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# Analysis of the Real World Application of Sensorimotor Psychotherapy for the Treatment of Complex Trauma

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Analysis of the Real World Application of  
Sensorimotor Psychotherapy for the Treatment of Complex Trauma

By

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MSW Clinical Research Project

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, MN  
In Partial Fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### Abstract

The focus of this research was to gain a better understanding of the challenges of working with clients who have experienced severe or chronic trauma. The conceptual framework used for this research project is based on neurologically informed attachment theory as it is presented by Daniel J. Siegel in his book *Pocket Guide to Interpersonal Neurobiology: An Integrative Handbook of the Mind* (2012). The sample consisted of five professional mental health therapists who currently work with clients in the treatment of trauma. All participants also completed the Level I Trauma Training for Sensorimotor Psychotherapy. This sample of therapists reported that the majority of their cases were related to trauma, post-traumatic stress disorder, depression, anxiety and dissociative disorder. After analysis of the transcripts, three main themes emerged in the questioning: 1) Sensorimotor psychotherapy was explored due to perceived limitations with existing approaches for the treatment of some highly traumatized clients 2) Attention to the therapeutic relationship is extremely important when working with highly traumatized clients and 3) Insights regarding the therapists role in the treatment of traumatized clients. Strengths of this study included the relatively experienced sample and the qualitative nature of the study which allowed the participants' voices and experiences to be heard. Limitations of this sample include the small sample size of five therapists and the homogeneity of the participants.

### Acknowledgements

This paper is dedicated to my children, Thomas, Anna and Sarah. No matter where I go, or what I accomplish, nothing will be a greater honor, or give me greater joy, than being your mom. I love who you are and I'll love whoever you are meant to become. There is nothing you can ever do or say that could possibly change my love for you. I will love you forever and ever, no matter what, no exceptions.

*Life is an opportunity, benefit from it.*

*Life is beauty, admire it.*

*Life is bliss, taste it.*

*Life is a dream, realize it.*

*Life is a challenge, meet it.*

*Life is a duty, complete it.*

*Life is a game, play it.*

*Life is a promise, fulfill it.*

*Life is sorrow, overcome it.*

*Life is a song, sing it.*

*Life is a struggle, accept it.*

*Life is a tragedy, confront it.*

*Life is an adventure, dare it.*

*Life is luck, make it.*

*Life is too precious, do not destroy it.*

*Life is life, fight for it.*

*Mother Teresa (1910 – 1998)*

This work is also dedicated to two women who truly changed my life. I will always be grateful to Patti Miller, M.A., L.P. and Judith Indrelic, M.A., L.P. for their care and compassion. They supported me through the most difficult time of my life and taught me it is possible to find wholeness and happiness. I truly believe I wouldn't be standing here today if it wasn't for their professionalism, care and support.

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The diagnosis of post-traumatic stress disorder is a term used to identify the emotional and physiological disorganization that can result from experiencing a negative emotional experience that pushes human coping abilities to their limits. However, trauma experts assert that there are actually many different variables that can impact the way a specific person reacts to a specific trauma. For example, if a person is raised in a nurturing environment, where they develop a healthy sense of self and experience love and acceptance they may be better equipped emotionally to heal from traumatic events. In contrast, if a person is exposed to constant or prolonged trauma, such as war, torture or ongoing physical and sexual abuse it is often much more difficult to reduce the symptoms of PTSD such as recurring nightmares, severe anxiety and flashbacks (Ogden, Minton & Pain, 2006; Fisher, 2003; Schore, 2002; Herman, 1992; van der Kolk, 2002; Rothschild, 2000).

Because trauma is such a complex experience, and the emotional and physiological reaction to trauma can present so differently in people, researcher and trauma expert Judith Herman asserts that an additional diagnosis of Complex Traumatic Stress Disorder should be added to the DSM (Herman, 1992). Judith Herman asserts that the root of complex trauma is a physiological change that occurs in the brain due to prolonged exposure to trauma or if the trauma occurs at a critical point in the brain development of the child. Herman states,

*“Complex trauma involves not only the shock of fear but also, more fundamentally, a violation of and challenge to the fragile, immature and newly emerging self. Complex trauma often leaves the child unable to self-regulate (i.e. to control his or her feelings, cognitions, beliefs, intentions, and actions), to achieve a sense of self integrity (i.e. the feeling and belief that one is a unique, whole, coherent, and worthy individual), or to*



*experience relationships as nurturing and reliable resources that support self-regulation and self-integrity.” (Herman, 1992, p. 17)*

Sexual violation of children is one example of abuse that can manifest into complex post-traumatic stress disorder in later life. According to the Rape Abuse and Incest National Network (RAINN) there are an estimated 31,200 sexual assaults perpetrated on children under the age of 12 years old each year (Rape Abuse and Incest National Network, 2012). In an analysis of the effects of sexual assault on its victims, data revealed that victims are three times more likely to suffer from depression, six times more likely to suffer from Post-Traumatic Stress Disorder, thirteen times more likely to abuse alcohol, twenty-six times more likely to abuse drugs and four times more likely to contemplate suicide than those who have not experienced sexual abuse (Rape Abuse and Incest National Network, 2012).

It is important to note that not all abused children will experience complex post-traumatic stress disorder. Some of the indicators known to impact the possibility of developing the disorder include the age at which the abuse occurred, the frequency, duration and severity of the abuse, the type of abuse and the relationship between the victim and the abuser (National Child Abuse Statistics, 2012).

Current first line treatments for PTSD are Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR). Both CBT and EMDR are frequently used by the Veterans Administration in the treatment of PTSD for war veterans (National Center for PTSD, 2011). For the purpose of this research, the term complex trauma will be used to refer to those individuals who have experienced severe and prolonged trauma that is resistant to treatment by more traditional therapies. This is the population that multiple trauma researchers believe could benefit from the inclusion of somatic processing, such as the use of sensorimotor

psychotherapy, into the cognitive processing (Bisson, 2009b; Ogden, Minton & Pain, 2006; Schore, 2002; van der Kolk, 2002; Rothschild, 2000).

The focus of this research is to gain a better understanding of the challenges of working with clients who have experienced severe or chronic trauma. The researcher had a specific interest in the treatment of clients who did not respond to, or could not tolerate, more traditional methods of talk therapy without being re-traumatized. Somatic psychotherapies, such as Sensorimotor Psychotherapy, incorporate mindfulness and attention to the experiences of the body into the therapy process. Conducting individual confidential interviews, with experienced therapists will allow the researcher to gain insight into the real world treatment of complex trauma.

This research is important to the profession of clinical social work because unresolved trauma can have far reaching impacts on our clients, regardless of the population we focus on serving. For example, many people who were abused as children are diagnosed with a variety of emotional and psychological conditions in adulthood. One long term evaluation of victims of child abuse revealed that as many as 80 percent of victims was diagnosed with at least one psychiatric disorder the time they reached age 21. This group presented with many problems, including depression, anxiety, eating disorders, and suicide attempts. Other common diagnosis associated with abuse and neglect are panic disorders, dissociative disorders, attention-deficit/hyperactivity disorder, depression, anger, posttraumatic stress disorder, and reactive attachment disorder (U.S. Department of Health and Human Services, 2012).

Five participants were interviewed for this study and a purposive sample was used. The research was conducted through individual interviews with participants and data was evaluated using grounded theory and qualitative methods of coding. The conceptual framework used for

this research project is based on neurologically informed attachment theory as it is presented by Daniel J. Siegel in his book *Pocket Guide to Interpersonal Neurobiology: An Integrative Handbook of the Mind* (2012).

## **Literature Review**

### **Overview of trauma and Post-Traumatic Stress Disorder**

Post-Traumatic Stress Disorder (PTSD) is a frequently used term that covers a wide variety of symptoms and associated diagnoses. According to Bessel van der Kolk, some form of this condition has been recognized in medical research since 1889 (van der Kolk, n.d., p. 7). When thinking about PTSD, it is often the symptoms of intrusive memories and hyper-arousal that come to mind. However, trauma researcher Judith Herman asserts that PTSD is much more complex than a single diagnosis because there are so many variables that impact the effect that trauma has on a particular individual (Herman, 1992).

Some people experience trauma and only have a brief feeling of stress which they are able to recover from with little or no professional intervention. Others, who experience the exact same trauma, become overwhelmed and are diagnosed with PTSD. According to Peleg & Shalev (2006), who conducted an analysis of longitudinal studies of PTSD, there are some specific pre-exposure and post-exposure variables that impact the long term effect trauma has on an individual. Findings suggest that people who have a life that feels stable and in control prior to the trauma and/or have a strong emotional and social support system, have the best chance of surviving a trauma with the least amount of negative residual impact. Other protective factors for surviving trauma include accepting that the trauma will occupy one's thoughts at times versus feeling like one is losing one's mind because she or he can't control the memories. New trauma treatments designed to help survivors manage their emotional activation related to fear and

anxiety are showing great promise (Etkin & Wager, 2007; Peleg & Shalev, 2006). These variables create the lens that the victim sees the trauma through and explain why “the interpretation of the trauma is believed to be based on the subjective response of the victim and not the severity of the trauma as a whole” (Peleg & Shalev, 2006, pp. 591-592).

Herman proposes that those who are diagnosed with PTSD actually fall into two distinct camps. She calls the first group “classic or simple post-traumatic stress disorder” (Herman, 1992, p. 119). These are people who generally have had a stable life and see the trauma as an anomaly that was traumatic and debilitating but can be overcome. Those who fall into the second category have experienced a “complex syndrome of prolonged, repeated trauma” (Herman, 1992, p. 119). This group includes many returning war veterans as well as adults who experienced trauma as children. In both cases, the victims believe at a conscious or unconscious level that the world is unsafe and trauma is an expected part of life (Herman, 1992). Additionally, recent research has shown that there may be two subtypes of acute or complex trauma: one that is primarily based on hyper-arousal and the other that is characterized by a dissociative response. Both of these subtypes represent distinct neurological and emotional coping processes related to chronic stress (Lanius, Bluhm, Lanius, & Pain, 2006).

Increasingly, clinical practitioners are acknowledging that a diagnosis of PTSD is too limited to account for all the different ways trauma affects a survivor. Trauma survivors often present with a wide range of symptoms and are often diagnosed with eating disorders, chemical addictions and excessive risk taking. All these responses, can actually be coping mechanisms used by the survivor to try to regulate a severely dysregulated nervous system (Wheeler, 2007; Fisher, 2003; van der Kolk, 2002; Terr, 1991).

