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# Embodied Healing: Clinician's Perspectives on Somatic Interventions for Trauma

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Embodied Healing: Clinician's Perspectives on Somatic Interventions for Trauma

by

Sarah L. Lazarewicz, BA

MSW Clinical Research Project

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of  
Master of Social Work

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

### **Abstract**

The focus of this research was to gain insight into the perspectives of clinicians on their experiences employing Sensorimotor Psychotherapy with clients who have experienced trauma. The conceptual framework used for this research project was based on modern attachment theory and interpersonal biology. To explore the research topic, qualitative research methods were employed to gather the experiences of mental health practitioners who currently use Sensorimotor Psychotherapy, examining why they view this model as an effective intervention for the treatment of trauma. The sample consisted of four licensed mental health professionals who currently use Sensorimotor Psychotherapy with clients who have experienced trauma. All participants had completed the Level II Trauma Training for Sensorimotor Psychotherapy and currently work in private practice. Data was collected through the use of semi-structured, in-person interviews, and analyzed through the use of grounded theory techniques. After analysis of the transcripts, three main themes emerged: 1) Importance of creating safety within the therapeutic relationship, 2) Use of mindfulness and somatic resourcing, and 3) Use of experiential practices. Strengths of this study include the gathering of the nuanced perspectives of clinicians working in the field with clients who have experienced trauma and the use of in-depth interviews that allowed the researcher to capture the voices of clinicians in their own words with a richness and depth unavailable with quantitative data. Limitations of this study include the small sample size, potential participant bias towards somatically focused therapies, and the lack of varied practice settings among participants.

*Keywords:* Sensorimotor Psychotherapy, somatic therapies, trauma treatment

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This paper is dedicated to my mother, Laura Loring, who is the true reason I turned towards the field of mental health and began the long, winding road towards graduation. Thank you for your gifts, both seen and unseen.

Endless appreciation to my chair, Courtney Wells, for her patience, clarity and encouragement, and to my exceptional committee members, Sean Fields, Angela Lewis-Dmello, and Hannah Michel. Your insights, guidance, and comraderie have been enormous gifts along this road. Thank you!

And to all of the clients I have had the privilege of working with and all those struggling to create a life after trauma, whose resilience, tenacity and incredible humanness inspired this work and continually remind me of what is possible, despite the odds.

*This being human is a guest house  
Every morning a new arrival.  
A joy, a depression, a meanness,  
some momentary awareness comes  
as an unexpected visitor.  
Welcome and entertain them all!  
Even if they are a crowd of sorrows,  
who violently sweep your house  
empty of its furniture,  
still treat each guest honorably.  
He may be clearing you out for some new delight.  
The dark thought, the shame, the malice,  
meet them at the door laughing,  
and invite them in.  
Be grateful for whoever comes,  
because each has been sent  
as a guide from beyond.*

~Rumi

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Traumatic experiences, such as war, sexual assault, physical violence, genocide, torture and emotional and psychological abuse, have long been a part of human existence. However, cultural and scientific understanding of trauma and its impact on the human psyche has developed gradually throughout history. Early psychological practitioners such as Sigmund Freud and Jean-Martin Charcot focused a great deal of their explorations of the human mind on illuminating the effects of traumatic experiences (Emerson & Hopper, 2011). Since the inclusion of posttraumatic stress disorder (PTSD) in the DSM-III (American Psychiatric Association, 1980), considerable research has been devoted to understanding the effects of trauma on the mind.

In the last 15-20 years, major developments in the field of neuroscience have dramatically increased our understanding of the immobilizing effect trauma can have on the body's natural stress response systems, shutting down the brain's ability to effectively tolerate stress (Ursano, Zhang, Li, Johnson & Carlton, 2009). We now understand that trauma deeply affects both the brain and body - not just a person's thought patterns. Many of the most distressing symptoms of PTSD and other stressor related disorders involve a cycle of environmental or internal triggering and activation of unconscious physical mechanisms related to the stress response. While the physical symptoms of trauma are widely understood, current first line treatment methods such as cognitive behavioral therapy (CBT) focus primarily on the thoughts and feelings related to the disorder, rather than distressing physical arousal that often plagues trauma survivors (Fisher & Ogden, 2009).

