

Mental Health Practitioners' Views on Why  
Somatic Experiencing Works for Treating Trauma

by

Michelle C. Olssen, B.S.W., LSW

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Committee Members

Kari L. Fletcher, Ph.D., MSW, LICSW (Chair)

Tamara Starkey, LICSW, SEP

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 individually 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**

Trauma is an issue that affects many people, and traditional trauma treatment techniques have fallen short of helping people to completely heal. The purpose of this project was to explore the views of mental health practitioners as to why Somatic Experiencing (SE) works in the treatment of trauma. Using a qualitative design, ten mental health practitioners currently utilizing SE techniques were interviewed about their experiences applying SE with trauma clients. Data was analyzed using content analysis and an inductive approach in which categories were first developed from the interview responses via open coding and then were linked to previous related literature. The findings of this study both supported and added to the existing literature by highlighting the themes of the client increasing body awareness, treatment proceeding at the client's pace, and empowerment of the client in the therapeutic process. In addition, many subthemes were found, with building a positive resource toolbox, creating balance without overwhelm, and normalizing the client experience by emphasizing their survival particularly of note as being sparingly mentioned in previous literature or not at all. These findings underscore the importance of how social work practice can be enhanced through a continued emphasis on the mind-body connection when working with clients affected by trauma, as well as assisting clients in gaining body awareness, and the ongoing development of the therapeutic relationship.

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# **Mental Health Practitioners' Views on Why Somatic Experiencing Works for Treating Trauma**

## **Introduction**

It is widely acknowledged that exposure to maltreatment is traumatic. The word trauma is from the Greek word that means "wound", which can be either physical or psychological (Harper, 2001). Psychological "trauma" is defined by the American Psychiatric Association as "an event or events that involve actual or threatened death or serious injury and/or a threat to the physical integrity of self or others" (American Psychiatric Association, 1994, p. 424). According to Herman (1997), traumatic events "overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning" (p. 33).

Emotional and psychological trauma is the result of extraordinarily stressful events that shatter one's sense of security, bring on intense fear contributing to a sense of helplessness, and influence how one views the self and the world. Traumatic experiences often involve a threat to life or safety, although any situation that leaves one feeling overwhelmed and alone can be traumatic, even if it doesn't involve physical harm. According to Rothschild (2000), an event will most likely lead to emotional or psychological trauma if the event happened unexpectedly, if the person was unprepared for it, felt powerless to prevent it, it happened repeatedly, someone was intentionally cruel, or it happened in childhood. It is important to note that it is not the objective facts that determine whether an event is traumatic, but one's subjective emotional experience of the event. Levine (1996c) also agrees that it is how one interprets an event as to

whether it is traumatic, and if it is interpreted as a threat to survival in particular.

Emotional and psychological trauma can be caused by one-time events, such as a horrible accident, a natural disaster, or a violent attack. Trauma can also stem from ongoing, relentless stress, such as living in a crime-ridden neighborhood or struggling with cancer. Symptoms of trauma may include: anger, irritability, mood swings, confusion, and anxiety, feeling disconnected or numb, feeling sad or hopeless, and withdrawing from others (Cohen, 1997).

There are two levels of trauma that have been identified and also compared through countless bodies of research: they are acute trauma and complex trauma. Acute trauma (simple trauma) can be defined as a single traumatic event that overwhelms an individual's ability to cope (Cook et al., 2005). Complex trauma can be used to describe the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and having an early-life onset (Cook et al., 2005). These exposures often occur within the child's caregiving system and include physical, emotional, and educational neglect and child maltreatment beginning in early childhood (Cook et al., 2005). According to the National Mental Health Association (2010), fifty percent of women and sixty percent of men have had at least one traumatic event in their lifetime.

Severe trauma can lead to the development of Post-traumatic Stress Disorder (PTSD), which is an anxiety disorder. Symptoms associated with PTSD include re-experiencing the event (such as through flashbacks), avoiding reminders of the trauma, and being constantly on alert (Rothschild, 2000). "The traumatic event appears to float free in time

rather than occupying place in past often coming without premeditation or determination of the will into present perception as if occurring now” (Rothschild, 2000, p. 12).

“Abnormal psychophysiological responses in PTSD have been demonstrated on two different levels: 1) in response to specific reminders of the trauma and 2) in response to intense, but neutral stimuli, such as acoustic startle” (van der Kolk, 1994, p 255). PTSD affects nearly eight million American adults (National Mental Health Association). The average age of onset for PTSD is 23 years old. While forty to sixty percent of those who get PTSD get better, one out of three will always have symptoms (National Institute of Mental Health [NIMH], 2005). The lifetime prevalence for adults of PTSD is 6.8%. The prevalence for males is 3.6% and for females is 9.7% (Harvard School of Medicine, 2010). The National Comorbidity Survey Replicated found that women (at 10.4 percent) were more than two times as likely as men (at 5%) to have PTSD at some point in lives (as cited in Pease, 2010). The child and adolescent lifetime prevalence of PTSD for those thirteen to eighteen years old is four percent. The lifetime prevalence for females is 6.6 percent and 1.6 percent for males in this age group (National Comorbidity Study-Adolescent, 2010).

However, not everyone who experiences a traumatic event will develop PTSD. Some factors that mediate traumatic stress include: unsuccessful biological defense responses, developmental history, belief systems, prior experiences, internal resources and social support (Rothschild, 2000). Other factors that can protect someone from experiencing traumatic stress, and the potential to develop PTSD, include: remaining in control of a situation by effectively fighting back or escaping the situation (if possible) and recognizing that many negative intrusive thoughts and sensations are symptoms of



trauma, thereby helping the person avoid continuing to set his or her self up to be retraumatized when experiencing life events reminiscent of that prior trauma (Scaer, 2006).

There are five different viewpoints, according to Levine (1996a), that are reflected in the various positions that have been taken in the psychological treatment of trauma in all its forms, including PTSD. The first is that the individual is considered permanently damaged and support, reassurance, medications, and the learning of coping skills are recommended to address the symptoms. Unfortunately for many without a lot of resources or the access to them, this may be their only option. The second viewpoint is that unconscious traumas are brought out via analytic methods and removed by reliving the trauma, the purging of emotions, and the relieving of emotional tension. Considering this viewpoint, however, and utilizing this approach may end up uncovering more trauma for the client and perpetuating an endless cycle of reliving the trauma over and over, thus contributing to ongoing terror and despair. The third viewpoint is a behavioral approach whereby the patient is exposed and desensitized to elements of the traumatic experience. Through the use of exposure, clients can confront unpleasant situations until the responses habituate or extinguish. Biofeedback and relaxation training can help deactivate high arousal responses. The fourth viewpoint is that trauma work is a lifelong, psychodynamic process. The final viewpoint considers that healing arises through the transformation of the “meaning” of the traumatic event (such as through hypnosis).

Somatic Experiencing (SE) emphasizes the uncovering of innate biological resources and the renegotiation of habitual response from paralytic freezing to active defense,

which is quite different from behavioral/exposure or reliving approaches. Exposure is effective to the degree that restructuring of psychophysiological resources was not available at the time of the trauma. Traumatic responses are only indirectly addressed with desensitization, biofeedback, and relaxation. The biological organization of paralytic freezing remains essentially unchanged with relaxation procedures (Levine, 1996a).

Somatic Experiencing (SE) differs from cathartic and behavioral approaches because it examines in a specific way how the (post-) traumatic reaction was originally patterned in the body and perceptual systems. SE seeks to renegotiate maladaptive responses to overwhelming threat, and does this by gradually and progressively deconstructing particular traumatic responses such as chronic freezing and restructuring maladaptive neuromuscular patterns as flexible, defensive, orienting responses. Though SE most similar to the final (fifth) viewpoint mentioned above, it has a much wider, developmental appreciation of the progressive, change-oriented role played by motor responses and body sensations as genetic potential (Levine, 1996a).

Two approaches to processing trauma with clients that have been utilized by mental health practitioners are top-down processing and bottom-up processing. Top-down processing involves clients utilizing cognitive strategies to manage or inhibit problematic feelings, thoughts, and behaviors (Solomon & Heide, 2005). Specific benefits to clients from this approach include: an understanding of how the trauma has affected them and how to change their beliefs and maladaptive ways of thinking, how to identify triggers and how they respond to them, and how to manage disturbing emotions and body sensations.

Top-down approaches such as Cognitive Behavioral Therapy (CBT), however, do not help one to resolve physiological hyperarousal (e.g., irritability, inability to concentrate, sleeplessness, becoming easily startled, and the tendency to perceive danger everywhere) or to process memories for traumatic incidents in one's life (Solomon & Heide, 2005). Clients' brains have not been desensitized and so they can still be activated by something their brain senses as a threat. The parts of the brain involved in managing emotions and balancing the body are affected, thus leading to non-productive individual responses. Levine (2010b) agrees that in [top-down processing], clients are made to "remember the worst part of trauma", causing them to become "completely overwhelmed" and that this is "not necessary" (p. 3).

Bottom-up processing, on the other hand, utilizes biologically informed therapy to help clients connect with their bodies and feelings, thereby helping them to learn how to tolerate intense feelings and release emotions appropriately (Solomon & Heide, 2005). Bottom-up processing, according to Levine (2010), lends itself to the client "experienc[ing] certain feelings and emotions associated with the event" and the "ability to make new meanings" (p. 7).

Biologically informed therapy for the treatment of trauma may include Body-Oriented Psychotherapy (BOP). BOP involves integrating body awareness with traditional talk therapy (emotional processing). It recognizes the importance of connecting the mind and the body while reducing dissociation during or after psychological distress. According to the United States Association of Body Psychotherapy (2009), the core of BOP is recognition of the "functional unity" between the mind and body, that "they are both functioning and interactive aspects of the whole." Types of body-oriented

psychotherapies include, but are not limited to, the following: Hakomi, Radix, Sensorimotor Psychotherapy, and Somatic Experiencing. However, this study will focus on Somatic Experiencing, a naturalistic trauma treatment method developed by Peter Levine.

According to Levine (2010), Somatic Experiencing occurs because:

*...the body is the container for all of our sensations and our feelings. And the problem with trauma is not so much the trauma but that our container has shrunk in relationship to it and one of the things we do in somatic experiencing is we really work with the person to widen the container and again that's---when a person is able to do that they start getting some sense of safety because when you're traumatized nothing feels safe anymore (p. 3).*

Few studies have been conducted on the effectiveness of Somatic Experiencing in the treatment of trauma, and none have focused on trauma clients engaged in a therapeutic process within a mental health setting.

In summary, trauma is an issue that affects many people, and traditional trauma treatment techniques have fallen short of helping people to completely heal. The current study will investigate the efficacy of Somatic Experiencing treatment for trauma by working with mental health practitioners who utilize these techniques. The aim of this paper will be to present a qualitative study that explores the research question: What are mental health practitioners' views on why somatic experiencing works for treating trauma? This study hopes to contribute to the existing knowledge of body-oriented psychotherapy as a treatment for trauma in general, and more specifically to the little researched area of Somatic Experiencing. Whereas other studies have focused on treating trauma with Somatic Experiencing at the community or global level, this study will contribute to social work knowledge in the treatment of trauma with Somatic

Experiencing techniques at the individual level. The next section will present a comprehensive review of the literature.

## **Literature Review**

In order to gain a better understanding of trauma, its psychophysiological effects, body-oriented psychotherapy applications, and the efficacy of Somatic Experiencing as a treatment for trauma, a comprehensive review of the literature was conducted. This literature review consisted of reviewing the effects of trauma on the mind and the body, body-based trauma treatments, and Somatic Experiencing as a treatment for trauma.

### **Effects of Trauma on Memory**

Many types of trauma can have lasting effects on memory, particularly the storage and retrieval of memory. The two types of memory systems are called the explicit and the implicit memory systems. Declarative (explicit) memory is conscious, intentional, and comprised of facts, concepts, and ideas. It is used to acquire information, such as a formal education (Scaer, 2001). Non-declarative (implicit) memory is unconscious, automatic, and instinctual. Examples are procedural memory and conditioned responses. Implicit memory is used in storing acquired skills, conditioned responses, and emotional associations (Scaer, 2001).

A 1995 study was conducted by van der Kolk and Fisler to look at trauma and the fragmentary nature of traumatic memories. Participants were 46 adults who had experienced some type of trauma (whether in childhood or adulthood), and all of whom met diagnostic criteria for PTSD on DSMIII-R. Of the participants who had experienced child trauma, 43% had suffered significant or total amnesia for trauma at some point in lives, while 77% of them reported confirmation of child trauma from family or another

source who knew about the abuse, from court or hospital records, or from confessions or convictions of the perpetrator.

All claimed to have come to develop a narrative of trauma over time. Five participants abused as children were even as adults unable to tell a complete narrative of what happened to them. Fragmentary memories appeared to support others' stories and their own intuitive feelings that they had been abused. All claimed they initially "remembered" the trauma in the form of somatosensory flashback experiences. Flashbacks occurred visually, through smell, affectively, through hearing, and kinesthetically, but initially sensory modalities did not occur together (van der Kolk & Fisler, 1995).