Living in a state of constant stress can have a substantial negative impact on all areas of a survivor's life including personal and professional relationships and academic functioning. Many people who have experienced extreme trauma seek to remain emotionally numb by disengaging from pleasurable aspects of their life like spending time with people they care about or even working to block out positive thoughts and emotions because of fear that they will be hurt or disappointed. Additionally, many survivors develop chronic sleep disorders like insomnia or nightmares as well as various gastrointestinal problems, headaches and other physical problems (Aupperle, Melrose, Stein, & Paulus, 2012; Bronner, Beer, Van Zelm Van Eldik, Grootenhuis, & Last, 2009; Herman, 1992).

Another recent finding is that people who suffer from PTSD often have a dual diagnosis of depression and suffer from impairments in cognitive functioning (van der Kolk, n.d.; Polak, Witteveen, Reitsma, & Olf, 2012; Aupperle et. al., 2011). Additionally, the negative impact on executive functioning appears to have a relationship to the intensity of the depressive symptoms with those who have more depressive symptoms showing lower cognitive functioning (Aupperle et al., 2011). This finding is significant because impaired cognitive abilities could prevent a client from being able to process the needed information in clinical interventions such as CBT (Polak, Witteveen, Reitsma, & Olf, 2012).

### **Complex trauma related to childhood abuse.**

The impact of abuse on children has been studied for decades. In her research in 1991, Terr identified two types of childhood traumas. She defined Type I trauma as the experience of a child who suffers one horrific blow like an assault, or a death, in a life that is otherwise stable. Type II trauma is experienced by those children who are repeatedly exposed to, or live in, an environment where they are repeatedly traumatized. According to Terr, the child who

experiences Type II trauma tries to protect themselves physically and emotionally through any coping strategy available to them. Some of these defenses include “massive denial, repression, dissociation, self-anesthesia, self-hypnosis, identification with the aggressor, and aggression turned against the self” (Terr, 1991, pp. 15-16). Additionally, traumatized children commonly attack their own bodies through cutting, suicide attempts or eating disorders in an attempt to numb the pain.

The impact of trauma on the brain of a developing child can have far reaching impacts. Research has shown that living in constant fear creates physiological changes in the child that impact virtually every area of their life including social, emotional and cognitive functioning (Perry, 2001; Terr, 1991). Adult survivors of childhood abuse often exhibit symptoms including “posttraumatic stress symptoms, dissociation, depression, anxiety, cognitive distortions, affect dysregulation, interpersonal problems with low self-esteem and somatic symptoms” (Duarte Giles, et al., 2007, p. 8). Children who have been sexually traumatized often have extreme views about sexual intimacy. Some want to avoid sexual contact at all costs while others aggressively seek out partners. Additionally, adults with a history of severe child abuse are more likely to be victimized in adulthood (Duarte Giles, 2007; Terr, 1991).

### **Neurological implications.**

Chronic traumatic stress in children has been shown to negatively impact brain development (Schoore, 2002) and negatively impact the ability of the child to regulate their own emotional states (Solomon & Heide, 2005; van der Kolk 2002). It is important to note that the physiological response to danger is often not under conscious control and as a result, people who have a history of trauma sometimes appear to overreact when faced with a minor stress. This

often results in shame for the person experiencing the distress because they fear they have lost control (van der Kolk, n.d.).

Understanding the physiological implications of chronic traumatic stress is incredibly complex, however, there are a few key concepts that are very important. One is that people don't survive the moment of trauma by stopping to think through the options. When people are threatened, animal instincts take over, heart rate and respiration increase and neurochemicals course through the brain temporarily shutting off non essential systems like the frontal cortex which is used for conscious thought (Fisher, 2003).

Automatically reacting to a situation has obvious life saving capabilities, however, because the frontal cortex is shut down during the traumatic experience, the person may lose the ability to cognitively process and associate it with other life experiences (van der Kolk, n.d.; Schore, 2012; Ogden, Pain, & Fisher, 2006; Fisher, 2003). In the long term, this can interfere with the part of the brain that allows people to turn their feelings into words which makes it difficult for people to talk through their trauma in an analytic manner (Solomon & Heide, 2005; van der Kolk, 2002; Siegel, 1999; ).

Beck states, "The problem of anxiety neuroses may be epitomized as an overactive alarm system. Their internal communication system is constantly telling them they are in a state of danger...resulting in the patient living in a constant state of anxiety" (1976, p. 155). Many researchers agree that this increased state of arousal and anxiety is tied into instinctual neurological processes that cannot be managed solely through cognitive methods of processing (Bisson J. I., 2009b; Felmingham, et al., 2008; Peleg & Shalev, 2006).

**Hyper-arousal versus hypo-arousal.**

Research has shown that there are basically two different subtypes within complex PTSD. The first type is called hyper-arousal and the second is called hypo-arousal or dissociation. According to Lanius, et. al. (2010, p. 8), the “subtypes can be viewed as different extremes of emotion deregulation. The first involves under-modulation and the second over-modulation to trauma-related emotional and somatosensory information.” Brain scans and other neurological research have shown that the two subtypes are also very different from a neurological perspective because both the hyper aroused state and the hypo aroused or dissociated state activate different areas of the brain using different neural pathways. Primarily, people who experienced childhood abuse experience the dissociative form of PTSD while others who were traumatized later in life experience the hyper arousal. However, it is possible for one person to experience both hyper-arousal and dissociation at different times in their life (Lanius, et. al., 2010; Ogden, pain, & Fisher, 2006).

Many people who have PTSD live in a chronic state of hyper-arousal with their central nervous system on alert at all times. This makes them vulnerable to trauma related stimuli and memories which can result in even more arousal (Ogden, Pain, & Fisher, 2006; van der Kolk, 2002). Brain research has shown that when a person is in a state of hyper-arousal the right hemisphere of the brain is more activated than the left hemisphere of the brain which, according to van der Kolk, “implies that, when people relive their trauma, they are imbedded in the experience: they are having the experience but cannot analyze what is going on in space and time” (2002, p. 387). Additionally, being in a chronic state of hyper-arousal makes people more prone to recall memories from another period of high arousal which makes flashbacks and nightmares more common (Fisher, 2003; van der Kolk, 2002)



One important finding in recent years is called the polyvagal theory which was initially described by Steven Porges (2011). According to Porges, “The polyvagal theory describes three stages in the development of a mammal’s autonomic nervous system. Each of these three major adaptive behavioral strategies is supported by a distinct neural circuit involving the autonomic nervous system: immobilization, mobilization, social communication and social engagement” (Porges, 2011, p. 16). This is important because Porges has found neurological correlates to describe why trauma survivors can’t cognitively stop their bodies from reacting to perceived threat (van der Kolk, n.d; Porges, 2011; Wheeler, 2007)

Dissociative PTSD is often seen in adult victims of childhood sexual abuse. (Lanius, et al., 2010). The act of dissociating involves disengaging from the external world, or the current experience of trauma, and focusing on the internal world of the mind. Children often describe this state as “going to a different place” (Perry, 2001, p. 7). As a child who is not in a position to fight or flee from the abuse, dissociation is a valuable tool to use in the moment the assault is happening (Ogden, Pain, & Fisher, 2006; Terr, 1991). The act of dissociating allows the child to survive in an environment of severe abuse while appearing “normal” to the outside world. According to Herman, “The child’s distress symptoms are generally well hidden...Most abused children reach adulthood with their secrets intact” (1992, p. 110).

### **Attachment theory and complex trauma.**

Attachment theory was originally proposed by Mary Ainsworth and John Bolwby. It is a conceptual framework based on the theory that the early relationship between a child and their caregivers has a strong impact on the way the child develops their sense of self and security. A child who has a good attachment experience is said to be securely attached and a child who has

experienced abuse that impacted their emotional or intellectual well-being is said to have a disorganized attachment (Siegel, 2012).

At the heart of the attachment relationship is the interaction between the caregiver and the child. According to Siegel (2012) this interaction “stimulates the activation and growth of integrative fibers in the brain. Integrative fibers in the brain are those that enable the coordination and balance of the nervous system at the heart of self-regulation. In other words, interpersonal integration cultivates neural integration”. Because children are not born with the ability to self-soothe or regulate their emotions they need to learn this through the actions of their caregivers. The ability to become self-regulated is very important to the emotional development of the child and into adulthood (Schoore, 2012; Schoore, 2002).

When the primary attachment figure is neglectful or abusive there is no strategy that a child can employ to make sense of the situation. Additionally, because the natural instinct of the child is to run to the primary caregiver for protection, there can be extreme confusion within the child that can lead to clinical dissociation (Siegel, 2012; Fisher, 2003). Schoore (2002) states, “The continued survival of the child is felt to be at risk, because the actuality of the abuse jeopardizes (the) primary object bond and challenges the child’s capacity to trust and, therefore, to securely depend” (p. 449).

According to Schoore, “It is now accepted that early childhood abuse specifically alters limbic system maturation, producing neurobiological alterations that act as a biological substrate for a variety of psychiatric consequences” (2012, p. 81). Additionally, for the child living in a constant state of stress, there will be an overactivation of the central nervous system (CNS). The changes to the limbic system, and the overactivation of the CNS makes children more vulnerable to anxiety and depression related to future stresses (Schoore, 2012; Heim & Nemeroff, 2001).

Children who experience extreme relational trauma most often react by going into a dissociative state. In a dissociative state the child moves into a state of physical and emotional withdrawal in an attempt to escape the situation. This becomes a learned process for the child that often is used through their entire lifespan. Schore (2012, p. 78) states “In this passive hypo metabolic state, heart rate, blood pressure, and respiration are decreased while pain-numbing and blunting endogenous opiates are elevated.” Fisher (2003) asserts that although dissociation learned from childhood trauma is a valuable coping strategy for the abused child it can manifest into physical and emotional symptoms that show up as PTSD even years after the event.

#### **Attachment based therapeutic approach for complex trauma.**

Judith Herman (1992) states, “The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only in the context of relationships; it cannot occur in isolation” (p. 133). When a therapist works with traumatized clients the therapeutic relationship is very important. Often traumatized clients are not used to being heard and understood and the process of building a relationship with a therapist can feel very threatening (van der Kolk, n.d.).

Transference is common as the client tests the therapist to determine if the therapist can be trusted. Transference is considered to be “an established pattern of relating and emotional responding that is cued by something in the present, but oftentimes calls up both an affective state and thoughts that may have more to do with past experience than present ones (Schore, 2012, p. 40). The difficulty in building a relationship with a traumatized client is that they frequently have a very difficult time trusting people and commonly expect to be hurt in any relationship. Therefore, it is critical that the therapist be very tuned in to the client as the client

works through the transference issues in an attempt to connect to the therapist (Schore, 2012; Schore, 2002; Herman, 1992).