To address this gap in treatment, clinicians have suggested that traditional cognitively based therapeutic treatments, which focus primarily on the thoughts and feelings associated with trauma, may be ineffective at combating some of the most distressing symptoms that are

hallmarks of trauma – constant re-experiencing of the event itself, intrusive thoughts, and general hyperactivity in the body’s natural stress response system (Ogden, Pain, & Fisher, 2006). Clinicians and researchers have begun to note the lack of treatments that can address the full sequelae of somatic and cognitive symptoms that are characteristic of traumatized individuals (Langmuir, Kirsh, & Classen, 2012).

In response to these conflicts, a new group of therapies aimed at incorporating body awareness into traditional forms of talk therapy have emerged. This group of treatments, which I will describe as “body-oriented psychotherapies”, includes a variety of therapeutic methods that attempt to address the non-verbal stress responses housed in the body following trauma. Sensorimotor Psychotherapy is one example of these emerging treatments designed to combat both the cognitive and somatic symptoms associated with traumatic stress (Ogden, Minton & Pain, 2006). Founder Pat Ogden observed how the symptoms of trauma prevented clients from living in the present – they existed in a constant state of either avoiding reminders of the trauma or re-experiencing the trauma when triggered by environmental cues (Fisher & Ogden, 2009). For the survivor, the traumatic experience created the inability to remain in the present moment. Sensorimotor Psychotherapy has evolved into a comprehensive therapeutic model aimed at healing trauma by beginning with the body. In Sensorimotor Psychotherapy, the body is used as a locus for therapeutic processing of the trauma.

The present study will summarize the relevant literature related to the treatment of traumatic stress and will present evidence for the use of the body-oriented treatment modality known as Sensorimotor Psychotherapy as a treatment for trauma. To analyze the clinician’s experiences implementing Sensorimotor Psychotherapy as a therapeutic intervention for trauma, the researcher interviewed four clinicians trained in this method, inquiring into which elements

of the method have led to the abatement of trauma related symptoms for their clients. Research methods for gathering data are described and the findings presented using direct quotations from individual interviews. Finally, an interpretation of the findings and suggestions for future research are discussed, as well as strengths and limitations of the study.

## **Literature Review**

### **Trauma: Definitions and Prevalence**

*The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) defines a traumatic event as one in which the witness is exposed to “actual or threatened death, serious injury, or sexual violence” (APA, 2013, Posttraumatic Stress Disorder section, para. 1). The term “trauma” is frequently used interchangeably to represent both the traumatic event, as it was experienced in the moment, as well as the emotional aftermath following the event itself (Ford & Courtois, 2009). Indeed, trauma practitioners have long noted that it is this spiritual and psychic wounding, lasting long after the bruises and physical scars have healed, that makes the experience of trauma so devastating. Traumatic events may include sexual or physical abuse, sexual assault, domestic violence, war, genocide, torture or acts of terrorism. What unites these markedly different contexts and experiences is the tendency to overwhelm the victim with a state of horror, terror, or helplessness.

While initial DSM-5 criteria for the stressor-related post-traumatic stress disorder (PTSD) diagnosis describes a traumatic event as one “outside the range of normal experience” (Black & Andreasen, 2014, p. 67), current epidemiological research indicates that the majority of adults (60% of men and 51% of women) have experienced at least one potentially traumatic event throughout their life course, suggesting that a traumatic experience is quite common (Straussner



& Calnan, 2014). A landmark study conducted by the Centers for Disease Control and Kaiser Permanente on Adverse Childhood Experiences (ACES) found that as many as two-thirds of adults are exposed to at least one form of psychological, physical, or sexual abuse, household physical violence, or family dysfunction in childhood (Felitti et al., 1998). These results indicate that exposure to traumatic events is far more common than initially believed.

Despite the prevalence of traumatic experiences, most people who are exposed to a traumatic event will not go on to develop psychopathology. A study of the U.S. general population found that while 21% of survey respondents reported exposure to at least one traumatic event, only 5% of those went on to develop PTSD (Perrin et al., 2014). Notably, the study found that women were more than twice as likely as men to develop PTSD. Additional studies have shown that sexual abuse and assault hold the highest risk for a subsequent PTSD diagnosis (Hapke, Schumann, Rumpf, Ulrich, & Meyer, 2006; Perrin et al., 2014). Other risk factors related to the development of PTSD include: the nature and repetition of the event (sexual assault, abuse, and being the victim of a crime were most highly correlated with PTSD), preexisting psychological or substance abuse disorders, witnessing violence, neuroticism, as well as problem-focused coping strategies (Perrin et al., 2014).