People appeared to construct a narrative that "explained" what happened to them as they became more aware of traumatic experience elements. After a lot of time, and even after acquiring a personal narrative, most subjects reported that experiences continued to come back as sensory perceptions and affective states. Traumatic "memories" appeared to consist of emotional and sensory states with little verbal representation. Memory traces tend to remain unmodified by the passage of time and further experience (van der Kolk & Fisler, 1995).

In a nonclinical study of 505 participants from the general population, Elliott (1997) found that those reporting delayed recall (partial or complete) of any trauma also had experienced significantly more types of trauma, more distress about the trauma (at the time of the event and at data collection), and were younger at the time of their earliest trauma. Delayed recall was reported by 115 participants (32%). Those most likely to

have continuous memories (no delayed recall) were those who experienced sexual assault as an adult with no penetration, had a major car accident, or experienced a natural disaster. Most common for partial recall was witnessing a murder or suicide and being a child abuse victim of physical abuse. Most common for complete loss of recall was being a child abuse victim of sexual abuse, witnessing combat injuries, experiencing rape as an adult, and witnessing domestic violence as a child.

### **Psychophysiology of Trauma**

According to Levine (1996c), as trauma is “locked” in the body that is where it must be accessed and healed (p.17). In exploring the psychophysiology of trauma, it is important to discuss the three most relevant nervous system divisions affected by trauma. The three nervous system divisions include the sensory, the autonomic, and the somatic. Herman (1997) discusses the connection between trauma and the nervous system when stating that “traumatized people feel and act as though their nervous systems have been disconnected from the present” (p.35).

**Sensory division of central nervous system.** The Sensory Division communicates with and carries all types of sensory information to the Central Nervous System through the five senses (sight, sound, smell, taste, and touch), as well as by body position, balance, posture, movement, pain, and hunger. It carries sensory signals from nerve receptors and sense organs to the CNS. It receives and transmits information inside the body. It sends information to the CNS from internal organs or from external stimuli. Sensory information is utilized to regulate the internal environment of the body. Information from the viscera (internal organs) indicates when one’s bladder is full,



stomach aches, blood pressure increases, and even the concentration of substances in the blood. The vestibular sense is the sense that allows an organism to sense body movement, direction, and acceleration, and to attain and maintain postural equilibrium and balance. Dizziness and/or vertigo could result if this sense was off or not working correctly. Proprioception is the ability to sense position, location, orientation, and movement of the body and its parts; without it, one would constantly need to look at his feet to be sure he was walking straight and upright (such as in the balance and coordination tests if suspected of drunk driving). Also, one would not be able to drive and look forward without watching his feet (Rothschild, 2000).

**Somatic marker hypothesis.** Relevant to both memory and the sensory portion of the nervous system is the somatic marker hypothesis, developed by Antonio Damasio. Damasio (1994) describes the emotional experience as comprised of body sensations elicited in response to various stimuli. These sensations and emotions are then encoded and stored as implicit memories associated with the stimuli that initially provoked them (as in classical conditioning). Memories of these emotions and sensations are then triggered into recall when similar stimuli are present, although the origin is not always conscious to the individual.

As Damasio (1994) believes that emotion is necessary to rational thought and that body sensations cue awareness of emotion, for one to be able to make rational decisions one must be able to feel the consequences of that decision. In short, the somatic marker hypothesis is that body sensations underlie emotions and are the basis for weighing consequences, deciding direction, and identifying preferences (Damasio, 1994).

**Autonomic nervous system.** The Autonomic Nervous System (ANS) controls involuntary body functions through the transmission of motor impulses to the smooth muscles, cardiac muscle, and glands. Body functions that are controlled by this system include digestion, heart beating, secretion, vasoconstriction (narrowing of blood vessels), and peristalsis (the contraction of smooth muscles to propel contents through the digestive tract). The heart, circulatory system, digestive system, respiratory system, and urogenital system are all affected by the proper functioning of the ANS (Rothschild, 2000).

The Autonomic Nervous System involves hyperarousal and fight/flight/freeze responses. The sympathetic branch is activated by the hypothalamus and there is heightened arousal (hyperarousal) and either a fight or flight response. Epinephrine and norepinephrine are then released, breathing and heart rate increases, and the skin pales as blood flows away from the surface to the muscles, thereby preparing for quick movement. When neither fight nor flight are perceived as possible, there is simultaneous heightened arousal of the parasympathetic branch and freezing results. Without completion of the thwarted fight or flight response and a support person to help complete it, trauma is not resolved and one may feel frightened, isolated, or hopeless (Levine, 1996c). Under normal circumstances, the Parasympathetic Nervous System (PNS) and Sympathetic Nervous System (SNS) function in balance with one another; both branches are always engaged but one is usually more activated and the other is suppressed. The SNS is aroused in states of stress, both positive and negative. The PNS is activated in states of relaxation or pleasure, rest, and sexual arousal (Rothschild, 2000).

**Neuroception and polyvagal theory.** Pertinent to the functioning of the Autonomic Nervous System and an individual's response to potential threats in the environment are the concepts of neuroception and the polyvagal theory, both defined and discovered by Stephen Porges. Neuroception is "detection without awareness" or sensing without knowing. Using neuroception, one detects whether someone or something is safe, danger, or a life threat. Psychopathology [such as in PTSD] may result from a person's inability to inhibit defense systems in a safe environment (Porges, 2004, pp. 19-20).

Porges (2004) developed the polyvagal theory as an organizing principle of the neural circuit within the autonomic nervous system. Immobilization occurs when a life threat is detected; there is death feigning and behavioral shutdown. The oldest branch of the vagus nerve that is located in the brain stem is involved. One becomes mobilized when danger is detected. There is active avoidance, and the fight/flight response is dependent on the sympathetic nervous system for a faster heart rate and greater ability of the heart to contract. Social communication and engagement occurs when safety is detected. A self-soothing and calm behavioral state is fostered by inhibiting the influence of the sympathetic nervous system on the heart (p. 22).

**Somatic nervous system.** The Somatic Nervous System (SomNS) controls voluntary movements in the body that are performed by the contracting of the skeletal muscles. Efferent nerves are at play. It also includes special nerve fibers that keep in touch with surroundings through the senses of touch, hearing, and sight. It involves the mechanism by which trauma is remembered implicitly (unconsciously) through the encoding of posture and movement. The SomNS involves the muscles, movement, and kinesthetic memory. Kinesthetic memory is the recollection of movement, weight, resistance, and

position of the body or parts of the body. It is responsible for voluntary movement executed through the contracting of skeletal muscles. The SomNS commands movement and assures accuracy. Behaviors, movements, and physical procedures are all performed through this system. For movement to be encoded and recorded as implicit memory, nerve sets that cause movement and nerves that give one the feeling of it are necessary. This helps you know you are making the correct movement (especially when not observing what you are doing) (Rothschild, 2000). Often, but not always, movements caused by the SomNS can be used to intentionally facilitate state-dependent recall. One can resume a particular body posture inherent in the traumatic situation to try to facilitate this (Rothschild, 2000).

### **Dissociation and Research**

Dissociation is a common factor associated with both severe trauma and the development of PTSD. Scaer (2010) discusses dissociation as:

*...in a state, numbing and avoidance... Numbing because dissociation is fueled by endorphins, and avoidance because of the fact that the dissociation is associated with experiencing an old traumatic memory, and as a result one avoids the experience. But in fact, I think dissociation is the thing that we perceive we are in what might be called the freeze response, which is the third phase of the fight/flight/freeze sequence when one does face a life-threatening event, and in the case of the freeze, when one is helpless (p 2).*

Flashbacks can also occur during dissociation. Rothschild (2000) describes a flashback as a “re-experiencing of a traumatic event in part or in its entirety” (p. 65). Scaer (2010) describes a flashback as the “interruption of one’s attention in the present moment by a dissociated capsule” (p.3). A dissociated capsule is described in the next paragraph.

**Dissociative capsule.** A dissociative capsule contains all relevant stored memories for each traumatic experience endured. Intrusion on the present moment occurs from an internal capsule reflecting all conscious and unconscious memories (emotional, cognitive, and body memory) of the traumatic event. The memories in the capsule “corrupt” the present moment by inserting past events into one’s present perception. Dissociation is the “perception of the past as present”; thus Scaer calls this the “dissociative capsule.” The number of life traumas determines the number of capsules stored in procedural memory. Trauma healing is the recovery of the “purity of the present moment”. If one is able to wipe out the somatic contents of the capsule, emotions and autonomic feelings will be neutralized. Declarative memories will remain but will be experienced as the past in absence of sensations and emotions (Scaer, 2006).

**Dissociation, trauma, and PTSD.** Dissociation is not mentioned as a symptom of PTSD in the DSM-IV or previous versions. Dissociation appears to be a set of related forms of split awareness. Split awareness can range anywhere from simply forgetting to dissociative identity disorder (in the extreme). Persons with PTSD have reported dissociative symptoms of an altered sense of time, a decreased ability to feel pain, and a lack of feeling terror or horror; this is similar to reports from those who respond to a threat by freezing (Rothschild, 2000).

A study by van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, and Herman (1996) investigated the relationship between the current diagnostic formulation of PTSD and the symptoms of dissociation, affect dysregulation, and somatization. The results of interviews with the 395 participants who sought treatment for trauma-related problems were compared to the 125 community subjects exposed to high magnitude stressors.

Results from the study showed that the associated features of PTSD (dissociation, dysregulation, and somatization) were found together in the same individuals and that their co-occurrence was at least in part a function of the age at which the trauma occurred and the nature of the traumatic experience. Subjects with current PTSD had significantly higher rates of endorsement of symptoms of all three than those who no longer met criteria. The group that no longer had PTSD also had a much higher symptom level than those who had never met criteria for PTSD.

Correlations between PTSD, dissociation, somatization, and affect dysregulation were all statistically significant. Treatment seeking subjects with PTSD scored significantly higher on dissociation and affect dysregulation than the community sample with PTSD. Subjects who met lifetime criteria for PTSD, but not current, scored significantly lower on dissociation, somatization, and affect dysregulation than did the Current PTSD group, but significantly higher than the No PTSD group. Subjects with interpersonal trauma as adults had significantly less dissociation and affect dysregulation than those with childhood trauma, but significantly more than victims of disasters (van der Kolk et al., 1996).

### **Body-Based Trauma Treatment**

**History of body-oriented therapies.** The history of body psychotherapy is rooted in the work of Wilhelm Reich. Body Psychotherapy has been both inspired by Wilhelm Reich's work and has suffered from it. His early work on Character Analysis was widely accepted as a reference work for psychoanalysis and other modalities of psychotherapy, while the next direct development of his work, Character Analytic Vegetotherapy (which

involves direct contact and touch with the body of the patient), was not accepted by the psychoanalysts.

Reich was excluded from the International Society of Psychoanalysis as a result of a book that he had published three years prior regarding psychology and fascism. This was due to the political situation in Germany at the time, and the German Psychoanalytical Society consisting of many Jewish members while trying to retain its standing with the (increasingly) Nazi German authorities.

The co-founders of Bioenergetics, Alexander Lowen and John Pierrakos, were clients of Wilhelm Reich and adopted his beliefs, his theories, and adapted his therapy into a modern format called Bioenergetic Analysis. John Pierrakos went on to include a psycho-spiritual component and developed Core Energetic Therapy. Charles Kelley, another client of Reich's, refined working with physical techniques on bodily tensions and developed Radix work.

Although Reich experienced trial, mass burning of all his books, and eventually died in prison, his theories experienced a resurgence in interest in the mid 1990's from the new psychotherapies of Encounter Groups, Humanistic Psychology, the Gestalt Psychology of Fritz Perls at Esalen, and countless Body Oriented therapies and psychotherapies that developed. The creators of these evolving therapies were indebted to Wilhelm Reich and his theories about the sexual, physical, emotional and psychological repressive effects on the client's body, repeatedly, daily, and throughout their childhood, which severely restricted their functioning potential and was the physiological basis of many neuroses and possibly psychoses as well. It was the constant

day-to-day repression of trauma by clients that contributed to their problems and was stored in their bodies and in their psychosomatic memories in multiple layers. Body Psychotherapy was effective in undoing some of these well-established holding patterns and freeing the body and the mind of these repressive effects (Young, 1997).

**How they work.** In a 2011 study, Schutt looked at Body-Oriented Psychotherapy (BOP) as a treatment for trauma. Showing respect for the client, being non-judgmental, and ensuring client readiness for the work are all important. Preparation for BOP includes educating the client on the cycle of trauma and the connection between the mind and body, as well as establishing a trusting therapeutic relationship. The therapist needs to inform the client about their “window of tolerance” when facing traumatic memories. The monitoring and tracking of body sensations involves the therapist checking in with the client and communicating about observations or signs of distress. Clients learn to be aware of sensations and the therapists look for signs of dissociation; this is body tracking in the present moment. Other results reported included the positive effects for clients, such as getting to the root of the issue, providing safety and relief because they felt they were being heard and held, and a deeper connection with self-empowerment because healing is from the client, not the therapist. These themes of empowerment and relationship are relevant to clinical social work.