When working with traumatized clients it is critical that the therapist be mindfully tuned in to the arousal of the client. The goal of trauma therapy is to allow the client to process the trauma at their own pace, in a safe and supportive environment without becoming emotionally or physiologically overwhelmed (Schore, 2012). When a client is re-experiencing trauma they often feel as if they are actually reliving the experience not just talking about it. This is because there are complex and instinctual processes a body goes through when people perceive they are in danger. If one cannot keep the body at, or be able to return to, a state of perceived safety people cannot process trauma effectively. The goal of effective therapy is to gradually allow the client to process more and more of the trauma and integrate it into their emotional life while learning how to return to that baseline, or safe state of being (Ogden, Pain, & Fisher, 2006; Fisher 2002).

According to Herman (1992, p. 184) “Programs that promote the rapid uncovering of traumatic memories without providing an adequate context for integration are therapeutically irresponsible and potentially dangerous, for they leave the patient without the resources to cope with the memories uncovered.” Trauma researchers agree that moving into exposure based therapies, before the client has developed skills for emotional regulation can often traumatize the client further (Lanius, et. al., 2010; van der Kolk, 2002; Herman, 1992). Additionally, exposure treatment should be used with care in cases where the client is experiencing dissociative or numbing symptoms because dissociation has been determined to be a significant negative predictor of success in exposure therapy (Lanius, et. al., 2010).

**Recommended first line treatments for PTSD****Cognitive Behavioral Therapy (CBT).**

The currently accepted first line treatments for PTSD are Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) (Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009; Seidler & Wagner, 2006). The cognitive model is based on the hypothesis that the fear of being threatened or in danger evokes a learned response that prompts the body to activate the emotional and physiological reactions related to anxiety (Bisson J. I., 2009a). Additionally, cognitive distortions in the areas of safety, trust, self esteem, power and relationship occur. The purpose of CBT skills is to teach the survivor how to override distorted negative emotions to better help them manage emotions and relationships (Duarte Giles, et al., 2007).

Exposure based treatments for PTSD, like CBT, have strong empirical support. These interventions are designed to facilitate the cognitive restructuring of trauma related memories with the goal of reducing, and eventually eliminating, the anxiety that is part of PTSD (Lanius, et al., 2010). In a typical trauma-focused cognitive-behavioral intervention the client is confronted with the disturbing event and asked to describe it and relive it in their imagination (Seidler & Wagner, 2006). Treatment components of CBT typically include psycho education, exposure, cognitive restructuring and anxiety management training (Harvey, Bryant, & Tarrier, 2003).

**Eye Movement Desensitization and Reprocessing.**

CBT offers many strategies that are helpful and effective for survivors but, because traumatic experience has so many physiological components, it is important that the body is also involved in the treatment protocol (Solomon & Heide, 2005). EMDR combines investigating all aspects of the disturbing memory, including sights, sounds, smells, images and cognitive,

emotional and physical sensations. While focusing internally on the reaction of the body to the disturbing information the client is asked to simultaneously focus on some type of bi-lateral external stimulation such as a hand moving back and forth at eye level or a light bar with a dot that moves back and forth in front of the client (van der Kolk, Posttraumatic therapy in the age of neuroscience, 2002; Seidler & Wagner, 2006; Bronner, Beer, Van Zelm Van Eldik, Grootenhuis, & Last, 2009). This process is repeated until the intensity of the experience is significantly lessened or eliminated (Bronner, Beer, Van Zelm Van Eldik, Grootenhuis, & Last, 2009).

EMDR is a combination of body-focused (bottom-up processing) and cognitive-behavioral (top-down processing) treatment. Cognitive components of the EMDR protocol include a form of cognitive restructuring where the client is asked to replace negative beliefs about themselves with positive beliefs. Additionally, the client learns containment strategies for managing intense feelings. The neurological implications of EMDR are not fully understood but one popular hypothesis is that the visual, tactile, or auditory stimuli alternately stimulate right and left sides of the brain which creates a state of mind where traumatic memories can be processed and integrated (Solomon & Heide, 2005). EMDR appears to be very effective in eliminating intrusive memories and nightmares and support for its use with adults in the treatment of PTSD can be found in over twenty controlled studies (Bronner, Beer, Van Zelm Van Eldik, Grootenhuis, & Last, 2009).

### **Limitations of CBT and EMDR.**

For the survivors who are able to follow through on these treatments, CBT and EMDR have shown to be highly effective. However, these treatments do have a high dropout rate, probably because the experience of reliving the trauma, without relief, can be extremely overwhelming (van der Kolk, 2002, pp. 388-389). In some patients, especially those who are

severely disturbed and destabilized by their traumatic experience, any kind of exposure may cause re-traumatization and increase the PTSD symptom level (Seidler & Wagner, 2006; Fisher, 2003).

One hypothesis is that therapies that require logic and cognitive intervention, such as CBT and EMDR, are dependant on the survivor being in a physiological state where they can logically process their thoughts and feelings. However, research has shown that even after years of therapy, immediate responses to triggering stimuli tend to be physiological rather than logical (Solomon & Heide, 2005). Recent discoveries in neuroscience research assert that traditional cognitive approaches do not pay enough attention to the experience of the felt sense of trauma and the automatic physiological trauma responses (van der Kolk, n.d.).

### **Sensorimotor Psychotherapy**

Body oriented therapy focuses on mindful attention to the body and emotions to support the client in processing unresolved physiological feelings or emotions related to the trauma (Price, 2004). Increasingly, neuroscientists and trauma researchers are providing empirical data to support the importance of the somatic experience in dealing with trauma (van der Kolk, n.d.; Schore, 2012; Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009; Ogden, Paine & Fisher, 2006; Price, 2005; Schore, 2002; Smyth & Poole, 2002). Schore states, “When self-psychology, like psychoanalysis in general, discards the biological realm of the body, when it overemphasizes the cognitive and verbal realms, it commits Descartes’ error, ‘the separation of the most refined operations of mind from the structure and operation of a biological organism’” (Schore, 2002, p. 437).

According to van der Kolk, “body-oriented therapies can directly confront a core clinical issue in PTSD: traumatized individuals are prone to experience the present with physical

sensations and emotions associated with the past. This, in turn, informs how they react to events in the present” (n.d., p. 19). In therapy, it is important to help the client learn to “be able to sense their sensations, emotions and behaviors while formulating coherent conclusions about the relationship between those and the images and thoughts that accompany them” (Rothschild, 2000, p. 161).

Sensorimotor Psychotherapy was developed in the late 1980’s by Pat Ogden, PhD. The theoretical model is built on traditionally accepted therapeutic interventions and neurologically informed trauma research. Sensorimotor psychotherapy works to diffuse the dysregulated autonomic arousal and support the client in building resources to manage their emotions and process their trauma safely (Ogden, Paine & Fisher, 2006). This method has a solid foundation in neuroscience and the board of directors includes internationally known trauma experts including medical doctors, neuroscientists, clinical social workers, psychologists, psychiatrists and body work experts. Some of the members of the board of directors of the Sensorimotor Psychotherapy Institute include Clare Pain, M.D., Ruth Lanius M.D., Ph.D., Ellert Nijenhuis, Ph.D., Allan Schore, Ph.D., Onno van der Hart, Ph.D. and Bessel van der Kolk, M.D and Janina Fisher, Ph.D. (Sensorimotor Psychotherapy Institute, 2012).

Ogden, Pain, & Fisher describe the model as follows:

“Sensorimotor psychotherapy is an approach developed to address specifically the resolution of the somatic symptoms of unresolved trauma. In sensorimotor psychotherapy, bodily experience becomes the primary entry point for intervention, while emotional expression and meaning-making arise out of the subsequent somatic reorganization of habitual trauma-related responses. That is, sensorimotor approaches work from the "bottom-up" rather than "top-down," By attending to the patient's body



directly, it becomes possible to address the more primitive, automatic and involuntary functions of the brain that underlie traumatic and post-traumatic responses. Sensorimotor psychotherapy is founded on the premise that "the brain functions as an integrated whole but is comprised of systems that are hierarchically organized. The 'higher level' (cognitive) integrative functions evolved from and are dependent on the integrity of lower level (limbic and reptilian) structures and on sensorimotor experience" (Ogden, Pain, & Fisher, 2006, p. 4).

### **Window of tolerance.**

Sensorimotor psychotherapy uses a concept called the "Window of Tolerance". This term is meant to illustrate how important it is for the therapist to actively watch and assist the client in modulating their arousal. At the "top" of the window is extreme hyper-arousal. In extreme hyper-arousal a client is very anxious and stressed and may have a racing heart and racing thoughts. At the bottom of the window is hypo-arousal where the client is so disturbed that they are in the "feigned death" or dissociation. When a person is in a state of hypo-arousal they can dissociate from the here and now and mentally take themselves to another place to avoid dealing with the present situation. The center of the "Window of Tolerance" is a point where the client is working through trauma but is not so dysregulated that they go into either hyper-arousal or hypo-arousal (Ogden, Pain & Fisher, 2006; Ogden, Minton & Pain, 2006).

The goal of focusing on the Window of Tolerance with a trauma survivor is to support them in stabilizing their physiological and emotional responses to perceived threat. As Fisher states, "A trauma survivor can have a meaningful, productive life without ever remembering or processing the trauma, but she cannot have such a life without doing the work of stabilization" (1999, p. 2). As the therapist mindfully works with the client as the client learns to better

manage their own sensory experience the goal is that the chronic fear will begin to subside so the client is better able to attend to the cognitive aspects of processing the trauma (Ogden, Pain & Fisher, 2006; Ogden, Minton & Pain, 2006).

**Body oriented focus.**

The body oriented focus of sensorimotor psychotherapy allows the client to focus on the present moment and supports the client as they focus on feelings and sensations instead of getting caught up in re-experiencing the trauma (Fisher, 2003). The focus on the present moment is important because learning to attend to the body in a safe environment can support the client in learning from their experience rather than being re-traumatized by it (van der Kolk, n.d.). Ogden, Pain and Fisher state,

“Often, just by uncoupling trauma-related emotion from body sensation and attending exclusively to the physical sensations of the arousal (without attributing meaning or connecting emotion to it), the physiological responses diminish and settle...These transformations at the sensorimotor level result in improvements in emotional and cognitive processing, emotions can be better tolerated, and cognitive processing reflects the incorporation of information from the body” (Ogden, Pain, & Fisher, 2006, p. 16).