### **Nature of Trauma: Types of Traumatic Experiences**

Because traumatic events can encompass such a wide range of experiences, trauma researchers have noted the importance of categorizing traumatic experiences and resulting disorders by the nature and severity of the event itself. In her classic text on childhood traumas, Terr (1991) categorizes traumatic experiences into two categories – Type I and Type II. “Type I” or “Single blow” traumas are single-incident occurrences in which the event is out of the blue, unexpected, or sudden (Terr, 1991). Examples include traumatic accidents, natural disasters,

terrorist attacks, single episodes of abuse or assault, or witnessing violence. Terr (1991) distinguishes these single blow traumatic events from “Type II” or “Long-standing” traumas, which are described as prolonged and repetitive, frequently of an interpersonal nature. Examples include ongoing sexual or physical abuse, domestic violence, community violence, war or genocide. While children suffering from both types of trauma experience considerable distressing symptoms, Terr (1991) notes the severity of symptoms accompanying Type II traumas in survivors. Experiencing repeated trauma, often at the hands of a caregiver or trusted adult creates a sense of anticipation that can result in “massive attempts to protect the psyche and preserve the self” (Terr, 1991, p. 15). When children experience constant victimization at this critical time in their development, they develop coping skills to survive the abuse that become deeply intertwined with their personality and identity. Coping skills such as denial, psychic numbing, self-hypnosis, dissociation, and rage, serve to help the child survive the abuse at the time that it occurs. However, these coping mechanisms frequently transfer into severe psychopathology later in life, creating complex symptom presentations and disorders.

Recent research on childhood trauma has expanded on Terr’s (1991) Type II category. An entire field of developmental trauma research has emerged to document the dramatic impact early childhood trauma can have on the developmental trajectory of the child (D’Andrea, Ford, Stolbach, Spinazzola & van der Kolk, 2012). The term “complex trauma” has been proposed to describe repeated, prolonged trauma experienced in childhood (Wamser-Nanney & Vandenberg, 2013). Research has begun to show that traumatized children present unique symptom clusters rarely observed in adults with PTSD or other trauma-related disorders (Wamser-Nanney & Vandenberg, 2013). For example, children who have experienced repeated victimization frequently display significant problems with affect regulation and interpersonal conflict

(D'Andrea et al., 2012). Multiply abused children have trouble understanding and expressing emotions, display increased aggression and are frequently unable to regulate their own extreme emotions (D'Andrea et al., 2012). Research indicates these severe problems in affect regulation for survivors of complex trauma are due to the lack of a healthy attachment relationship with a parent or caregiver (Ford & Courtois, 2009). This healthy attachment relationship provides the child with an important model for self-soothing and regulation of emotions (D'Andrea et al., 2012). Researchers have stressed the need for a developmentally appropriate trauma diagnosis that can specifically account for the complex coping mechanisms and problems of identity and affect regulation observed in children and adults with a history of prolonged, repetitive traumas (D'Andrea et al., 2012; Ford & Courtois, 2009; Wamser-Nanney & Vandenberg, 2013). Differentiating between single incident and “complex” trauma, as well as the differences in age of onset, is an important step in creating more effective treatments for trauma.

### **Impact of Trauma: Symptoms of PTSD**

The symptom presentations associated with trauma-related disorders such as PTSD are often highly complex. As previously mentioned, traumatic experiences of a prolonged or interpersonal nature frequently have the most severe symptom presentations. Symptoms required for a diagnosis of PTSD fall into four clusters: 1) persistent re-experiencing of the event, including intrusive thoughts, flashbacks or dreams, 2) avoidance of stimuli associated with the event, including avoiding thoughts, activities and persons that bring up memories related to the event, 3) changes in worldview and affect, including feelings of detachment and estrangement from others, inability to experience full range of feelings, and a sense of a lost or foreshortened future, and 4) increased arousal, including difficulty sleeping, irritability or angry outbursts, difficulty concentrating, hypervigilance or exaggerated startle response (Schiraldi, 2009).