**Effectiveness of and benefits to clients.** A study by Schulz (2010) looked at clinicians’ views on the utilization of body-oriented psychotherapies for the treatment of trauma. Many clients’ trauma-related symptoms did decrease in intensity and longevity. Clients were also able to integrate aspects of their traumatic experience. Clinicians saw themselves as guides who were there to assist clients by tracking for changes in and



pointing out slight alterations. They were there to guide clients through corrective experiences and promote trust in the process. Clinicians interviewed reported using a holistic approach to addressing individual client needs. They reported feeling naturally drawn to experiential and body based therapies due to their belief in the mind-body connection and the feeling that something was missing in traditional talk therapies. Type of trauma, how long it occurred, level of social support, client's perspective of the experience and the meaning applied to it were all factors that could influence the client's capacity to make alterations. Main goals of therapy noted were gaining awareness, regulating, and healing. Being mindful of client needs as to specific interventions and maintaining awareness on the relationship are also very important. Factors influencing the effectiveness of body based therapies include: intervention timing, therapist attunement with the client, and the client's capacity to do the work.

**Client views on body-oriented therapies.** In a study looking at why clients choose body-centered interventions over traditional talk therapies by Boy (2004), body therapies were seen as more effective, quicker, more integrative, holistic, and transformative than talk therapies alone. Clients agreed that talking did not go deep enough. Some believed that an integrative approach with both body-conscious and talk therapy would be ideal. Others felt that talk therapy was important to assist one in the ability to integrate emotional pieces of the self into conscious awareness. The strength of the therapeutic alliance and the clients' ability to trust the therapist were also reported as to what made the intervention strategy effective for them.

**Efficacy of body-oriented psychotherapy to treat sex abuse.** Body-oriented psychotherapy has been found to be quite effective in the treatment of sexual abuse

survivors. Price (2007) conducted a study with 24 women currently in psychotherapy for sex abuse recovery who received eight body therapy sessions consisting of a massage group and a body-oriented therapy group. Dissociation means gradually decreased from 12.2 at the baseline to 4.5 at the three month follow-up (with four other checks in between). There was a strong relationship between changes in dissociation and positive changes in health outcomes, as demonstrated by the variables of physical symptom discomfort, body association, and body investment.

Price (2005) found mixed results when comparing outcomes for 24 adult females in sex abuse recovery who were split into two groups, half receiving massage therapy and half receiving body-oriented therapeutic protocols. Although there was significant improvement on all outcome measures for both intervention groups, which lends support for the efficacy of body therapy in recovery from sex abuse, there were no statistically significant differences between groups. However, qualitative analysis revealed differences in how participants perceived their intervention experience and how it influenced their recovery. The massage group developed a behavioral perspective, in which they concentrated on how to take care of themselves and how they related to their physical self. The body-oriented group developed a somatic perspective, in which they were learning specific strategies to access somatic experiences and increasing their awareness of senses and feelings. The results of both of these studies indicate that BOP is an effective treatment for decreasing psychological symptoms and dissociation amongst individuals who have experienced childhood sexual abuse.

**Sensorimotor psychotherapy.** A more specific type of body-oriented psychotherapy is sensorimotor psychotherapy. Sensorimotor psychotherapy is a method for facilitating

the processing of unassimilated sensorimotor reactions to trauma and for resolving the destructive effects of the reactions on cognitive and emotional experience. Interventions help regulate and facilitate emotional and cognitive processing and the confronting of somatic issues by directly addressing sensorimotor processing useful to restoring normal healthy functioning for trauma victims. Integration of all three levels (sensorimotor, emotional, and cognitive) is essential. Reactions are integrated through restoring the balance and synergy between top-down and bottom-up processing (Ogden & Minton, 2000).

Essentials of this kind of psychotherapy include regulating affective and sensorimotor states through the therapeutic relationship and teaching the client to self-regulate by mindfully contacting, tracking, and articulating sensorimotor processes independently. The intention is to work to access enough traumatic material to work with, but not so much that the client becomes overwhelmed and dissociated (Ogden & Minton, 2000).

Top-down direction is harnessed to support rather than manage sensorimotor processing. The client is asked to mindfully track (through a top-down, cognitive process) the sequence of physical sensations and impulses (sensorimotor process) as they progress through the body, and to temporarily disregard arising emotions and thoughts until the sensations and impulses resolve to a point of rest and stabilization in the body. Self-regulation occurs as clients are able to observe, articulate, and integrate sensorimotor reactions on their own as well as by utilizing relationships (Ogden & Minton, 2000).

Sensorimotor Psychotherapy processing is similar to Somatic Experiencing due to the tracking of physical sensation, but it differs in intent. This is used as a prelude to holistic

processing on all three levels (cognitively, emotionally, and through sensorimotor avenues). The discharging of energy to complete the freezing response (as in Somatic Experiencing) is not accepted here. Instead, the client is taught to modulate his or her sensorimotor processes, which sometimes means stimulating arousal so that the client is in hyperarousal (Ogden & Minton, 2000).

Fisher (2010) discusses sensorimotor psychotherapy as both a body and a talking therapy with slower and more paced interventions. The point is to transform trauma by changing the trauma response, the relationship to the symptoms, and the interpretation of them. Fisher also states that in sensorimotor psychotherapy “more conscious attention” is paid toward keeping the client “aware and mindful” during sessions because it is considered an important piece (p. 2).

Other parts of sensorimotor psychotherapy include asking if the client is willing to notice sensations and having the client practicing and developing new responses. They believe that physiological function supports psychological function. Responses are “completed” rather than discharged (as in Somatic Experiencing). When responses are discharged, clients still have feelings and patterns are not changed (Fisher, 2010).

Fisher (2010) further stated that:

*The responses have to be completed rather than discharged. This is the reason that they keep repeating and why clients often have a very wonderful experience of discharge at a therapy session followed by the feeling of being just as depressed, just as anxious, just as overwhelmed as before. It's because discharge alone doesn't change these patterns (p. 6).*

A final item worth mentioning is that the sensorimotor psychotherapist simultaneously does what he or she asks the client to do, so that movements are being mirrored and sensations are noticed by the therapist and shared with the client as necessary.

### **Somatic Experiencing**

“Traumatized people relive the moment of trauma not only in their thoughts and dreams but also in their actions” (Herman, 1997, p. 39). Somatic Experiencing (SE) is partially based on the similarities between the regulatory system of animals and humans in dealing with traumatic events. It teaches clients how to slowly and safely complete survival actions, interrupted at the time of trauma, as they learn to renegotiate their traumas rather than relive them. It focuses on the client’s perceived body sensations (or somatic experiences).

Somatic Experiencing is a biological, body-oriented approach that alters fixated immobility reactions. SE tracks neuromuscular, autonomic, perceptual resources necessary for potentially life-threatening situations. It considers an individual’s present survival pattern as resulting from what was lacking at the time of traumatic activation (Levine, 1996a, p.2). SE approaches in treatment to “destructure thwarted anxiety response” and “restore defensive and orienting resources” (Levine, 1996a, p.21). “Life-preserving survival responses are activated [during a traumatic event] but if one is not able to complete them, these innate ‘action plans’ cannot discharge the vast amount of energy when ready to do so” (Levine, 1996c, p.12).

In a fairly recent interview, Levine (2010b) discusses the concept of “somatic resonance” as an important tool he utilizes when conducting Somatic Experiencing

techniques. This involves the therapist “picking up on”, “sensing” and even “tracking” his own felt sense, feeling, and experience while working with a client. For instance, even though he may not have a way to measure heart rate or temperature of a client, he can still “feel” these through somatic resonance.

SE has several main concepts: titration, renegotiation, pendulation, re-membering, reorientation, and discharge. Titration is the gradual, stepwise process of trauma renegotiation. Renegotiation is the process of healing or resolving trauma. Pendulation is the primal rhythm expressed as movement from constriction to contraction, and back to expansion (Levine, 2010a).

Levine (2010b) describes ‘re-membering’ as: “bringing these fragmented parts of our body and dissociation together in a coherent organization so the memory and of course in some cases the memory is very important especially if there is a memory of some kind of ongoing abuse that’s going on getting accurate information can be important in protecting other people” (pp. 6-7).

Levine (1996c) notes that there is a “dual” nature to trauma in that it can take away a person’s capacity to live life to the fullest but that it can also “transform and resurrect” (p. 14). Levine (2010a) describes a nine-step process to transforming trauma as the core elements in the process of Somatic Experiencing. Step one consists of creating an environment of relative safety in which distress lessens and the willingness to explore is encouraged. A possible roadblock to this step may exist in between sessions when the client is away from therapist modeling. Step two supporting initial exploration by touching into client sensations help clients find way to bodily sensations and capacity to

self-soothe; notice momentary positive shift in affect or body posture and try to direct client toward attending to sensations rocking back and forth rhythmic support shifting between fear and true sensations of immobility deepens relaxation, reduces grip of fear, allows more access to sensations. Step three utilizes pendulation (described above) in order to help the client get unstuck by knowing (sensing internally) that feelings can and will change no matter how bad one feels. They can then move ahead in time by accepting and integrating current sensations that previously overwhelmed them, recover balance, and return to life's moment-to-moment engagement. Step four is about titration (described above), which involves tapping into the smallest drop of survival bases in order to help renegotiate trauma. Therapists work to neutralize intense energy sensations and primal rage and non-directed flight without releasing the explosive purging of emotional tensions, all this when also dealing with potentially damaging forces.

Step five in transforming trauma involves providing corrective experiences so that the client can consciously feel his or her way through active, self-protective reflexes with precision. This can lead to a physical sense of agency and power, countering feelings of overwhelming helplessness and reducing fear. Step six involves uncoupling fear from the immobility response, which helps dispel fear, entrapment, and helplessness, thus breaking the feedback loop of terror and paralysis. Fears that fuel immobility are the fear of entering it (and experiencing paralysis, entrapment, helplessness, and death) or of exiting it (through an intense energy of "rage-based" sensations of counterattack). Step seven involves helping the client to discharge and regulate high arousal states, with passive responses replaced by active ones when exiting immobility in waves of involuntary shaking and trembling followed by spontaneous changes in breathing (tight

and shallow to deep and relaxed). Step eight assists the client in engaging in self-regulation in order to restore the pre-threat level of arousal and promote shifting state (process) of relaxed alertness and the building of resilience. In step nine, the client is reoriented in the here and now, given the capacity for presence, and is helped to realize that being in the here and now is reality. This is cardio and immune-protective, and helps one feel a sense of belonging and safety (Levine, 2010a).

Scaer (2001) endorses the benefits of Somatic Experiencing. He states that he has seen it work more effectively in resolving dissociative traits and behaviors than with other techniques such as Eye Movement Desensitization and Reprocessing (EMDR). Though the risk of flooding is moderate, he states that titration utilized by the therapist adequately addresses this. He has also seen how safe and effective SE can be in helping traumatized patients with chronic pain.

Studies utilizing somatic experiencing. Somatic Experiencing has only recently been explored as to treatment outcomes through the avenue of research. Studies completed thus far have all been applied at the macro level with natural disaster survivors. For example, a study by Leitch (2007) consisting of 53 survivors of the 2004 tsunami in Thailand, 67% of participants had partial to full improvement in symptoms reported immediately after treatment. At a one year follow-up, 95% of participants had partial or complete improvement in reported symptoms. In a study by Leitch, Vanslyke, and Allen (2009) of 142 social workers involved in the 2005 Hurricanes Rita and Katrina, similar results were shown. Ninety-one participants in a treatment group who received SE treatment displayed significant improvement in resiliency indicators and decreases in PTSD symptoms compared to the group of 51 participants who did not receive SE



treatment. Both of these studies indicate that SE is effective in reducing psychologically distressing symptoms in a post disaster situation.

Finally, results from a 2008 study by Parker, Doctor and Selvam exploring treatment outcomes from SE and involving survivors from a 2004 tsunami in India, indicated that 94.4% of the individuals who presented with trauma symptoms experienced significant improvements or were entirely free from symptoms after receiving treatment. The 150 participants in this study received a one time, 75 minute session of SE treatment with a follow-up assessment conducted at four weeks and eight months. To evaluate the effectiveness of the SE treatment, the participants were asked to rate changes (on a Subjective Units of Distress Scale) in their previously identified symptoms. This study shows promising results for individuals in a post disaster situation, especially given the brief treatment that the participants received.