At the core of sensorimotor psychotherapy is the knowledge that no matter how safe the therapeutic relationship may feel to the client, it won't stop the client from being activated when they speak about their trauma. Instead, by focusing on the body, the client is able to take a step back from their triggers and use their frontal lobes to process the experience in their body in a state of dual awareness (Fisher, 2003). Dual awareness is extremely important because it allows the client to stay in the Window of Tolerance and process the experience instead of just reliving it. This is very important because at the moment of trauma, frontal lobes shut down and the body

reacts instinctively. Mindful attention to the body, and mindful attention from the therapist, assist the client in bringing their frontal lobes back ‘on line’ so the client is able to stay grounded in the present and not be dragged back into the physiological and emotional reliving of the traumatic experience (Fisher, 2003).

### **Bottom up versus top down processing**

Sensorimotor psychotherapy is not intended to replace proven methods of “top down processing” such as psychodynamic or cognitive behavioral therapy. Top-down processing proposes that a significant change in a client’s thought processes will resolve the physical, emotional and behavioral symptoms that go with re-experiencing the trauma. This type of cognitive restructuring can be very effective; however it may be less effective with those clients who have long term complex trauma. Sensorimotor psychotherapy proposes that the sensorimotor piece, or “bottom up processing”, be incorporated into the therapeutic relationship, especially when dealing with clients who have experienced complex trauma. (Fisher, 2006; Ogden, Pain & Fisher, 2006; Ogden, Minton & Pain, 2006). Ogden, Paine & Fisher state,

“Top-down approaches that attempt to regulate arousal, emotions and cognitions are a necessary part of trauma therapy, but if such interventions over manage, ignore or suppress body processes traumatic responses may not be resolved. Similarly, bottom-up interventions that reinforce bottom-up hijacking, or fail to include cognitive processing as well, can sabotage integration of the effects of trauma and may lead to endless repetitive flashbacks, or hypo-arousal states” (Ogden, Pain, & Fisher, 2006, p. 17).

### **Developing resources and mobilizing defenses.**

As clients work on noticing their own physical and emotional experience resources become available. As clients tune in to their own needs they become aware of specific resources

they can use when they need to regulate their arousal. For example, sometimes a change in body posture, or taking a deep breath, or some type of physical movement like standing or turning or reorienting the gaze can be used as a cue for the client when they feel they are getting activated (Ogden, Pain, & Fisher, 2006). Rothschild states, "Sometimes a positive somatic memory can help an individual resolve a current difficulty without having to confront the terrifying traumatic memory that is triggering it" (Rothschild, 2000, pp. 118-119).

Additionally, many people who have been assaulted or abused were not able to defend themselves in the moment the trauma happened. For example, the sexual abuse survivor might have submitted to save her own life but still has a feeling that she wishes she could go back and fight like she wanted to. These incomplete actions of defense may subsequently manifest as chronic symptoms. As Herman (1992, p. 34) states, "Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated state long after the actual danger is over". By executing the physical actions, or mobilizing defenses, the survivor is able to begin processing the trauma at a sensorimotor, emotional and cognitive level (Ogden, Pain & Fisher, 2006; Ogden, Minton & Pain, 2006).

PTSD is a complex disorder made up of multiple, emotional, cognitive and physiological factors. Traditional cognitive therapies, such as CBT and EMDR, have been shown to be very effective with many populations. However, those who experience severe or chronic trauma, especially during childhood, have many physiological symptoms that cannot be addressed through cognitive therapy alone. Incorporating the body in psychotherapy, with a method such as sensorimotor psychotherapy, can support the client's healing by giving them tools that can better manage the physiological symptoms of their specific trauma (Wheeler, 2007; Ogden, Minton & Pain, 2006; Solomon & Heide, 2005; van der Kolk, 2002).

### Conceptual Framework

The conceptual framework used for this research project is based on neurologically informed attachment theory as it is presented by Daniel J. Siegel in his book *Pocket Guide to Interpersonal Neurobiology: An Integrative Handbook of the Mind* (2012). The concept of attachment research began in the mid twentieth century with the work of John Bowlby and Mary Ainsworth. At the center of the theory is the hypothesis that the relationship between the primary caregiver and a child can impact the emotional security and relational capabilities of the child.

If the primary caregiver is caring and tuned in to the needs of the child the child is more likely to develop a secure attachment. In theory, a secure attachment will have a positive impact on the child as they grow into adulthood because the child will have a healthy sense of self and good boundaries. In contrast, those children who experience neglect or traumatic abuse from their primary caregivers risk developing insecure attachments. Insecure attachments can have a negative impact on the child as it grows to adulthood because they may internalize the trauma and blame themselves (Siegel, 2012).

Daniel Siegel is an MD, a graduate of Harvard Medical School and is a professor at the UCLA School of Medicine. He has a specific interest in neurobiology and mindfulness and his career is focused on research and education related to healing emotional pain through creating new neural pathways. Siegel takes attachment theory one step further than Bowlby and Ainsworth and has conducted brain research that supports his hypothesis that early attachment can affect brain development and actually change the nervous system of a child. If a child has a negative attachment or lives with abuse or neglect there are physiological changes that can make it more difficult to handle stress or modulate emotions (Siegel, 2012).

Siegel has spent his career researching how the brain and emotions interact and has made some very interesting findings. For example, one common criticism of attachment theory is that it doesn't consider the genetic makeup of the child. Through his research, Siegel has found that there are people who are genetically predisposed to better manage emotional stress. There are people who experience extreme abuse as a child but find a way to survive emotionally and lead a normal life. There are others who might experience the same trauma and be mildly affected while others may be severely affected to the point of dissociation (Siegel, 2012).

Siegel's research has shown that, although there are some predetermined genetic factors, and there are some known neurological deficits that can exist as a result of childhood trauma there are ways to heal. Siegel's research into mindfulness has shown that it is possible to create new neural pathways that create a brain that can better manage stress and affect regulation. His approach to a neurologically informed view of attachment theory directly supports the strengths perspective that is so important to the social work profession. His work shows that although physiological changes may occur as a result of abuse or neglect in childhood there are ways that the adult can take control and heal physically and emotionally (Siegel, 2012).

The researcher chose this conceptual framework because it incorporates many of the themes identified in the literature review. Siegel's scholarship is focused on healing the brain physically and emotionally. His theories are based on empirical scientific evidence related to the brain while embracing emerging theories such as mindfulness, attachment theory and the need to focus on the somatic experience to process trauma.

## **Methods**

### **Sample**

The sample for this research project consisted of five professional mental health therapists who currently work with clients in the treatment of trauma. To be included as a participant, interviewees were required to have a current therapeutic license in the state of Minnesota (i.e. L.P, LMFT, LICSW, etc.) and be actively engaged in conducting individual therapy with clients. Participants were also required to have completed the Level I Trauma Training for Sensorimotor Psychotherapy. Any participant, who did not have a current therapeutic licensure, was not involved in individual therapy or who had not had formal training in sensorimotor psychotherapy was disqualified from the data collection process.

The researcher recently participated in the Level I Trauma Training for Sensorimotor Psychotherapy and began the search by contacting fellow participants to recruit volunteers for the individual interviews. The researcher's goal was to find a few interviews through recruitment and then use the snowball sampling method to identify the required number of participants for the study. The selected sample was used to better understand masters or doctoral level providers of mental health services who focus on the treatment of chronic and severe trauma.

### **Data Collection and Analysis**

The data collection instrument used was a semi-structured questionnaire and had two sections. The first section addressed demographic information related to the subject. Some of the demographic questions included the type of therapeutic licensure (i.e. L.P, LICSW), the number of years they have been licensed and working as a therapist, the primary population they work with and which therapeutic models they use in practice (i.e. psychodynamic theory, CBT,

EMDR, etc.). The data collected from the demographic questions were used to attempt to identify patterns or trends related to the population interviewed. The body of the interview focused on the “real world” treatment of trauma. The researcher presented ten to twelve questions based on themes identified in the literature review and focused on the therapeutic relationship. The actual questionnaire is attached to this proposal as Appendix A.

The interviews were conducted in person or by phone at a location agreed on by the researcher and participant. Suggested locations included the therapist’s office or a private, reserved room at a library to protect the confidential nature of the discussion. These interviews did not occur in a place where the discussion could be overheard by others such as a coffee shop or restaurant. Prior to meeting for the interviews the interviewee received information on the topics to be discussed as well as a copy of the Consent Form.

Each interview was recorded and those recordings were transcribed for analysis following the stage model of qualitative content analysis and grounded theory as presented by Berg & Lune (2012). Each interview was reviewed multiple times in an attempt to identify themes and categories. The first review was conducted with an open and unrestricted coding method in an attempt to identify authentic categories within the data. After the initial analysis the data was reviewed and coded, looking for themes related to relevant literature and associated research.

### **Protection of Human Participants**

Prior to any contact with potential research participants, the researcher submitted the required documentation for an expedited review to the University of St. Thomas Institutional Review Board (IRB) using the online tool at [www.irbnet.org](http://www.irbnet.org). Once IRB approval was received participants were recruited. The recruitment process included contacting colleagues who



attended the Trauma I Training in Sensorimotor Psychotherapy in Chaska, Minnesota from January 2012 through August 2012. The researcher attempted to recruit other interviewees using the snowball method of recruitment.

Each participant received an informed consent agreement prior to the scheduled meeting. The confidentiality agreement included information on the data collection process as well as the data storage and confidentiality of the data. Before the interview began, the confidentiality and informed consent agreement were reviewed and any questions were answered. If the participant agreed to sign the confidentiality and informed consent form, the interview process began. The formal informed consent form is attached as Appendix B.

The participants interviewed were licensed master and doctoral level therapists. Although individual therapists were not identified, the researcher summarized and reported on demographic information such as licensure and years of experience. Interview questions were focused on the interviewees' practice in general but specific examples of therapeutic interactions were discussed in some situations. For the protection of the therapist and their clients, all identifying information related to a specific client was redacted. Additionally, the interview participants' names and work locations were not published in the final report. A total of five practicing therapists were interviewed.

An audio recording of each interview was created using the researcher's laptop computer. To ensure confidentiality of the data, the computer was password protected and stored in the trunk of the researcher's car when the researcher was traveling with it. Within 24 hours of each interview the audio was copied to a flash drive and deleted from the laptop computer. That flash drive was password protected and stored in a locked file cabinet at the researcher's home.

Each audio recording was transcribed into a document that was stored on the same password protected flash drive as the audio files. To further ensure confidentiality of the data, when the researcher transcribed the data from the interview, she redacted any particularly identifying information, paying specific attention to any clinical content a participant might have shared. Participants were informed that the researcher may include individual quotes in the public presentation of findings however individual participants will not be named, their specific practice will not be identified, and information related to clients will only be shared in general terms that identify a client population.

