001). *The body bears the burden: Trauma, dissociation, and disease*. New York: Haworth Medical Press.
- Siegel, E. V. (1984). *Dance-movement therapy: mirror of our selves: the psychoanalytic approach*. New York: Human Sciences Press.
- Silvia, M. D. (2003). *Clinical social work students speak about use-of-self*. Unpublished Master's thesis, Smith College School for Social Work, Northampton, MA.
- Somatic. (n.d.). Retrieved October 28, 2006, from www.answers.com/soma&r=67
- Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.
- Stone, M. (2006). The analyst's body as tuning fork: embodied resonance in countertransference. *Journal of Analytical Psychology*, 51, 109-124.
- Suchet, M. (2004). Whose mind is it anyway? *Studies in Gender and Sexuality*, 5(3), 259-287.

Tinnin, L. (1990). Biological processes in nonverbal communication and their role in the making and interpretation of art. *American Journal of Art Therapy*, 29(1), 9-13.

van der Kolk, B. A., MacFarlane, A.C., & Weisaeth, L. (1996). *Traumatic Stress*. New York: Guilford Press.

Appendix A
Informed Consent for Current Students

Dear Fellow Smith College School for Social Work Student,

My name is Lauren Clarke and I am currently on my second year placement with Smith College School for Social Work (SCSSW). I am conducting a research study on social workers' sense of personal body awareness in therapy sessions. I will be using this data in order complete my thesis, along with a hope to publish and present my results in the future.

Your participation is requested because you are one of my classmates, a current MSW student from Smith College. Non-Smith students are excluded from the survey. If you choose to participate, you will fill out an online survey with questions concerning demographic and personal experiences associated with personal body awareness. The last three questions are open-ended and optional. The survey should take around 10-15 minutes to complete.

As this is an anonymous survey, with questions of a fairly non-intrusive nature, there are few risks to you if you choose to participate. Alternatively, your participation will aid in furthering the profession's knowledge on the body in social work practice in the future. Unfortunately, I am unable to give you any type of compensation for completing this survey beyond your own sense of contribution-Thanks!

You may leave the survey at any time and may also leave questions blank. Participation in this study is anonymous as I will have no record of who has participated and who has not. The survey can be found at surveymonkey.com, which uses firewalls and data encryption to protect your identity. Only my thesis advisor, a statistical analyst, and myself will have access to the data. The data from this study will be kept locked for a period of three years as required by Federal guidelines and destroyed if not needed for further use. Please be aware that once you have submitted the survey your information cannot be withdrawn from the study.

BY ANSWERING THE SURVEY, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please click the following link to be connected to the survey.
<http://www.surveymonkey.com/s.asp?u=18123107534>

Please do not hesitate to contact me if you have any questions, comments, or concerns. Please email me if you would like an executive summary of my results.

Thank-you very much,
Lauren Clarke
lclarke@smith.edu

Appendix B
Informed Consent for Graduates

Dear Smith College School for Social Work Graduate,

My name is Lauren Clarke and I am currently on my second year placement with Smith College School for Social Work (SCSSW). I am conducting a research study on social workers' sense of personal body awareness in therapy sessions. I will be using this data in order to complete my thesis, along with a hope to publish and present my results in the future.

Your participation is requested because you are a past MSW student from Smith College. Non-Smith graduates or current non-Smith students are not included in the survey. If you choose to participate, you will fill out an online survey with questions concerning demographic and personal experiences associated with personal body awareness. The last three questions are open-ended and optional. The survey should take around 10-15 minutes to complete.

As this is an anonymous survey, with questions of a fairly non-intrusive nature, there are few risks to you if you choose to participate. Alternatively, your participation will aid in furthering the profession's knowledge on the body in social work practice in the future. Unfortunately, I am unable to give you any type of compensation for completing this survey beyond your own sense of contribution-Thanks!

You may leave the survey at any time and may also leave questions blank. Participation in this study is anonymous as I will have no record of who has participated and who has not. The survey can be found at surveymonkey.com, which uses firewalls and data encryption to protect your identity. Only my thesis advisor, a statistical analyst, and myself will have access to the data. The data from this study will be kept locked for a period of three years as required by Federal guidelines and destroyed if not needed for further use. Please be aware that once you have submitted the survey your information cannot be withdrawn from the study.

BY ANSWERING THE SURVEY, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please click the following link to be connected to the survey.

<http://www.surveymonkey.com/s.asp?u=18123107534>

Please do not hesitate to contact me if you have any questions, comments, or concerns. Please email me if you would like an executive summary of my results.