### **Summary and Research Question**

The current research in regards to the efficacy of Somatic Experiencing techniques is extremely limited, with only a handful of studies completed but all focusing on outcomes of the utilization of these techniques with survivors of natural disasters. There are apparently no completed studies on, nor any known to be in progress, specifically regarding how and why Somatic Experiencing techniques work for clients in individual treatment with mental health practitioners who are trained in body-oriented psychotherapies such as Somatic Experiencing. As results from the three Somatic Experiencing studies (Leitch, 2007; Leitch, Vanslyke, & Allen, 2009; Parker, Doctor, & Selvam, 2008) presented in the Literature Review indicated, there are promising results

thus far in short periods of time when considering the distressing symptoms of trauma and their reduction utilizing Somatic Experiencing. Other studies reviewed on the efficacies of body-oriented psychotherapy in general (Schutt, 2011; Schulz, 2010; Boy, 2004), and in relation to the treatment of women who have been sexually abused (Price, 2005; Price, 2007), have all shown encouraging results as well. Given this thorough review of the literature, it is clear that more research is needed in exploring the application of Somatic Experiencing techniques in individual therapeutic situations as well as the evaluation of treatment outcomes. Therefore, the research question of this qualitative study is: What are mental health practitioners' views on why Somatic Experiencing works for treating trauma?

## **Research Lenses**

Researchers undoubtedly are prone to biases and view their research and subsequent data through particular lenses or a conceptual framework. This section provides a discussion of these lenses through which I viewed the research data outlined in this study. These lenses affect interpretation of the data but also allow the reader a well-rounded assessment of the data. Theoretical, professional, and personal lenses all impart certain biases that are discussed.

### **Theoretical Lenses**

For the purposes of this specific study, my conceptualization was drawn from trauma theory. Trauma theory takes into consideration the biological, cognitive, developmental, emotional, interpersonal, and spiritual aspects of individual experience. All of these factors contribute to how one interprets events and perceives the world. It is believed that each of these factors can have a profound impact on the other. In working with individuals who have experienced trauma, it is important to recognize that all of these factors play a part in how trauma manifests itself. For instance, what happens on a biological level can affect how an individual adapts to the outside world. Traumatic experiences can contribute to an obliteration of the self through each one of these factors.

Another theory influencing my conceptualization was Levine's psycho-physiological trauma theory, which is informed by what biologists (ethologists) call the immobility response, a survival enhancing fixed action pattern evolved in prey animals which is triggered by the perceived imminence of being killed by a predator. A third theory is holism, with an emphasis on the mind-body connection. All properties of a given system

cannot be determined or explained by its component parts alone. Instead, the system as a whole determines in an important way how the parts behave.

### **Professional Lenses**

I am a Licensed Social Worker; however, I am not working with individuals on a strictly clinical level. I have worked with clients presenting with a wide variety of symptoms, including trauma related. I have several years of experience in the child protection arena in particular. A bio-psycho-social-spirit philosophy is used by me when conceptualizing a treatment focus and approach with clients. This method is holistic in nature, as is body-oriented psychotherapy. My professional lens also examines the social worker/client relationship as an integral component to the work.

As a professional in the social work field for fifteen years, I am biased toward this strengths-based perspective when working with clients. The strengths-based perspective is client-centered and empowers clients to actively engage in their treatment. The therapist is simply an aid to help the client uncover unknown abilities and strengths. This is similar to beliefs represented in BOP.

My professional experiences have undoubtedly influenced the research project. At the onset of the project, I gave thought about the professional lenses through which the data will be viewed and the biases that may arise.

### **Personal Lenses**

I favor therapeutic methods that use a mind-body-spirit approach with an underlying foundation of empathetic attunement. Many modalities of BOP recognize the

relationship between client and therapist as an equally significant factor to the healing process. In trauma therapy, the work is sensitive to the needs of the client and where they are in their journey. This adherence to meeting the client where they are is a focus that I strongly believe in.

As I, my close friends and family, and even my clients, have all experienced complex traumas, none of which have appeared to significantly improve with traditional “talk” therapy, I recognize my bias towards non-traditional treatments for trauma. My cumulative experience in both the nursing and social work fields have contributed to my beliefs in treating the whole person as well as maintaining an emphasis on the mind-body connection.

## **Methodology**

The research question, “What are mental health practitioners’ views on why somatic experiencing works for treating trauma?” was explored through the use of qualitative methods. Qualitative research uses techniques that “examine how people learn about and make sense of themselves and others” (Berg, 2009, p. 8). Additionally, qualitative methods place a greater emphasis on understanding others within the “full context”; thereby allowing more “abstract and general concepts or theories” to “emerge from the data” (Monette, Sullivan, & DeJong, 2011, p. 432).

The specific method selected for this project was interviews. Using an interview format allowed the researcher to hear multiple voices and probe further with additional questions. In this format, the researcher was able to ask questions in any order and rephrase as needed (Monette et al., 2011). Monette, Sullivan, and DeJong (2011) write that interviews can be more accurate and flexible (in data collection) than mailed questionnaires. Interviews foster a unique flexibility which produces richer responses due to the control that the interviewer maintains. Lastly, observations, such as nonverbal cues and body language enhance the responses and evaluation of the data.

### **Sampling Procedures**

The researcher recruited ten mental health providers to participate in the study. The researcher selected mental health professionals who practiced Somatic Experiencing techniques, whether they were fully certified Somatic Experiencing Practitioners (SEPs) or in the midst of the three year training process. This was because all mental health practitioners are allowed and encouraged to practice the specific techniques during the

learning process. Names were obtained via word of mouth recommendations from a committee member and from the Somatic Experiencing webpage, [www.traumahealing.com](http://www.traumahealing.com).

The researcher also recruited practitioners by submitting a short announcement called an e-blast to the Somatic Experiencing Trauma Institute online newsletter. Practitioners interested in the study who saw the announcement in the e-blast contacted the researcher via e-mail or telephone if they wanted to participate.

All practitioners referred via the committee member, located online, and who responded to the e-blast were contacted by e-mail or via telephone by the researcher. The e-mails included a recruitment letter describing the details of the research study and how to contact the researcher if they were interested in participating (see Appendix A).

The selection of practitioners was based on a convenience sampling from those names listed and available to the researcher. The researcher's choice to conduct a convenience sample method of recruiting primarily local practitioners was based on feasibility and time.

### **Protection of Human Subjects**

This study posed minimal harm or risk to participants. During the interview no questions were asked that would breach client confidentiality or that would lead the researcher to gain specific information on past or present clients. The recruitment letter described the research study, its purpose, and other informational details, such as the researcher's contact information. Participants freely chose to participate in the study.

Potential participants were able to ask further questions about the study when they contacted the researcher and if they then chose, scheduled an interview.

Prior to each interview, written consent was obtained. Written consent for the telephone interview was obtained prior to that interview via receipt of a secure and confidential fax. The consent form outlined protection measures and was approved by the University of St. Thomas Institutional Review Board (IRB) (see Appendix B).

Before beginning the interviews, each participant was reminded that participation in the study was voluntary and that they were able to discontinue the interview at any time. All data collected was stored in a locked file in the researcher's home and accessible only to the researcher. The data from the audio recordings was not used for any other purpose than this study.

The researcher was thorough in the design of this study, giving close attention to maintaining confidentiality and anonymity to the participants and their clients. The researcher removed identifying information from the appendixes. The researcher kept identities confidential by not including any identifying information.

### **Instrumentation**

The interview schedule consisted of a mixture of open and closed ended questions in a semi-structured format (see Appendix C). The questions were created by the researcher based upon existing literature in the fields of trauma, body-oriented psychotherapy, and Somatic Experiencing. In order to ensure that the questions were clear and concise, the interview questions were reviewed by the researcher's committee and modifications were



made as recommended. The use of open-ended questions allowed the participants to discuss the subject more freely.

The interview structure was designed to focus on each participant's education and work experience first and foremost so as to look at how each participant's clinical background and time was spent working in trauma, with body-based methods, and with Somatic Experiencing contributed to the data. The middle section of the interview focused on how each mental health practitioner (participant) determined the appropriateness of SE for their clients, if they altered their SE techniques based on the type of trauma experienced by the clients, how they helped traumatized clients utilize their bodies in relation to Somatic Experiencing principles and techniques, and the patterns of progress they saw from their clients when applying said principles and techniques. The last section of the interview structure focused on comparing treatment outcomes of SE with those of other body-based methods, considering the risks and benefits of SE, noting if there were any limitations to only using SE as a trauma treatment, and finally, participants' input as to what they saw as the need for future research in the trauma and Somatic Experiencing arenas.

### **Data Collection**

Interview data was collected from nine face-to-face interviews and one telephone interview. All interviews were audio-recorded and later transcribed verbatim by the researcher. The interviews consisted of twelve questions related to the practitioners' perspectives on Somatic Experiencing techniques and why they work for treating trauma. Each participant was interviewed separately using the same interview schedule. The

interviews lasted from thirty minutes to one hour. Participants who interviewed face-to-face all preferred to conduct the interviews in their respective offices. One participant was interviewed via telephone due to residing and working outside the state of Minnesota.

### **Data Analysis Procedures**

Content analysis was used to examine the data and to identify recurring themes. Berg (2009) describes content analysis as a systematic method of identifying particular characteristics of messages. Transcribed interviews were utilized to identify codes and subsequent themes. An open coding process was used, which entailed carefully examining the data (responses) line by line; first, looking for similarities and second looking for differences (Berg, 2009). This open coding process allowed for themes to emerge.

The researcher thoroughly analyzed the data utilizing an active analytical stance. Each completed transcript was reviewed three times. The first reading was done unfiltered. In the second reading, the researcher read the transcripts, highlighting and circling possible themes as they appeared in the data. The third reading completed the process of inductive analysis, which involved allowing the data to emerge in the analysis process. According to Monette et al. (2011), inductive analysis offers a more “valid representation” of that being studied because the themes come directly from the data (p. 226). By using an active analytic stance, the researcher was engaged and challenged by the data.

After the themes were identified, the researcher created files so that supporting documentation could be matched up with each theme.

### **Description of Participants**

Out of the thirteen mental health professionals identified and contacted as potential participants, ten agreed to participate in an interview. There were a total of nine female participants and one male participant. The majority of the participants were Licensed Independent Clinical Social Workers (LICSW) and Licensed Psychologists (LP). Other participants were registered and/or certified in play therapy, marriage and family therapy, and dance movement therapy.

Per inclusion criteria, all participants had to be mental health professionals who were either fully certified Somatic Experiencing Practitioners (SEPs) or in the process of the three year training to become one. Four mental health practitioners were fully certified as Somatic Experiencing Practitioners. One had completed all of the training but had not completed the paperwork to become officially certified. Five were in the midst of the three year Somatic Experiencing training, with two in the advanced (third) year and three in the intermediate (second) year of the training.

The participants' experience working with trauma ranged from eleven years to over forty years, with twenty years being the average. The participants' experience working with body-based methods ranged from two years to thirty-six years, with twelve years being the average. Six practitioners had an average of three to five years of experience with Somatic Experiencing techniques. Two had about a year, one had less than a year, and one had eight years of experience with Somatic Experiencing techniques.

The participants had a range of other therapies and techniques that they were trained in. Three participants were trained in Eye Movement Desensitization and Reprocessing therapy, although not all of them continued to use it, preferring instead to utilize Somatic Experiencing to assist clients in working through their trauma. Additional training noted by participants included play therapy, sand play therapy, muscle testing, thought field therapy, hypnosis, guided imagery, emotional freedom technique, and cognitive behavioral therapy.

Finally, the participants worked with various client populations. Of the ten participants, seven identified as being in private practice. Three participants reported that they only see adult clients. Four participants reported seeing about half adult clients and half children clients. One reported that she sees all ages. Three of the ten also work with couples, and two do family therapy.

## Findings

Results of this qualitative study which examined the views of mental health practitioners utilizing Somatic Experiencing (SE) techniques with their clients affected by trauma, and what they saw as contributing to why SE worked so well in the treatment of trauma, will now be presented. The themes and subthemes ascertained from the data were described, and relevant direct quotes were then applied to each theme and subtheme. The section was concluded with a summary of all of the findings of the study.

The interviews resulted in the development of three main themes. The themes arose out of the question areas that the interview touched upon, including (1) the importance of the client increasing body awareness, (2) the importance of treatment proceeding at the client's pace, and (3) the importance of client empowerment. Within the theme of body awareness there were four subthemes including (B1) the body leads, (B2) the body speaks, (B3) finish what the body started, and (B4) the body survives. Within the theme of client pace there were five subthemes including (C1) going slowly, (C2) client readiness and safety, (C3) client adjusted and settled within present environment, (C4) balancing moving forward with not flooding, and (C5) educating and coaching the client. Within the theme of empowerment there were five subthemes including (E1) building distress tolerance, (E2) developing a positive resource toolbox, (E3) quick and deep healing, (E4) increasing client independence, and (E5) managing symptoms more effectively. These themes are outlined in Table 5.1.