### **Strengths and Limitations**

Current research related to neuropsychology shows empirical evidence that the physiological experience of trauma cannot always be addressed through cognitive interventions alone. This research attempted to compare the empirical or theoretical research with the real world practice of providing therapeutic interventions for survivors of severe trauma. Although the sample size was limited to five subjects, this purposive sample provided valuable insights for the researcher on the challenges associated with working with severely traumatized clients. Additionally, through individual interviews, the researcher gained insight into practice of the participants and gathered information on which therapeutic interventions were perceived as beneficial in their practice.

An additional strength, and potential limitation, of this research is that the initial recruitment method included targeting licensed therapists who attended the Sensorimotor Psychotherapy Level I Trauma Training. Completion of this eight month training by a subset of the participants ensured a formal knowledge of this established form of body oriented

psychotherapy. It may also bias responses toward those of a group of practitioners committed to this form of practice.

Limitations of this research include the small convenience sample of five participants. To actually draw empirical conclusions related to the treatment of trauma a much larger sample size would be required with much more stringent requirements on the client populations being treated and the method of treatment used. Additionally, because the original recruitment method targeted therapists who attended sensorimotor psychotherapy training it can be assumed that those participants are interested and open to the concept of body oriented psychotherapy.

## **Findings**

### **Participant Demographics**

For this qualitative research project, the researcher interviewed five therapists who were all licensed to practice in the State of Minnesota. Four of the therapists interviewed were licensed psychologists (LP), one was a clinical social worker (LICSW) and one had an additional licensure as a licensed alcohol and drug counselor (LADC). All therapists were very experienced and had been working in the field for between 14 and 30 years. The average years of experience among the participants were 19.8 years in practice.

This sample of therapists reported that the majority of their cases were related to trauma, post-traumatic stress disorder, depression, anxiety and dissociative disorder. Other primary diagnoses included addiction, borderline personality disorder, chronic pain management, dissociative identity disorder, eating disorders and mood disorders. A complete list of primary client diagnoses is displayed in Table 1.

Table 1  
*Primary Client Diagnosis*

<b>Diagnosis</b>	<b>Responses</b>
Anxiety	5
Depression	5
Dissociative Behaviors	5
Post-Traumatic Stress Disorder	5
Trauma History	5
Addiction	2
Borderline Personality Disorder	2
Chronic Pain Management	2
Dissociative Identity Disorder	2
Eating Disorders	1
Mood Disorders	1

The participants in this study used a variety of theoretical frameworks in their practices. The most frequently used included Sensorimotor Psychotherapy, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing and Mindfulness. Other frameworks incorporated into practice were 12 Step Practices, Acupressure, Emotional Freedom Therapy, Gestalt Theory, Guided Imagery, Hakomi, Hypnosis, Internal Family Systems and Spirituality. A complete list of the frameworks discussed is displayed in Table 2.

Table 2  
*Primary Theoretical Frameworks*

<b>Diagnosis</b>	<b>Responses</b>
Sensorimotor Psychotherapy (SP)	5
Dialectical Behavior Therapy (DBT)	4
Cognitive Behavioral Therapy (CBT)	2
Eye Movement Desensitization and Reprocessing (EMDR)	2
Mindfulness	2
12 Step Practice	1
Acupressure	1
Emotional Freedom Therapy (EFT)	1
Gestalt Theory	1
Guided Imagery	1
Hakomi	1
Hypnosis	1
Internal Family Systems (IFS)	1
Spirituality	1

**Interview Themes**

The interviews with participants were conducted using a semi-structured interview process. After analysis of the transcripts, three main themes emerged in the questioning: 1) Sensorimotor psychotherapy was explored due to perceived limitations with existing approaches for the treatment of some highly traumatized clients 2) Attention to the therapeutic relationship is extremely important when working with highly traumatized clients and 3) Insights from regarding the therapists role in the treatment of traumatized clients. All responses were organized under one of the three themes of questioning and then coded for themes within the response.

**Overarching Theme 1: Sensorimotor psychotherapy was explored due to perceived limitations with existing approaches for the treatment of some highly traumatized clients.**

One of the researcher’s main areas of questioning was related to why sensorimotor psychotherapy was of interest to the therapists. In this sample of participants, the average time in practice was 19.8 years and all had attended the Level I Trauma Training for Sensorimotor Psychotherapy in the past year. The researcher was interested in determining why the therapists had decided to learn about sensorimotor psychotherapy at this point in their career. When asked questions related to why sensorimotor psychotherapy was incorporated into their practice four major subthemes emerged. These subthemes are identified in Table 3 below and discussed in greater detail in the following paragraphs.

Table 3  
*Overarching Theme 1*

<p><b><i>Sensorimotor psychotherapy was explored due to perceived limitations with existing approaches for the treatment of some highly traumatized clients.</i></b></p>	<p><b><i>Subtheme 1.1</i></b> <i>Therapists were introduced to sensorimotor psychotherapy through professional relationships</i></p>
	<p><b><i>Subtheme 1.2</i></b> <i>Cognitive interventions alone were not sufficient for some clients</i></p>
	<p><b><i>Subtheme 1.3</i></b> <i>Therapists had an emerging interest in neuroscience and trauma</i></p>
	<p><b><i>Subtheme 1.4</i></b> <i>Belief in the importance of the mind / body connection</i></p>

***Subtheme 1.1: Therapists were introduced to sensorimotor psychotherapy through professional relationships***

Of the five therapists interviewed, one learned of sensorimotor psychotherapy after seeing Pat Ogden’s book, *Trauma and the Body a Sensorimotor Approach to Psychotherapy* while she was out looking at books one day. She stated, “I saw her book someplace and it really

looked interesting. Then I saw that Pat [Ogden] was going to be in Iowa for a one day presentation and I went. It was so interesting and just seemed to make sense. I've wanted to attend the formal training ever since."

Three of the five therapists were introduced to sensorimotor psychotherapy through a colleague. One of the therapists stated, "I had one colleague take training in [Peter] Levine's Somatic Experiencing (<http://somaticexperiencing.com>) and another take the sensorimotor training. I really felt the mind / body connection was something that was missing from my practice. I've been working with mindfulness for years but sensorimotor training helped me actually put a framework around the stuff with the body."

Another therapist was introduced to sensorimotor psychotherapy while working with a client who had a long trauma history. That therapist felt frustrated because she couldn't find a way to better support the client and the client continued to be extremely depressed and suicidal. The client wanted to continue seeing that the therapist but the therapist felt the client needed more support. The therapist agreed to continue seeing him individually if he would join a DBT group to receive the additional support she didn't feel she could provide. The therapist explained her experience in this way,

"Several years ago I had a trauma client and he was involved in a DBT class with [redacted] who was also a sensorimotor Psychotherapist. Sometimes all three of us would meet for a consultation and I was so impressed with my client's deep trust in the other therapist and her immediate appreciation for the practice of sensorimotor psychotherapy. I knew it was something I wanted to explore."

*Subtheme 1.2: Cognitive interventions alone were not sufficient with some clients*

All five of the therapists interviewed for this research project do a lot of work with traumatized clients and all have been trained in and use cognitive forms of trauma therapy. Four of the therapists have used DBT and two of the therapists were trained in CBT. All of the therapists expressed the importance of working cognitively on issues with clients. However, all five also stated that there are some highly traumatized clients that can't approach or tell the trauma story until they have figured out how to manage their emotions. All felt that these clients were ideal candidates for body oriented psychotherapy. One therapist interviewed stated, "Cognitive therapy alone doesn't work well with severe trauma. Most people know what they should think or how they should act but they can't make their emotions understand that. You can't get a body to change its physiological reactions by being logical. It goes so much deeper than that."

Many clients with trauma histories have been in therapy in one form or another for a long time. A common theme among the participants in this study is that clients get frustrated and hopeless because they feel like they have "tried everything" and nothing is helping them to get past the pain. One of the participants stated,

"What I am seeing is that a lot of therapists only work with the head and that is why they can't get through to the trauma work with some clients. The body work is something new and different and once clients see how it can really help them stay grounded and resourced they really like it. Because it's different it gives them hope that maybe there is a way out of the trauma because trying to 'think themselves out of it' wasn't working."



***Subtheme 1.3: Therapists had an emerging interest in neuroscience and trauma***

All five of the therapists interviewed had an interest in neuroscience as a way to better understand how trauma is stored and processed in the brain. All participants also stated that it is important to include the physical body in the treatment of traumatized individuals. One participant shared that they explain the importance of understanding the brain and trauma in the following way:

“I usually start by doing some psycho education about the triune brain...I tell them that their 'private protection system' is engaged for valid reasons during the actual trauma but later the body can misinterpret threat and start the physiological trauma response when they are actually safe. I tell my clients that this method [sensorimotor psychotherapy] can help them learn how to better manage their physiological responses so they aren't always getting hijacked by their emotions.”

One of the five therapists had taken training in body oriented therapy called Hakomi (<http://hakomiinstitute.com>). This therapist had incorporated many of the practices of Hakomi into their work but felt something was missing so they pursued training in sensorimotor psychotherapy. This therapist stated,

“I took the Hakomi training years ago and it's much like sensorimotor but with much less neuroscience behind it. It is the mindfulness, and the science behind what that mindfulness actually does to the brain – the learning about their body and developing their own resources – that is so important to this work.”

***Subtheme 1.4: Belief in the importance of the mind / body connection***

All five of the therapists expressed an interest in a holistic approach to trauma therapy that included working with the physiological effects of trauma within the body. One participant

stated, “I started my work heavy in DBT and I felt like it was really incomplete so I started looking at trauma therapy in a broader, more holistic approach that includes mind, body and spirit.” Another participant stated, “I start with the goal of helping clients to experience emotion without letting it get control of them. It is often really hard to get people out of their heads and reconnected to the feelings and emotions in their body.”

One therapist stated that it felt like a natural progression to incorporate the body in her psychotherapy practice. She stated, “I really felt like the mind body connection was something that was missing from my practice. I’ve been working with mindfulness for years but sensorimotor helped put a framework around the work with the body.”

**Overarching Theme 2: Attention to the therapeutic relationship is extremely important when working with highly traumatized clients.**

The participants in this study had extensive experience in treating clients who had experienced trauma in many different environments. All of the therapists currently saw clients on an individual basis and three of the five coordinated weekly support groups. All five of the therapists also had experience with inpatient treatment that included both voluntary and involuntary confinement to a hospital. When asked what they felt the most important aspects of working with clients who had experienced trauma four consistent subthemes emerged. These subthemes are identified in Table 4 below and discussed in greater detail in the following paragraphs.