Thank-you very much,
Lauren Clarke
lclarke@smith.edu

Appendix C
Clinicians' Body Awareness Scale

This survey is to address social workers' personal body awareness in psychotherapy sessions. It is also a measure to investigate possible any correlations between particular types of awareness, personal characteristics, and population served. You may skip a question at any time or leave the survey at any time. If you complete the survey and press send, you have agreed to participate in the survey and will not be able to remove yourself at the point from the study. Thank-you in advance for your participation!

Section 1: Personal Demographic Questions

- 1) Gender: Female Intersex
 Male Transgender
- 2) Please type your age: _____
- 3) Racial Identity: African-American Asian
 Black Biracial
 Hispanic/Latino/Latina Multiracial
 Pacific Islander White/Caucasian
 Other
- 4) Sexual Orientation: Asexual Bisexual
 Gay Heterosexual
 Lesbian Queer
 Other
- 5) Please type your years of experience in practice: _____
- 6) Please indicate if you are a: Graduate Student
- 7) Please choose which term best describes your theoretical orientation:
Behavioral (e.g. cognitive, dialectical, schema) _____
Psychodynamic (e.g. relational, ego psychology) _____
Systems (e.g. narrative, solutions focused) _____
12-Step _____
Other _____

- 8) Choose one primary practice setting:
- Day Treatment Facility _____
 - Inpatient Unit _____
 - Medical Social Worker at Hospital _____
 - Outpatient Clinic _____
 - Private Practice _____
 - Residential Program _____
 - School _____
 - Other _____

Section 2: The Population You Serve

1) Think of your current caseload. Please indicate the approximate number who are struggling with:

- Anxiety disorder _____
- Developmental disability _____
- Mood disorder _____
- Personality disorder _____
- Psychosis disorder _____
- Substance abuse _____
- Trauma _____
- Other _____

2) Again, think of your current caseload and indicate the approximate number of clients who are:

- Adolescents (13-18) _____
- Adults (31-64) _____
- Children (0-12) _____
- Seniors (65 +) _____
- Young adults (19-30) _____

Section 3: Personal Body Awareness

1) Please comment on how you have been aware of these bodily sensations during therapy sessions.

	Never (1	Sometimes 2	Often 3	I haven't noticed 0)
Coughing				
Constricted throat				
Dry throat				
Increased heart rate				
Decreased heart rate				
Trembling				
Sweating				
Sweaty palms				
Crying				
Tearing eyes				
Yawning				
Sleepiness				
Falling asleep				
Headache				
Tension in jaw				
Tension in back				
Tension in neck				
Tension in arms				
Pain in jaw				
Pain in back				
Pain in neck				
Pain in arms				
Rigidity in body position				
Uncomfortable body position				
Abnormal body position				
Sexual/erotic arousal				
Erection				
Thirst				
Hunger				
Need to defecate				
Need to urinate				
Feeling of being "outside of your skin"				
Feeling of being disconnected from your body				

Section 4: Personal Bodily Experiences

- 1) Have you have ever had a personal experience of:
- | | | |
|--|-----|----|
| Serious or life-threatening physical illness | Yes | No |
| Physical disability | Yes | No |
| Debilitating accident(s) | Yes | No |
| Other trauma | Yes | No |
- 2) Are you suffering from a current:
- | | | |
|--|-----|----|
| Serious or life-threatening physical illness | Yes | No |
| Chronic physical illness | Yes | No |
| Physical disability | Yes | No |
| Other trauma | Yes | No |

Section 5: Written answers

- 1) Is your body or your bodily responses in sessions a factor in your assessment and practice with clients? Please describe.
- 2) Are your clients' bodies and bodily responses a factor in your assessment and practice with clients? Please describe.
- 3) Do you have a story of a time when you became very aware of your body in a session with a client? Please describe. (For example: falling asleep or feeling aroused.)

Appendix D
Human Subjects Review Approval

January 6, 2007

Lauren N. Clarke
3129 37th Street, Apt. 3
Astoria, NY 11103

Dear Lauren,

Your amended materials have been reviewed. You did a good job with the letter including the important informed consent material and making it clear what it means to send in the survey. Your participants will be well informed.

There is one sentence you need to delete. In the Informed Consent part of the Application, you forgot to delete that you are giving them resources. There is one small change needed in the letter. Please delete what seems to be everyone's favorite phrase, the one about "in partial fulfillment" and tell them it's for your thesis.

We are glad to give final approval at this time and trust you will send Laurie your material with these minor changes. She will let me know when they come.

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. Several people are using Survey Monkey this year and I will be most interested to learn how it goes.

Sincerely,
Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Ann Marie Garran, Research Advisor