Table 5.1

*Themes, Subthemes, and Sample Responses of Practitioners who Incorporate Somatic Experiencing into Their Practice*

Themes	Subthemes	Sample Response
<i>Body awareness</i>	B1 The body leads	...so they have that little beginning confidence that their body is telling the truth and that they're ready to go I would just as soon find out from their body which way to go...and that's the sort of follow the client piece again...
	B2 The body speaks	...to learn what they're sensing in their body...when you're hungry what does that feel like versus when you're not hungry...if you feel good what does good feel like inside... getting the language of what's going on in your body so you can tap into the...brain stem kind of stuff.
	B3 Finish what body started	...tapping into...the brain stem where trauma is stored in the nervous system...so that the intensity level the nervous system isn't jumping...they can work through what they didn't get to work through and...they're not as activated anymore.
	B4 The body survives	...the SE in particular obviously hones it down into a very specific modality of working with the body and...how the body is affected by trauma and how we hold and store those...memories... with trauma it's viewed or it's helped me to view each client obviously as an individual...because everybody has a different response.
<i>Client pace</i>	C1 Go slowly	...I think going slowly...is really the key...you certainly don't want to send somebody into their body when they're not...in a state where they can feel confident enough to go there...
	C2 Client readiness and safety	...when clients come in...meeting them where they're at...because some clients come in and they're more aware of their bodies and what [they] are sensing...go where they're at and where they're willing to go.
	C3 Client adjusted and settled within present environment	...they might be a client who says every part of their body hurts so then we'll say what part of your body doesn't hurt as much as everywhere else and then stay focused on that area...if they can actually do this it can spread and the rest of their body will begin to settle.
	C4 Balance moving forward with not flooding	I'm gonna do some assessment...take a minute and just feel your feet on the floor and...if they are having a hard time with that we are going to

back off actively going to trauma stuff and we're gonna work on practicing self-regulation skills and dealing with stress as just a basis that needs to be there before we go actively after the trauma.

C5 Educate and coach client  
I might say I am a Somatic Experiencing Practitioner this is the type of work that I do if you're interested there may be some things that you have experienced that have been traumatizing in your life and we can work on that here and so between now and the next session I'd like you to think a little bit more about that...and so it's... real...[and] it doesn't make somebody feel like they have to fit into my paradigm.

*Empowering*

E1 Build distress tolerance  
...that they actually have some things that they can do to help themselves experience this navigate it calm themselves down...to help them soothe and stabilize their emotions...so they need... some skills and some resources to strengthen them to face the trauma... helping the client know how to stabilize when they've been out of control...[with] experiences and emotions.

E2 Develop positive resource toolbox  
...with SE...you can jump in and jump out again...go into that hard part a bit and then come out...gently go in and maybe they're not ready to go into that hard part yet...so it's working on ...what feels good in the body...it depends on your client and history of trauma and their support system and all those types of resources who was there for them who wasn't there for them...

E3 Treat trauma quickly and deeply to integrate whole person  
...SE isn't a fast approach but it's very deep and it's almost like it's an oxymoron in a way because...it's slow inception but then when it reaches this place it's like dramatic and huge and then it seems fast...

E4 Increase client independence  
When they're home I want them to...be ...practicing so that they can learn to use an image...and track their own body and then their body can become a resource for them and that they...can have something that goes with them wherever they are which is fun to watch...them learn how to do that.

E5 Manage symptoms  
...they could get some symptom reduction from the trauma...from being stuck in whatever spot they're at...

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*Note.* B= body awareness; C = client pace; E = empowering; SE = Somatic Experiencing.

## **The Importance of the Client Increasing Body Awareness**

The first theme that was emphasized was the importance of the client increasing his or her level of body awareness, which is the ability to recognize different parts of one's own body, their relative position during movement, and their relationship to the environment. The four subthemes that emerged were: letting the body lead, making connections from what the body is saying, finishing what the body started, and recognizing the importance of what the body does to survive.

**The body leads.** All ten participants described the importance of “following” and “trusting” where the client's body wanted to go. Three specifically mentioned the development of the client's “mind-body connection.” In response to the question regarding what patterns are seen in clients making progress, Participant D stated:

*...they usually become calmer...they develop more resiliency so that something that might have blown them over in the past it doesn't seem like such a big wind anymore...they become more self-aware in general are more aware physically they tend to be in their bodies more...one new thing that happens for people is that they develop a friendly relationship with their bodies instead of it being a place where bad things happen people experience their bodies in ways they haven't before and that's generally pretty positive...*

Participant C spoke about knowing and understanding the body and believing one can cope with things. In response to a question about the risks and benefits of Somatic Experiencing, Participant C stated that, “benefits are this big piece of building in a sense of awareness of my body and trust in my body's capability to get through things.”

Participant G spoke about trusting the knowledge of the body when discussing what parts of her Somatic Experiencing training had resonated with her thus far:



*...the body knows what it needs to do what it wants to do what it's going to do and just allowing that to happen um allowing the movement or allowing the image to be voiced or whatever it is and...it's different for each person uh there's no wrong way you know whatever is the experience...so you read this and you hear this but again to have that experience of it really shifts and the body does know and hold the wisdom I really have seen that...*

Participant J spoke about the trauma of surgery and the importance of allowing the body to experience awareness:

*... so the insight about how my body dealt with that and being able to allow myself to experience it as though it was an attack gives energy to then say my body needs to release that because my mind's got it all figured out but my body needs to release what that felt like to know that I was letting someone attack me...*

**The body speaks.** Five participants discussed the importance of the client “understanding and making connections within the body”, such as noticing “body position changes”. In other words, paying attention to what the body is saying about what they are feeling and thinking. Participant C spoke about interpreting body cues and acting accordingly in response to a question about how to help clients utilize their bodies to promote change:

*I am interested in getting people connected back to their bodies as the best primary source of information they have for their life... that they will have learned to notice when their stomach is in a knot and go you know what my stomach is not real happy about this I think I need to do something else here, um, so that they begin to make that connection...and are tuned in more to what their body's saying and able to use that to make decisions and go places.*

Participant D stated the following about making connections when the body speaks:

*...when they have a different experience in their bodies and they suddenly say whatever and they do it in one session and I think I didn't have to try to talk them into that you know they came up with it themselves...*

Another way participants talked about the body speaking was through their own personal experiences during their Somatic Experiencing training where their body position changed. Participant D shared an example of how just practicing a SE skill brought healing to her from a previous trauma she had sustained:

*We split into pairs to practice one specific SE skill with each other and so I worked with this woman for twenty minutes and she worked with me for twenty minutes and...we didn't work on a specific thing it was just see if you can do this particular skill after that there was a break and so I went out and sat in the lobby and I was just looking around and I noticed that for the first time since I had fallen off a ladder about a year earlier I could hold my head like this without feeling nauseated.*

Participant E described a similar experience of personal healing from trauma brought about by utilizing SE skills:

*... I volunteered during one of the classes and...the teacher did a demo with me and later that night I was at home and I was in my kitchen and I'm looking around going this is weird I feel like my head is more up...and I thought oh that's weird oh it's just my imagination you know and I went back to class the next day and the instructor who was in the session with me and some of my other classmates came up to me independently and said you're holding your head differently and I was like whoa and then I'd had this chair at the office that I was working at it was this big chair and if I was gonna sit upright I'd always have to tell myself to push my head back to you know sit up properly or whatever and after that training I went back and... I sat down in the chair and I could feel the back of the chair with my head and I didn't even consciously tell myself to sit that way it just happened so I've experienced it myself where you know just even how you hold...your body because if there's all that trauma in there it actually impacts how you hold yourself and so that's a pretty significant change for me.*

**Finish what the body started.** Five participants talked of the significance of SE being a treatment that “addresses the trauma right where it happens”, in the “instinctual or limbic brain” in order to help the client “complete the trauma response.” In other words SE helps finish what the body started. In response to a question regarding how to help utilize the body to promote change in traumatized clients, Participant B stated:

*...that piece of kind of hooking them to the physiological expression...SE really articulated it in a way that was very useful for me um and also holding space for the nervous system to really integrate the work so that...the whole idea of discharge...as a necessary part of that process that was new to me.*

Participant H spoke about how the focus in trauma work is in the instinctual, limbic brain; that is, where SE targets:

*When a person is traumatized this part of the frontal lobe is offline you know it's working with those instincts the instinctual part of the brain which is the reptilian brain or the limbic system... that deals with the fear the amygdala deals with the fear and the shame and the rage those are the parts that we want to bring out we want to bring out that instinctual response of the body... in needing to fight back from out of a freeze response or to run... to discharge the energy.*

Participant E stated that “SE is...really about completing incomplete responses in your nervous system and it's very much nervous system based.”

Participant E also talked about her play therapy work and trauma in kids and gave an example of using SE with a child client during a session. She described here her observations of the freeze and fight response in that particular child and her response:

*I had a child who had a trauma and got triggered by something right before he came to session and he crawled up the stairs saying my legs don't work my legs don't work so now... with the SE training I'm like okay you're in a freeze the freeze response [he] crawls up the stairs not having his legs work and he gets to the top and I go... what do you need me to do he's like push on my feet so I push on his feet and give him that contact to kind of help his feet come back and we're just in the hallway so I'm pushing on his feet and I push him as he crawls all the way into the playroom and then when we get in there he gets up because now he's out of the freeze and he goes right into a... fight response and gets out the bop bag and just beats up the bop bag so we went from freeze to coming out of freeze to fight response.*

**The body survives.** Two participants specifically discussed the “body as a resource” and the idea of “normalizing” for the client what they are experiencing in their bodies. In discussing whether she would alter her techniques with a client based on the type of trauma he or she experienced, Participant B stated:

*...the underlying structure which is kinda basically a lens for understanding what is happening physiologically and... it is this very specific process and you know it's like this is how your body does survival you know um and so that part there's nothing to alter because that is how we're hard wired.*

Participant A spoke about how the body gives us information about how it survived:

*Okay you know I think I'd [be] starting with their body is a resource and kind of even normalizing like some people get frustrated like why do I jump every time I hear a loud noise well that's a startle response... and normalize it like your body is meant to do that that's how it protected yourself um so kind of explaining those steps of what your body needed to do the fight or flight freeze and letting them know that's a good thing instead of bad...*

Finally, Participant I spoke about educating clients on how responses have helped them in the past to survive but are now hindering them:

*I think it's helpful for them to understand strengths to understand that their symptoms have been often that they were survival things that they had to do to get through difficult situations they're not bad or weak or anything like that they are normal for the situation that they were in but now they've gotten stuck in these patterns, um, so I think it takes some of the shame helps deal with some of the shame that people have about having symptoms, feeling weak, feeling like failures and so forth.*

### **The Importance of Treatment Proceeding at the Client's Pace**

The second theme was the importance of treatment proceeding at the client's pace. It was important to go slowly, determine the client's readiness and sense of safety, ensure that the client was adjusted and settled in the present environment, balance moving forward without flooding, and educate and coach the client.

**Go slowly.** Six out of ten participants noted the importance of going slow or "slowing down" as needed to obtain the best therapeutic results. While discussing how her education, skills, and training had informed the way she works with trauma clients, Participant F stated:

*It [SE] has taught me to slow down, to take people's story in small pieces, to very much balance their story [and] their traumatic experiences with a higher dose of positive so that... when they go back to talk about their traumatic experiences their memories about them are much less intense and upsetting.*

Participant H discussed the risks and benefits of SE:

*...it is a slow gentle therapy... a person can have a lot of trauma and you go in...real slow it's not intrusive basically you're not going into the trauma you're going into the experience that's associated with it the sensations associated they might not be associated with this trauma it's the way their body is organized they go into this hyperalertness or...numbing and that's kinda what we work with it's less exposure oriented basically that doesn't mean you can't make big mistakes you know we all do when we're first starting with clients keep an eye on them cuz they can go into overwhelm without you even recognizing it so that's why it's important to...move at a real slow pace.*

Participant A, when responding about her favorite part of the SE training thus far, stated:

*...kind of just slowing people down enough to get into their bodies and...orientating to the room even moving in here...from the waiting room to here and just not jumping in right away just letting clients learn to you know it's weird but where do you wanna sit where is more comfortable for you and sometimes we gloss over all of that stuff but if you slow it down enough then they know okay I want to sit over here versus being close to the door and...how even that plays a part of like them knowing and getting in touch with themselves...*

Finally, Participant J emphasized the importance of going slowly when she described

how the body can be cleansed by being “heard”:

*... SE is very deep and it's usually a real huge kind of...relief because then your body can really heal like it's been purged you weren't ignoring me when you went in for that surgery you weren't ignoring me you were actually doing what you needed to do so [I] can accept this healing person's knowledge and skill when you come back to it and slow it down and say now I'm gonna give you the attention that you wanted during that time that I couldn't because I was...anesthetized and I was in pain so I couldn't do it then but when I come back in a SE session and am given huge opportunities for the body to say hey I want to be heard what was that like to be laying on your stomach having somebody open up your back and when it slows down enough so you can actually experience it, it is actually quite profound.*

**Client readiness and safety.** Six participants spoke about ensuring the client was “comfortable” and “willing” to engage in the specific SE techniques. Participant J spoke

about providing comfort, safety, staying connected, and building the therapeutic relationship:

*I want them to feel comfortable enough to explore whatever it is to feel safe, enough to go to a deep enough place where there's connection with themselves, and where they are able to get to what is going on...it's really relationship-oriented therapy with Somatic Experiencing being a way to get there.*

When responding to a question about if he would alter his techniques based on the type of trauma clients experienced, Participant H stated: "It's really about them feeling comfortable in their own skin basically or um confident...they can...deal with things you know feel comfortable in their body."