Table 4  
*Overarching Theme 2*

<b><i>Attention to the therapeutic relationship is extremely important when working with highly traumatized clients.</i></b>	<b><i>Subtheme 2.1</i></b> <i>It is extremely important to develop a solid therapeutic relationship before beginning to do trauma work.</i>
	<b><i>Subtheme 2.2</i></b> <i>Dealing with dissociation during a session</i>
	<b><i>Subtheme 2.3</i></b> <i>Helping clients learn to better regulate their emotions</i>
	<b><i>Subtheme 2.4</i></b> <i>Addressing suicidality and self-harm</i>

Subtheme 2.1: It is extremely important to develop a solid therapeutic relationship before beginning to do trauma work.

Each of the therapists interviewed felt that one of the most critical parts to working with traumatized clients, especially those with complex trauma, is to build a solid therapeutic relationship before delving into the trauma work. One participant stated, “When I get a new client, I tell them that before we will go into any deep trauma stuff we need to do some groundwork. I tell them we will start by dealing with the here and now, day to day stressors in their lives and work back from there. Going into the trauma story too soon can re-traumatize them and I don’t want them walking out of my office more traumatized than when they came in.”

Another therapist described the importance of the therapeutic relationship by saying, “When I start working with someone I tell them that we need to start with grounding, resourcing and containment and just build the relationship first so we can build in the tools that will support them when they move into the really tough stuff.”

Another participant discussed the importance of starting with the client wherever they are at in their process. When she finds it hard to connect with someone she will often begin with working on grief as a way to build trust in the therapeutic relationship. She states, “You can

have grief without trauma but you can't have trauma without grief. Sometimes I start with the grief work and build the relationship out from there."

One therapist discussed the importance of realizing that a client, or the environment the client lives in, may have normalized the traumatic experience to the point where the client doesn't even see themselves as someone who has experienced trauma. One therapist stated, I think a lot of people are out of touch with the fact that they even have trauma and sometimes their defenses are such that they can't see it, nor should they, because it would be too much to bear at that point."

***Subtheme 2.2: Dealing with dissociation during a session***

Another common theme that came out of the interview process was the importance of being aware of clients who are dissociative and having methods to intervene when that happens.

Another participant described a technique they use with dissociative clients by stating, "First I remind them to breathe and ask them to look at me. I try to make eye contact and tell them what I'm seeing like, 'It looks like I'm losing you. Can you tell me what is going on for you right now?' Usually just getting them talking or asking them to stand up or rub their arms or something, you know, getting them to come back to the here and now, usually takes them out of that dissociative place and brings them back to the present."

Many of the therapists stated that dissociative clients often have a hard time looking at the therapist or may prefer to sit with their eyes closed. One participant spoke about their strategy for working with clients who are not comfortable looking directly at the therapist. The participant said,

“If they are sitting there with their eyes closed it can be hard to see if they are dissociating. I try to have people keep their eyes open and if they aren’t comfortable looking at me I just ask them to look at something in the room. The goal is to be able to see their eyes to know that they are engaged in the present – that they know they are in this room with me and that they are safe. You can’t do the hard work unless the client is emotionally in the room with you.”

***Subtheme 2.3: Helping clients learn to better regulate their emotions***

Another very strong theme that appeared during the coding of the interviews was the need to help clients learn how to regulate their emotions. One participant said, “In the beginning, when people are flooded, or have a lot of triggers, the first phase of resourcing is critical. You can’t go any deeper until they figure out how to deal with the emotions that feel like they are controlling them. Beginning to be able to manage emotions is critical if you want to actually do any trauma work.” Another participant stated, “There is nothing cathartic or healing about telling the story and reigniting the trauma until a person can handle the emotions that explode with the story. They will be re-traumatized – not healed.”

Another participant stated, “I think the most critical piece of starting a relationship for trauma work is to help them figure out how to deal with their emotions. I tell them that before we get into the really deep stuff I want them to be able to tolerate the waves of emotions like sadness, anger and fear and recognize what they feel like in their body. To me the big think is learning how to calm the system down so the person can get grounded...They need to be in a place of relative comfort – I say relative because so many people can’t image being in a place where they feel completely safe – before we start going into the really hard stuff.”

***Subtheme 2.4: Addressing suicidality and self-harm***

Each of the participants discussed the importance of talking with clients to address their risk of suicide or self-harm. Because trauma clients are dealing with such overwhelming emotions they often turn to harming themselves to relieve some of the anguish. A frequent theme was that the risks need to be assessed and it is often difficult for a therapist to know when the risks are high enough that they need to intervene and when they should stand back and just provide support and safety planning. One participant stated,

“I always assess clients for self-harm and I tell them I am not an over reactor when it comes to talking about safety stuff. I take it seriously but I find, with some people, that their distress is calmed by knowing they have an option of suicide...But I do take it very seriously, I haven't ever called an ambulance or the police for a client but I have actually driven a client to the hospital and made sure they kept their word to get help.”

Another participant explained,

“I always provide crisis information to my clients and give them a number they can call 24/7. This is a flexible contract but I think it is important to always put the information out there even if the client isn't openly suicidal. It is important to make sure they have some resource if they need it.”

Another participant discussed the difficulty in dealing with an issue of self-harm like cutting. She stated, “Dealing with cutting can be really difficult because often people can't let go of the cutting until they've made progress through the trauma work. You have to be really careful with this one because it's a coping mechanism for dealing with the emotional pain but it's not a big jump to go from cutting to suicide – even accidental suicide. Cutting is really common but really serious and it definitely need safety planning around it.”

Yet another participant described their approach to dealing with suicidality in the following way,

“When I worked at an inpatient hospital we had 24 hour guards and a guy still snuck part of a pop can into the shower and slit his wrists and died. I say that because if people are determined enough to suicide they will find a way. My personal measure is that I ask myself if I can sleep tonight if I let this person walk out of my office in this state. If the answer is no then I need to call the ambulance or do something to make sure they get help. The thing is you never know for sure. It’s really hard. You just do the best with the information you have.”

**Overarching Theme 3: Insights regarding the therapists role in the treatment of traumatized clients**

The third area of questioning that was of particular interest to the research was related to advice the participants would give to new trauma therapists. They were asked to think about things they wished they had known when they were beginning their careers as a trauma therapist and four consistent subthemes emerged. These subthemes are identified in Table 5 below and discussed in greater detail in the following paragraphs.

Table 5  
*Overarching Theme 3*

<b><i>Insights regarding the therapists role in the treatment of traumatized clients</i></b>	<b><i>Subtheme 3.1</i></b> <i>Make sure you actively engage in self-care</i>
	<b><i>Subtheme 3.2</i></b> <i>Don’t underestimate the importance being in the moment</i>
	<b><i>Subtheme 3.3</i></b> <i>Understand and acknowledge your own limitations</i>
	<b><i>Subtheme 3.4</i></b> <i>Be honest and ethical and compassionate with your clients and with yourself.</i>

***Subtheme 3.1: Make sure you actively engage in self-care***

One common theme that emerged during this discussion was the importance of taking care of one's own needs as a clinician. One participant stated, "Going into this work you need to know that it will take a while to get over the trauma of working with traumatized people. It is hard and you've got to make sure you take care of yourself so you are able to take care of other people." Another participant said, "You need to do your own work to survive emotionally. My own therapy was certainly critical to my personal sense of well-being. You are going to be triggered by what you hear and when you are, you need to deal with it. If you don't, it will tear you apart."

Three of the participants discussed the importance of their own spiritual practice and stated that it is a key stabilizing factor in their life. One participant said, "I'm a big meditator and my spiritual practice is incredibly important to me. I feel like there is a direct link and if I fall down on my spiritual practice I fall down on my professional practice. When I am in touch with my spiritual practice I drive home at night at peace because I know my higher power is at work and is in control."

***Subtheme 3.2: Don't underestimate the importance being in the moment***

Another consistent theme was the importance of being a therapist who is emotionally engaged in a partnership with their client. One participant stated, "I think there are so many ways to come up alongside a client without making what I think should happen be the only way...The client and therapist relationship has to be a partnership. You need to be there with them – not try to force them to go where you think they should go." Another participant expressed a similar message in the following way, "I would never ask a client to go where I have not taken myself. That doesn't mean that I have to have a trauma history; it means that I have to



have the willingness to examine myself at the deepest level before I can ask a client to go there. I feel really, really passionate about that. Don't you dare take a client where you aren't personally willing to go."

Another participant expressed the need to be a compassionate witness by stating, "Just show up and stay present. I believe that as a trauma therapist that is the biggest gift you can give. Just show up and be a compassionate witness to wherever they go. So if they sit in your office and say that want to hurt someone you hold that with compassion, or when they say they want to cut themselves you hold that with compassion. To be able to do that and not change the subject on them, and not invalidate them, but to actually show up at that depth, I think that is the biggest gift you can give." Another participant stated their opinion in this way, "Strive to see every client as a whole and holy being."

***Subtheme 3.3: Understand and acknowledge your own limitations***

All the therapists interviewed expressed the importance of understanding your own limitations both personally and professionally. One participant stated, "I've figured out what I can and can't do. For example, I can't work with traumatized kids or people who are traumatizing kids or animals. It is just something I can't do. I can't keep myself in a healthy place or provide the service the client needs so I just don't do it."

***Subtheme 3.4: Be honest and ethical and compassionate with your clients and with yourself.***

Another theme that developed out of the questions was the importance of doing the work with integrity and having compassion for the clients and for oneself as one learns to do the work of a trauma therapist. One participant said, "A lot of new therapists are overly critical or overly confident of their work. If a client continually tells you that you are the greatest person on earth

it is important to keep it real...Keep everything in perspective, model honesty and humility and make sure you are doing the work with the client and not to them.”

Another participant spoke about the fear and self-doubt that is often experienced by therapists. She stated, “Remember the feeling you get when you hold a brand new baby – being so afraid that you are going to drop it or hurt it – that’s the way most people feel as a new therapist. Don’t be so afraid of mistakes. Do your best and do it with integrity and compassion...A lot of new therapists are afraid to admit when they’ve made a mistake. Remember, therapy is about relationship and being honest, and acknowledging you aren’t perfect, is a great way to model healthy relationship.

## **Discussion**

### **Introduction**

Many research studies cite two main therapy methods as the first line treatment for PTSD. They are Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR). Cognitive Behavioral Therapy is based on using logic and conscious thought patterns to recover from trauma, to think differently in relation to arousal and to separate past and present. Methods of treatment that have been successful include retelling the traumatizing story over and over to a therapist until it loses its power or breaking down situations that cause stress and logically working through them to reduce the anxiety. Eye Movement Desensitization and Reprocessing (EMDR) uses many of the same cognitive processing techniques as CBT but adds more awareness of how the body reacts when talking about positive or negative. Unfortunately, both CBT and EMDR studies have found a high dropout rate among clients that are severely traumatized because talking about the trauma can be too much to handle (Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009; Seidler & Wagner, 2006).