Participant I spoke about helping clients to access internal resources:

*...finding the skills or places in oneself that again are comfortable or comforting or um regulated or, um, positive in in tone or whatever so... they need something to fall back on before they get into the heart of the traumatic work.*

Finally, while discussing the overall research question about her view on why Somatic Experiencing works for treating trauma, Participant A stated:

*I definitely talk with the client see where they're at what their comfortability is with it um their willingness to kind of tap into the body. Sometimes with clients... they don't want to do that so, um, then I kinda back off with Somatic Experiencing but will maybe ask them questions about...how does that feel in your body [a] little kind of just touching the surface of Somatic Experiencing if they're not... willing to go there but if they are then ... it's kind of their willingness and wanting to their curiosity of it... I think sometimes certain days you know people just want to talk versus checking in with the body so then it'll...definitely be directed by the client um and... I certainly... can put in my... thought of okay this is a body thing let's see if you're comfortable going there but gently also kind of going there with them.*

**Client adjusted and settled within present environment.** Six participants spoke about the importance of keeping the client "oriented" and "grounded". When asked about how she would help a client use the body to promote change, Participant J spoke

about building awareness, and assessing what is both comfortable and stressful for the client:

*...so the orienting is one way of helping people to become more aware of when am I comfortable in my body and when am I experiencing something that's causing me to have that fight flight or freeze reaction and then all you're doing is tracking and following the neurology of it as best you can by watching different things that they do with their body...*

In response to the same question, Participant B spoke about promoting safety awareness without producing overwhelm in the context of building a relationship:

*...to me that's the skill and that...is how to safely and appropriately help people start to be present and aware of what's going on in their body in a way that is helpful and useful and doesn't overwhelm them and I have lots and lots of different ways and a lot of it is just really putting out a sort of a starting place but really tracking what's going on at all levels...what happens in their body what's happening in their physiology what's happening in their words all of those kinds of things and, um, it is very much of a relational process.*

Participant A added to the question by adding her approach if the client was dissociating:

*So...if a client was starting to dissociate I would bring them...back into their body I would ask them like what...if any part do they feel right now in their body is it your foot can you feel your feet on the ground can you feel yourself in the chair and start to...really work that part and then that [they] can feel that [in the] here and now and sometimes it might be a little bit more directive like okay I need you to...feel your feet I'm bringing them back down then...to their feet or their ear whatever [it] may be [that] they can identify in the present...if they can hear my voice focus on that and what does that feel like...*

Finally, Participant E spoke about her own experience with helping her daughter adjust and settle in her environment after a trauma:

*So you just become much more aware it helps me parent like when my daughter fell off her bike last spring and hurt her elbow but we just sat there I said don't get up we just sat and you know I comforted her of course and while I was comforting her um you know make sure there wasn't an immediate emergency of course first but...her body started doing what it's supposed to do she started orienting I didn't tell her what to do I didn't tell her what she was doing either I just let her do it she just started like slowly doing this orienting which is what her body needed to do cuz she ran over a*

*stick or something and she didn't know it was there it flipped her so her body didn't know what happened so this orienting helped her come back to... being able to be secure in its environment and then when she was settled she got back on the bike and we still ended up having to go to the ER because there was a bump on her elbow and we didn't know if it was broken or not and it wasn't but... I think that... knowing that helped prevent that from becoming another trauma for her.*

**Balancing moving forward with not flooding.** Six participants spoke about utilizing the “client’s history as a guide”, and of those six, three noted that they “continue to assess the client’s tolerance level” and three noted “not overwhelming” the client was key.

Participant H talked about the balance needed: “You really want the client to experience what...they’re feeling in their body and so... you want to contain them...that’s the name of the game is containment so that they don’t go into overwhelm or dissociation.”

Participant H brought up the importance of history when determining if SE is appropriate for a client: “I think it’s always appropriate for clients [when using] Somatic Experiencing...the history is probably the main way and how much trauma is in the history [if the] person has a lot of trauma in the history...”

Participant B spoke about assessing and understanding a client’s ability to be in his or her body so there is no overwhelm while discussing how to help a client use his or her body:

*... just helping them be aware of what’s going on in their body without being sucked in and drowning in it kinda being overwhelmed and flooded by that... In general, you know, if somebody isn’t in their body I’m assuming they have some pretty good reasons for not being aware of it and so I want to as much as I can have an understanding of why they aren’t in their body... I wanna know the exit routes. Other days, people talk about it differently...but just basically I don’t want to go into anything that has the potential to be overwhelming unless I know how we’re going to get out of it...and then so the specifics of that really depend on the person because...some folks have a lot of trauma.*

Participant A discussed how she would utilize scaling techniques when talking to clients about what they were sensing in their bodies:



*Yeah that's a good way to... help them kind of put words to it so I think you know I can use scaling is a great one...is it okay if you're feeling tight...how much is that tight you know is it one through ten is it ten being really tight is it a ten you can use that throughout the session um also kind of giving them...a laundry list of...things is it tight is it open is there a flow you know what does that flow feel like...is it a fast flow or a slow one is there temperature is there color image anything to make that experience more kinda just come alive and for them to feel that.*

Participant B also spoke about assessing and finding a balance in order to establish pace:

*That's part of doing the SE, um, is that...talking piece and that going back and forth, but it's sort of...there and I think that's the skill is when it's useful to use words and when it's useful to work with the body and...how you move back and forth and when you should move back and forth.*

**Educate and coach client.** Finally, four participants talked about being sure to educate the client by “explaining” and “being clear” with them, while also approaching them as a “coach” that is “curious” and is “inviting” them to “try out” these techniques.

Participant D spoke about coaching and skill building with the client when determining if SE is appropriate for a client:

*I'm asking...them to be able to observe um and to be able to report and to track and to be able to be curious about their experience and I'm also doing a lot of coaching so that...it becomes less...a therapy that I'm doing to them and more skills that they are learning so that they can learn how to use them themselves.*

Also speaking to how she helps determine if SE is a fit for a client, Participant G stated:

*Well I...think it's appropriate it's just whether or not the client wants to go there so...I think it's always appropriate and...I'll offer it to the client or I'll do some education around it...but ultimately it's up to them to choose...so I mean in particular...if there's been a lot of...long history of trauma...I think it's very useful then...*

Finally, Participant I, when discussing how to help clients utilize their bodies to promote change, stated:

*I'm pretty...clear with clients...this is an approach I use this is some of the...basic principles the reason for doing them is this I kinda give a cognitive framework for this... rather than...just going off in all directions I like the cognitive framework so I*

*give clients a cognitive framework this is why what would you be interested in would you be willing to try that sort of thing...*

### **The Importance of Client Empowerment**

The third theme was the importance of client empowerment. The client was empowered through building distress tolerance, developing a positive resource toolbox, increasing independence, and improving the ability to manage symptoms.

**Build distress tolerance.** Seven of ten participants specifically mentioned that clients can “tolerate emotions and sensations better” as the result of gaining empowerment through SE treatment.

Participant H discussed how he determined if SE is appropriate for a client:

*I mean you have to go slower [it] might take a little longer...but the main thing...you can generally see within the first couple sessions...how things are gonna progress if they're able to ah be in their bodies and stay with those difficult sensations that then ah it can move along more quickly and [they can] resource themselves...knowing that...they're safe in the present and that the sensation's gonna shift after a while...as long as they're able to be in their body...it can move along fairly quickly.*

Participant E responded to the question about patterns seen in clients making progress:

*...maybe they learn that there's a lot of sensation in their body...they become more grounded they become less reactive to situations that used to really activate them...those situations don't activate them in the same way anymore they can control their temper better...*

Participant I also addressed this question:

*...people coming to understand...to not be panic-stricken by big emotions to understand that that they can in fact learn to tolerate them and kinda let them...experience and let go of those things...they don't have to be upset by...a big emotion or big sensation that they experienced in the body so they're doing a better job of learning to just understand okay it's here I can cope I can live through this it's gonna go away and so that sort of capacity for understanding that they have some*

*resilience and that they're not gonna be overwhelmed by everything that happens to them and that they don't have to rush to change that...don't have to flip into avoidance or drinking or...whatever the things they have done previously to avoid feeling what they feel and it's okay to feel what you feel and so that I think is an attitude change that I've seen in a number of clients that...just tolerate the sensations and let them pass through their body is an advance for a lot of people*

Participant A spoke about similarities and differences in treatment outcomes for SE and other body-based treatment methods:

*[In] Somatic Experiencing you can work through that so that the intensity level the nervous system isn't jumping...when they hear the door slam maybe they can complete that...trauma response that maybe didn't get completed and so now it's not stored there anymore so the outcomes are...much better for the client that they can work through what they didn't get to work through and...they're not as activated anymore.*

**Develop positive resource toolbox.** Five of ten participants talked about the client “developing their own toolbox”, “building on positive resources”, and developing ways to “self-soothe.” Participant F stated the following about SE in general:

*...to very much balance their story their traumatic experiences with...a higher dose of... positive so that...when they go back to talk about their traumatic experiences their memories about them are much less intense and upsetting*

Participant G spoke about not forgetting the positive when working to help the client strengthen the self:

*...clients um usually gloss right over that so... [let's] say whatever happened they just to give an example a promotion at work and they [say] “yeah, but” or well let me go back to that the negative stuff which is important to go there but also...I'm constantly coming back to yeah but this great thing just happened and so let's give that its...time to shine because we give the other...gunk its time to shine which it needs but on an equal basis and I'm constantly saying this it's that obvious that's due its respect so what is that getting them to feel that deeply just really relish in what that positive thing's gonna mean so we always start off with a positive resource and we always end with positive and really just allowing the body to linger because they're not going [to do] that on their own I mean we don't [do this] enough especially clients who are experiencing trauma never do that so that's so huge[ly] important it's a gift really to give them I think.*

Participant I spoke about helping the client teach his or her self to soothe emotions and manage sensations in preparation for deeper trauma work when helping the client use his or her body to promote change:

*After that, assuming the client is willing than my first aim is to help a client do well at first help the client develop resources so [there is] more access to...states in which they actually feel comfortable rather than uncomfortable so that in whatever way [that] would be step number one step number two would be helping the client develop ways to self soothe so that they can figure out if they're... [having] some sort of surge or uncomfortable sensation that they actually have some things that they can do to help themselves experience this navigate it calm themselves down so whatever it is so to help them kinda soothe and stabilize their emotions both of those I think are necessary before they can actually get into the trauma.*

Participant C spoke about building up a client support base so as to improve distress tolerance and treatment outcomes:

*...facilitate my client acquiring a solid place to stand inside themselves with resources and from that place once that's established then we touch that yucky stuff and then we come back and then we touch it again and then we come back but that solid base of resources and support and whatever....if they don't have that they're gonna be tipping into the hole...really easily...and so I will do well by them if I help that happen.*

**Treat trauma quickly and deeply to integrate the whole person.** Four participants described SE as offering “quick” results once the discharge of energy has occurred. Four participants described SE as going “deeper” than other trauma treatments and therefore contributing to the client’s sense of empowerment. Three participants characterized SE techniques and results as being “all- encompassing” and “pervasive”. While responding to a question regarding the average length of time she might see clients, Participant C stated:

*This is an effective, quick - I mean it's like get to the heart of the matter and the piece that I love is access[ing] that person's individual body/spirit wisdom and it goes way beyond what I could ever make happen...*

Participant G spoke about the release a client has through discharging energy while working with SE techniques as one thing that had been a favorite part of her training:

*Wow this is really being just gripped it's like wow or whatever it is in the body... so being able to notice that and then as it shifts...it's just freeing so it just shows you how deep this stuff really is the memories you experience...*

Participant I spoke about the third dimension in trauma work being in the body and the bigger change that she has seen come about:

*I have found it to be extremely beneficial and very exciting because you do see changes in people that you know just didn't happen with... just staying with the cognitive and the affective realms adding in this other dimension I think has just made a huge difference.*

Participant G spoke about SE and the similarities and differences in treatment outcomes:

*It brings it full circle um so yeah people get better and they...live very healthy lives...but I don't...see the full circle sort of aliveness I guess I think can happen when you really tap into...the internal ah states of being but hey it still works CBT you know I have done CBT ah with clients not...currently...*

**Client increases independence.** Four participants brought up that the client “standing up for themselves” and “becoming less dependent” were signs of empowerment. Participant C stated the following about patterns in clients making progress: *I will hear from clients that they are accessing tools within themselves to use when I'm not around I thought about what you said I remembered what we did...*

Participant D stated the following in response to the same question:

*Their vision gets better we could say that...when our nervous system has been in flight or fight mode under attack vision both physical vision and...our abstract vision of the options kind of narrows I mean people will actually get tunnel vision when they're under attack when they are able to develop some resiliency and confidence in their ability to deal with things their nervous system settles towards the end of the process some people will say wow colors look brighter has that always been there I never noticed that before and that's all based in physiology*

Participant E regarding changes that she has witnessed in clients demonstrating their increasing autonomy and independence:

*...and in turn people...as they become more aware of their own self and their own body they actually end up having better boundaries they become more aware of their own personal space they become more able to say no to people which is hard for a lot of people especially for a trauma victim to say no and they start to connect with their own sense of...power and choice and control without everybody else having control over them and they get triggered less often.*

Participant H stated the following regarding the dramatic changes he has seen as clients make progress in SE treatment, including increased independence:

*...she feels confident she feels empowered she feels like she can handle anything now and we really didn't work on a lot of stuff...recalling particular incidents it's just about how do you feel...and what do you experience in your body you talk about your relationship...with your mom what would you imagine you'd like to happen what would your body...feel like what would it want to do...so it's going through movements and...when that energy discharges you have a different client...it's really that the rewarding things about SE sometimes you don't know it's amazing how it works once that energy's out how the client has more room in the body...the container is emptied so to speak and...they feel very good about themselves and can handle anything and this client it was like the mom was kind of the child and she was kind of the adult just because of the petty stuff they used to argue about.*

**Client increasingly able to manage symptoms.** Finally, four participants specifically brought up “symptom reduction” as being a sign of progress toward the goal of “trauma resolution.” Participant I spoke about SE producing more progress for the client and bigger relief in symptoms in less time when responding to question nine about similarities and differences in treatment outcomes:

*I have found SE to be hugely helpful in just helping people make progress um it's really quite extraordinary the degree to which people can escape from traumatic experience from the past...when they've been... in therapy many times many years and when you see them being more comfortable and achieving more relief in a period of a few weeks or a few months compared to years previously by incorporating body into everything else that you're doing there's no doubt in my mind how useful an intervention it is...the one client I mentioned that had all the dissociation last summer she said how come after six months I've made more progress than the last seven years*

*of therapy...and that's not because of me it's because the method was more appropriate to her needs and her experience*

Participant F spoke about how SE techniques can improve one's quality of life when discussing the risks and benefits of SE: *Hmm benefits they resolve their trauma, they feel better, they feel, they live, they participate in life, they don't cry and they don't shut down.*

Participant A spoke about patterns she has seen in clients that are making progress:

*...I think...first off would be awareness of their body sort of what they're noticing but also an element they're less anxious less...depressed...or they're not getting as riled up when somebody tells them something negative where they are maybe not um feeling it as much inside...so it goes back to the body of seeing changes in their body but that affects their mood too...*

Finally, Participant D spoke about how SE can help improve client symptoms:

*Well SE is...very good with certain things particularly good with anxiety and trauma and anything that involves the autonomic nervous system and what happens to it...when there is real or perceived threat so that by extension that also includes depression...fears... all kinds of anxiety disorders.*

## Discussion

This research explores the views of mental health practitioners utilizing Somatic Experiencing (SE) techniques with their clients affected by trauma, and what they see as contributing as to why SE works in the treatment of trauma. The participants in this study both support and add to the current literature. This section examines the consistencies between recent studies and the current findings from this research as well as the differences and emerging themes that presented during the research. The themes from this study are then further examined in relation to the literature review.

### **The Importance of the Client Increasing Body Awareness**

**The body leads.** One way that clients can increase body awareness is by letting the body lead (B1). Following the body assists both the therapist and the client by leading them where to go in treatment even if the client is not yet aware of it. This subtheme is minimally supported in the literature. Price (2007) found that a positive change in an outcome variable titled body investment was strongly correlated with the reduction of dissociation levels in study participants. Body investment referred to how one viewed their body and tended to behave toward it. It included the following elements: attitude, feeling, body care, body protection, and comfort in touch. If one can invest in his or her body, he or she is, in a sense, trusting it and can then choose to follow where it leads. This study by Price differed from the present study in that it considered body-oriented therapy in general with a very specific population, whereas the present study regarded a very specific body-oriented therapy called Somatic Experiencing and outcomes with trauma in general. The present study illustrates the importance of allowing the body to



do what it is going to do, so as to let the client become more aware of his or her body and body experience, therefore assisting the client in developing a more friendly relationship with the body.

**The body speaks.** It is important to pay attention to the body and notice when it is speaking. The body communicates feelings and sensations. This subtheme is also minimally supported in the literature. Upon qualitative analysis, Price (2005) discovered that the participants in her study whom had more of a body orientation focus developed a somatic perspective, in which they were learning specific strategies to access somatic experiences and increasing their awareness of senses and feelings. This refers to the body speaks (B2), in which participants were understanding and making connections within their body from what their body was saying to them as a way to increase body awareness.

Price (2007) found that a positive change in another outcome variable, this one titled body association, was strongly correlated with the reduction of dissociation levels in study participants. Body association referred to one's connection to the body, both physically and emotionally. If one can associate with one's body on all levels one can, in a sense, more accurately decipher when the body is speaking, thereby increasing body awareness. As noted above, this study by Price differed from the present study in that it looked at a general therapeutic technique with a very specific population, whereas the present study focused on a very specific therapeutic technique with trauma in general. The present study illuminates the idea of the body as a resource that the client can utilize to connect what his or her body is saying to what it is thinking and feeling by paying attention and noticing such things as body position changes.

**Finish what the body started.** Somatic Experiencing is, in essence, primarily about finishing what the body started that it did not get to complete due to specific traumatic responses. Schulz addressed finishing what the body started (B3) in her 2010 study. She stated that when clinicians examined bodily or emotive responses during the interactive experience, this informed them that the clients seemed to be experiencing the interaction on a deeper level, which then suggested involvement of the limbic system. This involvement was a factor in authentic integration. Schulz (2010) also touched on the overall theme of body awareness when she mentioned that gaining awareness is a main goal of therapy. Working with the body through awareness allowed clients to heal on a level beyond conscious thought. It was further mentioned that there was greater awareness of one's internal processes. The present study stresses hooking treatment to the physiological responses, instinct, and the limbic brain where trauma happens; allowing the freeze fight flight responses to happen; and the discharge of energy to address fear, shame, and rage within the client.

**The body survives.** Body awareness includes the knowledge that one's body instinctively knows how to survive and it therefore behaves in whatever ways are necessary to ensure this. Interestingly, there is no mention in the literature of subtheme four, the body survives (B4). Although only a few participants talk about this, the researcher feels it is important enough to discuss in the findings and to consider as an aspect of body awareness that needs further attention. It is important for us to know that we are not crazy, that our bodies are doing what they are doing to help us survive, that we can acknowledge this, sit with it, and release it. The present study features the concept of

normalizing bodily responses for the client in order to teach that his or her body is meant to respond and protect them, resulting in symptoms that are part of his or her survival.

### **The Importance of Treatment Proceeding at the Client's Pace**

The mental health practitioners interviewed for this study agree that proceeding at the client's pace is essential to the success of Somatic Experiencing in the treatment of trauma. This theme is mentioned in the literature as well. Schulz (2010) stated that the main goal of therapy is regulating, which refers back to theme two, in that one can best stay regulated if he or she is allowed to proceed at a pace that is comfortable for them. Schutt (2011) reported that a positive effect for clients includes a deeper connection with self-empowerment because healing is from the client, not the therapist.

**Go slowly.** At the heart of proceeding at the client's pace is not rushing, and ensuring that things move slowly. Going slowly (C1) is also seen in the literature. Schutt (2011) referred to moving slowly in order to process memories without retraumatizing the client. Things are slowed down to make them manageable. Schulz (2010) discussed slowing down, giving the client permission to slow down and notice, and the therapist naming what he or she is seeing from the client. The present study underscores the importance of going into the experience associated with the trauma with the client and addressing different aspects of the experience in smaller pieces so that the body feels heard.

**Client readiness and safety.** Client readiness and safety (C2) refers to if the client feels safe and ready to go into the body experience. Schutt (2011) noted that showing respect for the client, being non-judgmental, and ensuring client readiness are all important. Schutt also emphasized the positive effects for clients of body-oriented

therapies, including providing safety and relief because then the client felt they were being heard and held. Schulz (2010) stressed that a factor influencing the effectiveness of body based therapies was the client's capacity to do the work, i.e., were they comfortable enough and were they willing. She also noted that a sense of safety aids in the therapeutic process. The present study emphasizes that a client has some comfort with his or her body, feels safe enough, and is willing to access and go into the body.

**Client adjusted and settled within present environment.** The importance of the client being present, in his or her body, and able to feel sensations and emotions, cannot be overemphasized. Schutt (2011) touched on the subtheme of the client adjusted and settled within the present environment (C3), emphasizing a focus on sensation, wondering, and staying present with trauma. She also talked about grounding the client so as to better tolerate what needed to be processed and staying present. The current study highlights the goal of orienting and tracking client's body responses in order to help them remain present and focused so that the body and mind can stay connected and on the same page.

**Balancing moving forward with not flooding.** When utilizing SE techniques, the practitioner continually assesses the progression of the treatment and the client's tolerance level in order to attain a balance between the client moving forward and keeping the client contained enough so he or she does not flood and/or experience overwhelm. The subtheme of balancing moving forward without flooding (or overwhelm) is mentioned once in the literature but is greatly emphasized by the participants in this study. Schulz (2010) found that factors influencing the effectiveness of body based therapies included intervention timing (i.e., when to intervene) and

therapist attunement with the client through assessment, both of which helped to avoid producing overwhelm in the client (C4). This particular subtheme of the present study is expressed by participants to be of vital importance when utilizing SE techniques with trauma clients. It is also articulated by many of the participants to be the main reason why they prefer using SE to other trauma treatments; i.e., there is a greatly reduced chance of flooding or overwhelm developing in the client using SE than any other trauma treatment they apply. The present study points out that the practitioner needs to consider the client history and move slowly back and forth between the positive and negative resources so that the client can become more aware without flooding.

**Educate and coach client.** In order to truly proceed at the client's pace, the practitioner educates the client on all options and coaches the client by guiding and encouraging his or her own decision-making. This subtheme, educating and coaching the client (C5), is seen throughout the existing literature (Schutt, 2011; Schulz, 2010; Leitch, Vanslyke, & Allen, 2009). Schutt (2011) found that preparation for body-oriented psychotherapy included educating the client on the cycle of trauma and the connection between the mind and body. Schulz (2010) highlighted that clinicians utilizing body-oriented psychotherapies in trauma saw themselves as guides who were there to assist clients by tracking for changes in and pointing out slight alterations. They were there to guide clients through corrective experiences and promote trust in the process. They utilized education to explain the trauma response of the body. Leitch, Vanslyke, and Allen (2009) briefly mentioned utilizing psychoeducation in the treatment groups in their study. The present study maintains that the practitioner should ask, express his or her

curiosity, and clearly explain his or her reasoning to the client to ensure the client is always aware there is a choice.

### **The Importance of Client Empowerment**

**Build distress tolerance.** It is important when utilizing SE techniques to assist the client to build distress tolerance. The client (as well as the practitioner) needs to know what he or she can handle; he or she needs to feel and experience and sit with those sensations and emotions as long as possible. There is no mention of this subtheme in the literature, although it is emphasized by most participants in the study. It is a little surprising that building distress tolerance is not specifically referred to or even mentioned in the SE studies, given that it is an essential step when utilizing SE techniques with trauma clients. This may be due to the brief nature of the intervention and limited contact with participants. The present study articulates the importance of the client being in his or her body and staying with sensations and emotions as long as possible, so that he or she realizes that sensations and emotions shift and move, their intensity decreases, and he or she can then experience less reactivity and have more control.

**Develop positive resource toolbox.** This subtheme speaks of helping the client gather and utilize tools to care for/soothe themselves. There is no mention of this subtheme in the literature, although it is emphasized by most participants in the study. It is also surprising that developing a positive resource toolbox is not specifically referred to or even mentioned in the SE studies, given that it is also an essential step when utilizing SE techniques with trauma clients. This could also be due to the brief nature of the intervention and limited contact with participants. The present study affirms the

importance of the practitioner helping the client to balance accessing and acknowledging the positive along with the negative so that he or she can know and feel the difference and have positive resources to draw from going forward.

**Treat trauma quickly and deeply to integrate the whole person.** Another way that Somatic Experiencing techniques empower trauma clients is by treating the trauma quickly and deeply, thereby integrating the whole person (E3). In other words, SE appears to be a truly holistic way to treat trauma, both in theory and in application. This subtheme is supported in the literature. Schutt (2011) reported that a positive effect for the client in body oriented psychotherapy as a treatment for trauma is getting to the root of the issue where complete healing and transformation can occur. Boy (2004) showed that body therapies are seen as more effective (going deeper), and are quicker, more integrative, holistic, and transformative than talk therapies alone. Clients agreed that talking does not go deep enough. The body awareness clients attained made an affective connection possible so one could heal on the deepest level. The present study indicates that SE gets to the “heart of the matter”, that something “shifts”, there are changes, and the client develops an “aliveness” which practitioners find quite difficult to describe.

**Client increases independence.** As clients venture through treatment applying Somatic Experiencing, their level of independence increases and empowers them for significant change (E4). One participant of the present study mentioned that it was like he had a different client altogether as his client’s independence grew. There is no mention of this subtheme in the literature. It may be that because all of the studies utilizing SE were done in a natural disaster situation with limited time for intervention and inability to follow up with participants in depth, that increasing client independence

was unable to be assessed. The present study accentuates a client's increasing independence as consisting of such things as accessing his or her toolbox without the presence of the therapist; seeing/experiencing things differently; possessing better boundaries; and connecting with his or her own personal power.

**Client increasingly able to manage symptoms.** The emotional and physical pain of trauma can be so distressing; no wonder one may concentrate on just trying to feel better. It is no surprise, then, that managing symptoms and symptom reduction (E5) is seen throughout the literature, particularly in regard to the reduction of trauma symptoms. All three studies utilizing Somatic Experiencing that are introduced in the Literature Review discussed trauma-related symptom reduction, whether they specifically referred to the arousal, intrusion, and avoidance symptoms associated with posttraumatic stress disorder, or dissociation symptom reduction, or reduction in trauma-related observed and reported symptoms (Leitch, Vanslyke, & Allen, 2009; Parker, Doctor, & Selvam, 2008; Leitch, 2007).

Schulz (2010) also mentioned that trauma symptoms decreased in intensity and longevity in participants in body-oriented therapies. Participants in the present study specifically mention the reduction of depression and anxiety symptoms they see in their clients. The present study asserts that SE provides more comfort and relief in a shorter amount of time and less shut down for the client than other treatment methods.

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

Social work practice can be enhanced through a continued emphasis on the mind-body connection when working with clients affected by trauma, as well as assisting clients in



gaining body awareness, and the ongoing development of the therapeutic relationship. Other implications for social work practice include proceeding at the client's pace and empowerment of the client (also themes of this study). Finally, through participation in personal sessions, the building of his or her own toolbox, increasing body awareness, and the healing of his or her own personal trauma, the clinician (social worker or otherwise) can begin to know themselves better and thus more effectively assist clients in healing trauma through the utilization of Somatic Experiencing.

### **Recommendations for Future Research**

The recommendations for future research include a combination of both those of the participants as well as those of this researcher. This is due to the fact that this is an exploratory research study wherein minimal research has been done to date. Thus, inquiries are made of the participants as to their opinions on the subject.

Participant B expressed ideas about comparing SE to other approaches and what works best with different populations:

*...I would love to see research with SE but more research on kind of understanding all the different ranges of approaches...and the strengths and weaknesses of the different approaches as a comparative thing rather than trying to pick a winner... kind of more articulation of what kinds of ways of working work with different kinds of people and ages and diagnoses and traumas and...what is similar and what are differences when do you know...*

Participant B went on further to discuss research aimed at the mind-body connection:

*...to really understand how whatever's happening in your mind and emotion is also being expressed and reflected and communicated on a body level and that sort of starting to...really look at those correlations because...in my experience that is always happening...but there aren't that many studies out...*

Participant E talked about some more specifics related to potential studies:

*I think it'd be great for people to track some clients...going through their SE therapy um and to track symptoms prior to the start of therapy and symptoms after that would be awesome. I'd like to see [a study] with a survivor of childhood abuse physical or sexual...and... chronically their symptoms before and after treatment.*

Participant I spoke in general about a potential research design:

*...we need...to do...outcome studies... ...you don't want to be constrained too much by one protocol... ...it seems like it would be very doable to do an outcome study on...clinical populations with trauma who are then treated with something like SE and see what kind of change in functioning symptom relief etcetera that you get.*

To summarize the above statements, the participants' research recommendations include: comparing Somatic Experiencing to other trauma treatment approaches and what works best with different client populations; keeping at the forefront the role of the mind-body connection in further SE research; research that tracks client symptoms before, during, and after SE treatment; and a research design that allows one to follow the client over time and is not restricted by protocols.

In addition to the recommendations from participants in this study quoted and summarized above, this researcher has recommendations for future research. As not all trauma is experienced the same by each individual, and there is not one trauma treatment that works for every person, studies that explore how to effectively combine SE with other therapies and techniques (i.e., integrated trauma treatments) is needed. Some of the mental health practitioners interviewed for this study have already begun doing this.

Research that aims to investigate how SE can best be applied when working with different kinds of trauma (e.g., developmental trauma, combat trauma, and trauma from surgery) can shed light on any nuances in these varied traumatic experiences. Finally, any research that can further demonstrate that Somatic Experiencing works in the

treatment of trauma, and how it works, is important to establish a solid evidence base, particularly in light of insurance companies' tendencies to cover treatments and services that have done so.

### **Strengths and Limitations**

This study examines mental health practitioners' views on why Somatic Experiencing works for treating trauma. The study has both strengths and limitations. One strength is that the interviewees are given the opportunity to provide lengthy and more in-depth responses due to the nature of a semi-structured interview over a survey or structured interview. A second strength of the current study is the participants' diverse work settings and areas of practice. Many are in private practice, sometimes in an office, other times in an office in their home. They are in private practice with other practitioners or on their own. They work with professionals who are first responders to community crises and volunteer their time with individuals in crisis who come for counseling at a walk-in clinic. Two of the participants also coordinate and assist with the Somatic Experiencing trainings. Although varied in work settings and areas of practice, they all bring valuable experience and knowledge obtained through the application of SE techniques with people involved with multiple traumatic situations.

A third strength is that the research conducted and the results obtained from the study add to the body of knowledge in an area that is fairly new and just beginning to establish an empirical base. A final strength of the study is the participation of ten participants. Although this is a small number for a study done in a short amount of time, their participation is a testament to the importance of this topic to SE providers. The SE

community is still quite small, and the fact that this researcher receives the response she does in the short time frame speaks to the importance of SE as well as to the amount of interest and excitement around sharing the kind of results they have seen in their direct practice.

There are several limitations in this study. The small sample size and convenience sampling eliminate the ability to generalize the information found to a larger population. It is a limitation that not all participants were interviewed face-to-face, specifically in regard to being able to have the benefit of the nonverbal communication from the interviewee, as well as easier to follow-up with any questions about their responses. A final limitation is the lack of direct experience or first-hand accounts from the clients themselves; the viewpoints of clients are solely represented through the practitioners' lenses.

## **Conclusion**

The purpose of this research project is to explore mental health practitioners' views on why Somatic Experiencing works for treating trauma. The participants of this study bring years of experience and a wealth of knowledge related to working with clients affected by trauma, working with the body, and specifically utilizing Somatic Experiencing principles and techniques in their practice. The little existing research on Somatic Experiencing and how it works in treating trauma is primarily of quantitative design and is applied only in a community setting, emphasizing statistical analysis and short answer survey collection from groups of people who had experienced the trauma of different natural disasters. The researcher felt that more in-depth information was needed

as to the efficacy of Somatic Experiencing when applied in individual therapeutic settings and gathered from the very mental health practitioners providing the services. Their stories are provocative and informative in ways quantitative data cannot express. Many findings in this project are supported by existing literature, either directly or indirectly. Still, in this researcher's opinion, the findings from this study add a whole other dimension to this as yet understudied treatment technique.

Bringing the body into therapy provides an opportunity for clients to connect with their own inner capacity for healing, and a way for clients to live in a more embodied, integrated way. Somatic Experiencing provides clients with the tools to become more aware of their own body, and to use this awareness to process and regulate emotions in order to work out future issues on their own. Somatic Experiencing builds on the ideas of resilience, and awareness of the present experience as key factors in allowing clients to work through issues in their own time, while becoming more aware of themselves and their interaction with others in their environment.

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## Appendix A

### Letter of Recruitment

Dear Mental Health Professional,

I am writing to you as a graduate student in the program of Clinical Social Work, at the University of St. Thomas and St. Catherine University. Currently, I am conducting research that explores mental health practitioners' views about Somatic Experiencing and why it works as a treatment for trauma. This is occurring under the supervision of my graduate advisor, Kari Fletcher, ABD, MSW, LICSW. My research is specifically oriented toward looking at the application of these techniques within individual treatment settings. I am interested in hearing your experiences with trauma, Somatic Experiencing, and body-oriented psychotherapies. In order to do so, I am inviting you to participate in an audiotaped interview. This interview will contain questions that will investigate such things as factors that affect if and how these techniques are applied with certain clients, how the body is utilized to promote change utilizing these techniques, and patterns seen in clients as they progress in treatment and begin to heal from their traumatic experiences.

In order to participate in this study, you must be a licensed mental health professional and you need to currently use Somatic Experiencing techniques in your practice. In addition, it is also important that you have experience working with trauma victims utilizing these techniques. The interview should take approximately one hour. Access to your taped interview will be limited to myself and the transcription of the interview may be accessed by either myself or my research committee. Throughout the duration of the interview you may decline to answer any questions that are presented.

Your participation will add to the existing research regarding the application of Somatic Experiencing techniques with persons experiencing traumatic symptoms by providing the perspective of why and how they work within individual therapeutic settings. It will also contribute to the much-needed body of empirical research that explores the effectiveness of these therapeutic interventions, specifically when working with trauma. I hope that you decide to take part in the interview. Please feel free to contact me with questions or concerns you may have at the phone number or e-mail listed below.

Sincerely,

Michelle Olssen

## Appendix B

### CONSENT FORM UNIVERSITY OF ST. THOMAS GRSW682 RESEARCH PROJECT Mental Health Practitioners' Views on Why Somatic Experiencing Works for Treating Trauma

I am conducting a study about Somatic Experiencing as a treatment for trauma. You were selected as a possible participant because you have been trained in and/or are practicing Somatic Experiencing techniques with individuals who have experienced trauma. I am interested in hearing your perspective. I invite you to participate in this study. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Michelle Olssen, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Kari Fletcher.

#### **Background Information:**

The purpose of this study is to explore mental health practitioners' views on why Somatic Experiencing works for treating clients with trauma in individual therapeutic settings.

#### **Procedures:**

If you agree to be in this study, you will be asked to: commit to a time and location for the interview, sign the consent form prior to beginning the interview, and to participate in the audio taped interview itself. Interviews are anticipated to last approximately one hour in length. Due to the length of the interview and the subject matter that will be discussed, a somewhat private meeting place is desired.

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

There are no identified direct risks or benefits to participation in this study. There is no compensation for participation in this study.

#### **Confidentiality:**

The records of this study will be kept confidential. The audio tape of our interview will be used to generate transcriptions, after which the tape will be destroyed. The information gathered in the interview will be used anonymously to formulate my research paper. I will do so by exploring commonalities and differences in the content of the interviews. In addition, I will give an oral presentation regarding my findings. All information and materials pertaining to the interview will be kept in a locked file in my home. This is where all materials will stay until my research is complete and then it will be properly disposed of. The audiotape and transcript will be destroyed after use. A transcription of the interview will possibly be viewed by my committee members for the purposes of data analysis. The content of the interview is for educational purposes only and will not be discussed in any nature outside of the University of St Thomas. Specific examples

that are described in the interview may be used in the findings of the research. Any information that is applied to this research will be free of identifying information, on both the part of the client and the interviewing clinician.

**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 will be utilized for purposes of this study.

**Contacts and Questions**

My name is Michelle Olssen. You may ask any questions you have now. If you have questions later, you may contact me or my instructor, Kari Fletcher. You may also contact the University of St. Thomas Institutional Review Board 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. I am at least 18 years of age.

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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**

## Appendix C

### Research Interview Questions

1. Can you tell me a bit about your job role?
  - a. In what ways has your education, skills, and training informed the way that you work with clients when treating trauma?
2. How long have you worked with clients experiencing trauma? How long have you been practicing body based methods?
3. How long have you been practicing Somatic Experiencing techniques with clients? Are you fully certified or in the process of being trained?
4. What is the average length of time that you see clients utilizing body based methods?
5. How do you determine if Somatic Experiencing and/or other body based methods are appropriate for the client? Do you have certain guidelines? Do you consider factors such as diagnosis, symptoms, type of trauma, and level of trauma (simple or complex) in your determination?
6. Do you alter your techniques based on the type of trauma clients have experienced? If yes, how so? If no, why not?
7. How do you utilize the body to promote change in traumatized clients, in relation to body based methods in general, and Somatic Experiencing more specifically?
8. What patterns do you see in clients that make progress (i.e., in their thoughts, feelings, behaviors, body awareness)?
9. Compared to other body based methods or other trauma treatments in general, what are the similarities and what are the differences in treatment outcomes for clients treated with Somatic Experiencing?
10. What are the risks and benefits of Somatic Experiencing techniques?

11. Are there limitations to utilizing Somatic Experiencing as a sole treatment for persons who have experienced trauma? If yes, how so?
12. Where do you see the need for future research regarding Somatic Experiencing as a treatment for trauma?