Sensorimotor Psychotherapy is an emerging method of therapy that has been shown to be highly effective with those severely traumatized clients who are not yet capable of dealing with the trauma at a logical or cognitive level. Many people who have been traumatized are constantly in a state of high arousal and high anxiety and they can't calm down no matter what they do. Sensorimotor Psychotherapy focuses on mindful acts like deep breathing to help the client learn to physically relax and control their emotions instead of letting the emotions control them. Once they are able to better manage their anxiety they are more open and able to start working through their issues at the cognitive level (Ogden, Minton & Pain, 2006).

For the purpose of this research, the term complex trauma was used to refer to those individuals who have experienced severe and prolonged trauma that is resistant to treatment by more traditional therapies. This is the population that multiple trauma researchers believe could benefit from the inclusion of somatic processing, such as the use of sensorimotor psychotherapy, into the cognitive processing (Bisson, 2009b; Ogden, Minton & Pain, 2006; Schore, 2002; van der Kolk, 2002; Rothschild, 2000).

## **Key Findings**

### **PTSD versus Complex PTSD**

The fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) was published by the American Psychiatric Association (APA) in 2000. According to the National Center for PTSD (<http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp>), PTSD is can be diagnosed based on the following: “a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms.

In 1992, Judith Herman (1992) proposed that the definition of PTSD is too limited a definition for this complex disorder. Herman identifies one group as “classic or simple post-traumatic stress disorder” (Herman, 1992, p. 119). These are people who generally have had a stable life and see the trauma as an anomaly that was traumatic and debilitating but can be overcome. She defines the second group as “complex trauma” because these people have experienced “complex syndrome of prolonged, repeated trauma” (Herman, 1992, p. 119). This group includes many returning war veterans as well as adults who experienced trauma as children. In both cases, the victims believe at a conscious or unconscious level that the world is unsafe and trauma is an expected part of life (Herman, 1992).

Feedback from participants in this study appears to support the theory that there is a wide range of symptoms within the spectrum of symptoms used to diagnosis PTSD. Participants reported that those who have a long history of trauma, particularly those who were chronically abused in childhood, have symptoms that are much more difficult to treat. Additionally, those who were chronically traumatized may come into therapy for many reasons other than the specific trauma. It is common to have multiple issues going on at one time including depression, suicidality, chemical addiction, sleep disorders and other anxiety disorders.

### **First Line Treatments for PTSD**

The currently accepted first line treatments for PTSD are CBT and EMDR (Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009). For the survivors who are able to follow through on these treatments, CBT and EMDR have shown to be highly effective. However, these treatments do have a high dropout rate, probably because the experience of reliving the trauma, without relief, can be extremely overwhelming (van der Kolk, 2002, pp. 388-389). In some patients, especially those who are severely disturbed and destabilized by their traumatic

experience, any kind of exposure may cause re-traumatization and increase the PTSD symptom level (Seidler & Wagner, 2006; Fisher, 2003).

Participants in this study agreed that cognitive processing and thought restructuring was very important but only two used the formal CBT intervention. Two of the participants had been trained in EMDR but both agreed that it wasn't particularly useful to for the clients they worked with. One finding that the researcher found interesting was that the most common technique used by the group was Dialectical Behavior Therapy (DBT).

DBT is a therapeutic intervention that was developed by Marsha Linehan, Professor of Psychology at the University of Washington. According to PsychCentral (<http://psychcentral.com/blog/archives/2011/06/28/marsha-linehan-what-is-dialectical-behavioral-therapy-dbt>), DBT is a modified form of CBT that also includes work on mindfulness and self-acceptance and was designed to treat people who are at a high risk of harming themselves or attempting suicide as well as people diagnosed with borderline personality disorder. DBT takes a three pronged approach to treatment by involving the clients in individual counseling, group based skills classes and one on one coaching as needed.

Because the majority of participants used DBT, the researcher wonders if the participants interviewed have a high number of clients who present with a more complex trauma. Additionally, because DBT utilizes many of the same principles as Sensorimotor Psychotherapy, such as mindfulness, emotional regulation and taking steps to modulate arousal, DBT could be explored as a supportive tool that could be used in conjunction with sensorimotor psychotherapy.

The participants in this study expressed that CBT and EMDR were not as effective with many of their clients with very complex symptoms. van der Kolk (2002), stated that CBT and EMDR are successful for those who can remain in therapy but that there is a high rate of drop

out due to the trauma of reliving the experience. Because CBT and EMDR were not seen as being as effective as DBT it may support the theory that the clients of the participants in this sample may have suffered from chronic or complex trauma.

### **Emotional Regulation**

Research by Lanius, et. al (2010), describes two different extremes of emotional regulation. One is called hyper arousal and may be more commonly known as the fight/flight/flee response. Hyper arousal often looks like a state of extreme anxiety. The other extreme is called hypo arousal and is commonly also referred to as dissociation. Hypo arousal / dissociation are often associated with the automatic response of feigned death. In this state a person may mentally disengage from their physical body or the current circumstances. Primarily, people who experienced childhood abuse experience the dissociative form of PTSD while others who were traumatized later in life experience the hyper arousal. However, it is possible for one person to experience both hyper-arousal and dissociation at different times in their life (Lanius, et. al., 2010; Ogden, Pain, & Fisher, 2006).

All participants interviewed for this study had clients who were hyper aroused and prone to extreme anxiety but dissociation appeared to be a larger problem and was mentioned more frequently. Every participant spoke about the need to be vigilant with their clients to ensure the client was not dissociating during the session, or, if the client did dissociate, that the therapist be aware and able to bring them back to the present moment. In the literature review, multiple resources identified dissociation as being more common in people who were chronically abused as children (Lanius, et. al., 2010; Ogden, Pain, & Fisher, 2006). This finding again seems to support that the clients of the participants in this study may have a high rate of individuals who have experienced complex trauma.

### **Integrating Traumatic Memories**

The participants in this study shared that a number of their clients aren't able to recall details surrounding specific traumatic events such as the age they were molested or the events that preceded an attack. The really traumatic memories seem to come back as flashbacks and intense physical sensations like increased heart rate or a rush of anxiety. The therapists interviewed repeatedly stated that they didn't even try to go into the trauma work until the client was able to tolerate the painful emotions that flooded them when they thought about the trauma. The participants feedback appeared to support Rothschild's statement that therapy should be used to help the client learn to "be able to sense their sensations, emotions and behaviors while formulating coherent conclusions about the relationship between those and the images and thoughts that accompany them" (Rothschild, 2000, p. 161).

### **Multiple Diagnoses**

One finding that the researcher found particularly interesting in the literature review was that clients who have experienced severe or chronic trauma tend to have a wide variety of symptoms and emotional difficulties including addiction and suicidality. The literature in this area was supported by the feedback of the participants. A common theme was the idea that a person has to stabilize the presenting symptoms before he or she can begin the trauma work. For example, most of the therapists in this research study had clients who were also involved in a DBT program. DBT was originally developed for clients that have borderline personality disorder or are severely depressed and at a high risk of self-harm and can be a useful support to chronically traumatized clients. One participant stated, "I've never seen 'just a trauma client', they come in for addiction, or trouble with their relationships or wanting to kill themselves and

we have to get through that, you know get them at least emotionally on an even keel, before going for the trauma work.”

### **Resilience Factors**

Another topic in the literature review that the researcher found very interesting was the concept of resiliency related to trauma. Again, this theme seemed to be supported by the comments of the participants in this research study. There are many children who are abused who go on to be victimized by a lifetime of abusive relationships, the majority, however, do not. One of the therapists spoke about how hard it sometimes is to actually find out about clients’ pasts because there is so much shame and self-hatred involved, especially for adults who were sexually abused as children. One participant stated, “A lot of people believe at their core that they are fundamentally bad and that is why they deserve whatever bad things happened to them. They never got that support, you know that person who loved them and protected them, they didn’t have that and so they took all the pain and blame. It can be suffocating to the point where they can’t even speak the words of the abuse. It’s just too painful.”

### **Importance of Therapeutic Relationship**

When working with traumatized clients it is critical that the therapist be mindfully tuned in to the client. The need to be emotionally present was another theme that was reinforced by the participants in this study. One therapist spoke of a client who came in one day and asked why she wanted to “fire him” as a client. He believed that the therapist was angry with him and no longer wanted to work with him. The therapist did not have issues with the client so she didn’t understand why he thought that. Eventually he told the therapist that he could tell she was upset with him during the last session. She didn’t remember being upset so she pulled out her calendar to see if she could remember what was going on that day. When she looked at her schedule she



realized that immediately before her session with the client she had been told that a close friend and colleague would be leaving her organization.

The therapist told the researcher that this was just one example of how perceptive trauma clients can be. One therapist spoke about the importance of being mindfully attuned by explaining to the researcher that this sensitivity to the moods of others had been a useful survival tool for people who have experienced trauma, especially if it was a trauma that happened in childhood. That same participant went on to explain that although many trauma clients are very sensitive to the emotions of the therapist they often interpret whatever negative emotion they “see” as being a reflection of something they, the client did. All of the therapists spoke of intentionally taking the time to build a trusting relationship with their clients. One of the therapists said, “A major part of counseling is working on the client/therapist relationship. If a client hasn’t had a good role model for health relationships they don’t know how to ‘do’ a healthy relationship. It can be really scary.”

Another theme that emerged from this research is that clients, especially those who were abused in childhood, can feel a deep and intense sense of guilt and shame about what has happened to them. Even if the client logically knows that the event or events that happened to them were not their fault their self-image and self-concept is often so fragile that they approach every relationship believing they will eventually be rejected or hurt. One therapist spoke about a client seemed to pull back from her every time they made another revelation about the sexual abuse in their childhood. This therapist said she saw it as a test of the relationship when the client pulled back. She stated, “it was like she was testing me to see if I could still want to work with her after I found out another one of her secrets. It felt like she would reach out to me, trust me with another piece of her story and then either lash out at me or pull back from me because

she felt she was going to inevitably be rejected by me. This dynamic of shame and testing is something I'm always aware of and something that I spend a lot of time working on."

### **Transference and Countertransference**

Another consistent theme that came out of the literature review was the importance of being aware of transference between the client and their therapist. According to Schore (2012), transference is "an established pattern of relating and emotional responding that is cued by something in the present, but oftentimes calls up both an affective state and thoughts that may have more to do with past experience than present ones" (p. 40).

One theme that was very prominent during this research, but was not as prominent in the literature review, was the importance of understanding counter-transference. The participants in this research study shared strong opinions about the importance of therapists doing their own emotional work and finding a personal coping mechanism, either through spirituality, or physical activity or some other type of self-care that would allow them to find a way to deal with their own personal stress. All participants felt it was critical that the therapist do their own emotional work to allow them to navigate the pull of countertransference in the therapeutic relationship.

## **Sensorimotor Psychotherapy for the Treatment of Complex Trauma**

### **Conceptual Framework**

The conceptual framework used for this research project is based on neurologically informed attachment theory as it is presented by Daniel J. Siegel in his book *Pocket Guide to Interpersonal Neurobiology: An Integrative Handbook of the Mind* (2012). This framework combines the work of early attachment theorists John Bowlby and Mary Ainsworth with recent scientific discoveries related to the physiological effect of emotional trauma on the brain. The

researcher chose this conceptual framework because it incorporates many of the themes identified in the literature review.

Siegel uses current research in neurological science to evaluate the physiological implications of trauma on the brain. Sensorimotor psychotherapy also utilizes neurological research to explain key concepts of processing traumatic memories including the importance of understanding top-down versus bottom-up cognitive processing. While Siegel uses neurological research to explain how new neural pathways can be created based on mindfulness and cognitive processing, similarly, sensorimotor psychotherapy also utilizes the mindful processing of emotions and sensations in the body as a way to make meaning of and learn to deal with, memories that can be overwhelming and terrifying.

### **Strengths and Limitations of Research**

#### **Strengths**

For this research project, a small convenience sample was used for data collection. All of the participants of this research project had completed at least the Level I Trauma Training for Sensorimotor Psychotherapy. This ensured that all participants had a solid understanding of the concepts of sensorimotor psychotherapy. This was a relatively experienced sample with the average amount of time each of the participants had been in practice being 19.8 years. All participants were licensed therapists in the state of Minnesota and were currently working with clients in the treatment of trauma. These therapists came from different licensing tracks and participants had the following certifications, LP, LICSW and LADC. Additionally, the individual interviews and qualitative nature of the study allowed for the participants voices and experiences to be heard.

### **Limitations**

Limitations of this sample include the small sample size of five therapists and the homogeneity of the participants. The participants in this research study all had over 14 years of clinical experience and all practiced in and around the Twin Cities metro area of Minnesota and had all completed the sensorimotor psychotherapy training within the past twelve months. This study could be strengthened if the scope of participants was increased and additional variables were included in the analysis. Examples of additional variables could include using participants from different areas of the country or categorizing the practice settings by rural, suburban or urban. Another variable that may strengthen the results would be the inclusion of participants who had more experience in the use of sensorimotor psychotherapy or had taken more training beyond the Level I Trauma Training in Sensorimotor Psychotherapy and/or from those operating from different theoretical vantage points. Additionally, it may be helpful to include new therapists to those who had been in practice longer to identify if there are any significant differences in the way sensorimotor psychotherapy or trauma treatment in general is incorporated into their practice. Another variable that could be interesting to consider is the clinical diagnosis of the clients being worked with. Although many clients who have experienced trauma present with multiple diagnoses there may be some interesting correlations that could be found between diagnoses and the efficacy of sensorimotor psychotherapy.

### **Implications for Future Research**

Finding effective methods to support people in recovering from trauma is currently a very important topic in America. At this time there are multitudes of returning war veterans who return with PTSD. There is also emerging interests in the sexually victimized such as those

forced into prostitution and human trafficking. Although many people self-medicate to manage their stress and anxiety it is clear that can be a very destructive.

Research related to trauma and PTSD needs to continue to evolve in order to generate more empirical data related to what types of trauma treatments work best with which categories of clients. In reference to broader literature, some suggestions for creating more robust data sets could include requiring specific information for each research project to make it easier to compare findings. Some of these variables could include a complete study of enrollment data that includes precise information on inclusion and exclusion criteria and drop out numbers. Additionally, it would be helpful to have comprehensive participant demographics (Spinazzola, Blaustein, & van der Kolk, 2006).

In general, there are some factors that researchers hypothesize could increase the efficacy of trauma studies. One factor is the inclusion of longitudinal studies for PTSD. Currently, the majority of studies related to PTSD are conducted at a set point in time. A better understanding of the progression of PTSD over time could yield some interesting information that could affect how it is treated (Cardenas, et al., 2011). Additionally, longitudinal studies could evaluate the role of social support and other protective factors in the development of chronic PTSD and have the potential to identify interventions that could be used to improve a client's resilience in an effort to better protect them from further traumatization (Peleg & Shalev, 2006).

Further studies on brain development, and the effect of trauma on the developing brain are also needed. Currently, emerging evidence from clinical studies suggests that exposure to early life stress is associated with neurobiological changes in children and adults who may put them at greater risk for issues such as anxiety and depression. (Heim & Nemeroff, 2001).

Further studies on brain development are needed to understand impact of trauma on a specific

period of brain development to determine better prevention and treatment options (Heim & Nemeroff, 2001). Current studies have shown that coping deficits in right hemispheric self-regulation can result in a limited ability to modulate the intensity and duration of affects, especially biologically primitive affects like shame, rage, excitement, elation, disgust, panic-terror, and hopeless despair. According to Schore, (2002) “Under stress, such individuals experience not discrete and differentiated affects, but diffuse, undifferentiated, chaotic states accompanied by overwhelming somatic and visceral sensations” (p. 462). The challenge then is to evaluate emerging techniques that build up and restore a person’s internal regulation capacity.

Herman (1992) states, “In general, the diagnostic categories of the existing psychiatric canon are simply not designed for survivors of extreme situations and do not fit them well. The persistent anxiety, phobias, and panic of survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not the same as ordinary psychosomatic disorders. Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder” (p. 118). Additionally, it is important to continue to study the wide range of symptoms experienced by victims of trauma and accept that there is no one treatment that will cure all clients.

### **Implications for Clinical Social Work Practice**

This research, and the treatment of complex trauma in particular is extremely important to the profession of clinical social work because unresolved trauma can have far reaching impacts on our clients, regardless of the population we focus on serving. An understanding of the physiological effects of trauma, in particularly the way the ability to self-regulate emotions is affected, can have a substantial impact on the way we adapt interventions to support clients. Traumatic events have the ability to debilitate a client and often show up as various symptoms,

such as eating disorders, clinical depression or suicidality that may not appear to be obviously related to a trauma. Another key factor is that in many instances people live in environments where the abuse is so normalized that they don't even classify their life experiences as traumatic.

The discipline of social work is rooted in the strengths perspective and in allowing people to direct their own lives and decisions. Additionally, social work strives to see the whole person as part of a system that interacts with all aspects of their environment. This model is commonly referred to as Person in Environment (PIE). Using a more holistic approach to the treat trauma, one that incorporates the body, mind and spirit, is directly in line with the basic tenants of the social work profession. Additionally, having a strong base of knowledge related to how trauma affects people physically and emotionally is critical to effective interventions in this profession.

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## Appendix A

### Interview Questions

#### Demographic Questions

- What is your specific licensure (i.e. LP, PhD, LICSW)?
- How long have you been in practice?
- What type of environment do you practice in (i.e. private practice, a hospital, eating disorders clinic, etc.)?
- What treatment methods have you been trained in (i.e. Psychoanalytic, CBT, EMDR, etc.)?

#### Research Questions

- What are some of the challenges developing and maintaining a therapeutic relationship with a client who has experienced trauma and/or has attachment issue?
- What types of interventions are used when a client is in severe distress during a session and how is safety planning used?
- Are body oriented therapeutic techniques used? If so, which techniques have been most effective in practice?
- Is psychoeducation used? If so, how is it used, when is it introduced and what are some of the important topics?
- How is the treatment of chronic trauma different than the treatment of a single instance of trauma?
- If the therapist is involved in group or community interventions for the treatment of trauma, how is their practice adapted to meet the needs of a group versus an individual?
- Has neurological research informed their treatment of PTSD and, if so, how?

- How has their treatment of trauma changed over the course of their career and what was the catalyst for the changes.
- In your opinion, what makes someone a successful trauma therapist?
- If you could give one piece of advice to a new trauma therapist what would it be?

## **Appendix B**

### **Informed Consent Form**

#### **University of St. Thomas GRSW681 Research Project**

#### **Analysis of the Real World Application of Sensorimotor Psychotherapy for the Treatment of Complex Trauma**

I am conducting a study about the real world treatment of complex trauma. I invite you to participate in this research. You were selected as a possible participant because you work with clients who may have experienced complex or prolonged trauma. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Marie Elaine, graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Dr. David Roseborough.

#### **Background Information:**

The purpose of this study is to interview clinicians specializing in the treatment of trauma with the goal of identifying therapeutic interventions that have been successful in the treatment of trauma. I am specifically interested in interventions used with clients who have experienced severe or prolonged trauma.

#### **Procedures:**

If you agree to be in this study, I will work with you to determine a date and time to meet for a one hour interview. At the time of the interview I will ask questions related to your therapeutic work with clients and the interventions you have found most successful. During the actual interview, I will record our conversation and will also take hand written notes. Following our meeting, I will transcribe the interview for coding and analysis.

The goal of this research is to provide real world recommendations on best practices for the treatment of trauma. The researcher intends to conduct individual interviews with 8-10 therapists. The output for this research will be a formal research paper and a presentation at the Clinical Research Program Symposium on May 20, 2013.

#### **Protection of Human Participants**

Prior to any contact with potential research participants, the researcher submitted the required documentation for an expedited review to the University of St. Thomas Institutional Review Board (IRB) using the online tool at [www.irbnet.org](http://www.irbnet.org). Recruitment of participants did not begin until after formal IRB approval was received. The recruitment process will be conducted using a purposive sample. Initially, the researcher will contact therapists who completed Sensorimotor Psychotherapy training. Further participants will be sought using the snowball method of recruitment.

**Risks and Benefits of Being in the Study:**

The study has no risks associated with this study and this study has no direct benefits to its participants.

**Confidentiality:**

The records of this study will be kept confidential and only general themes will be shared when reporting findings. Identifying information regarding participants, their clients or their work environments will not be published except in very general terms. Research records will be kept in a locked file in my office. I will also keep the electronic copy of the transcript in a password protected file on my computer. The audiotape and transcript of the interviews will be retained by the researcher in a locked file cabinet.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw; data collected about you will be destroyed and will not be used as part of this research project.

**Contacts and Questions**

My name is Marie Elaine. You may ask any questions you have now. If you have questions later, you may contact me at xxx-xxx-xxxx. You may also contact the chair of my research committee, Dr. David Roseborough at xxx-xxx-xxxx. You may also contact the University of St. Thomas Institutional Review Board at xxx-xxx-xxxx with any questions or concerns.

You will be given a copy of this form to keep for your records.

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

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Signature of Study Participant

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Date

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Print Name of Study Participant

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Signature of Researcher

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Date