Schiraldi (2009) suggests that trauma survivors vacillate between re-experiencing the traumatic event, becoming aroused and then making attempts to avoid the symptoms: the cycle begins when the individual is thrown back into the original event, reliving the feelings and physical stress response of the event when triggered by external or internal cues (thoughts or reminders of the event). The individual then becomes physically aroused, experiencing the racing heart, sweating and bodily activation that accompanied the original event. The cycle is completed when the individual then makes either conscious or unconscious attempts to avoid this highly distressing combination of symptoms, employing numbing (restricting all emotions, including joyful and positive feelings along with negative, upsetting feelings) or other strategies such as dissociation, as a means to escape such distressing feelings and sensations (Schiraldi, 2009). According to Ogden et al. (2006), this cycle of stimulation, arousal and avoidance keeps the trauma as unprocessed fragments within the person's memory, disrupting the normal integration process that typically follows a stressful event. This disruption "leaves the survivor with a somatic experience that is linked to overwhelming negative emotion and maladaptive cognitions that is readily activated by both internal and external cues" (Langmuir et al., 2012, p. 214).

One of the hallmarks of trauma and stressor-related disorders is over- or under-active physical arousal. Following a traumatic event the body becomes hypersensitive to even small stressors. "PTSD is characterized by extreme general physical arousal and/or arousal following exposure to internal or external triggers. The central nervous system has become sensitized by an overwhelming trauma" (Schiraldi, 2009, p. 8). Symptoms from this cluster may include: elevation of certain stress hormones in the blood, elevated heart rate, elevated blood pressure,

hyperventilation, tightening in the chest or stomach, lightheadedness, sweating, tingling, cold and sweaty hands (Schiraldi, 2009).

Despite the centrality of these distressing physical symptoms in trauma symptom clusters, current empirically validated therapeutic interventions for treating trauma (such as CBT and exposure therapy) do not involve methods for combatting the intensified physical stress response and autonomic arousal evoked by exposure to traumatic events (Ogden et al., 2006).

### **Sensorimotor Psychotherapy**

**History and theoretical foundations.** Developed by Pat Ogden in the 1980s, Sensorimotor Psychotherapy is a comprehensive psychotherapy model aimed at addressing both the cognitive and physical symptoms of PTSD and other trauma related disorders (Fisher & Ogden, 2009). While working with severely traumatized patients in an inpatient psychiatric clinic, Ogden observed that traumatized clients appeared to be “hijacked” by their body’s physical stress response and were often deeply disconnected from their bodies. She also observed that traditional talk therapies appeared inadequate at addressing the elevated stress response and autonomic physical arousal that proved so distressing for traumatized individuals. Blending knowledge and techniques from traditional psychodynamic and cognitive therapies with emerging knowledge from the fields of somatic psychotherapy, mindfulness, yoga, structural integration and dance, Sensorimotor Psychotherapy uses principles of body-awareness and mindfulness to directly address the habitual trauma responses that have become so imprinted in the bodies and physical responses of trauma survivors (Fisher & Ogden, 2009). The theory behind Sensorimotor Psychotherapy holds that effective trauma treatment must engage all clusters of trauma symptoms, addressing the cognitive (thoughts), emotional (feelings related to

the event or trauma responses), and somatic (bodily sensations) aspects of trauma experience (Ogden et al., 2006).

**“Bottom up” vs. “top down” therapies.** In order to truly combat the elevated stress response and hyper-arousal associated with trauma, Ogden and colleagues (2006) argue that a “bottom-up” (starting with the body) approach is needed. To do this involves noticing the subtle physical sensations, patterns and impulses held within the body following a trauma. Ogden et al. (2006) argue that when a trauma survivor is triggered, their ability to think clearly becomes severely limited. They lose access to the prefrontal cortex, the part of the brain involved in rational decision-making and abstract information processing, and begin operating from the primitive “fight or flight” part of the brain known as the amygdala. In essence, the individual becomes trapped in their pre-verbal stress response, unable to think clearly or process new information related to the event. Sensorimotor Psychotherapy techniques were developed with this neurobiological knowledge in mind. During the psychotherapy session, the therapist consistently directs the client to notice their bodily experience as they discuss their thoughts and feelings related to the traumatic event. As Ogden et al., (2006) put it, “the client’s body gradually becomes his ally rather than his enemy in the process of healing from trauma” (p. 267).

**Sensorimotor evidence base.** While numerous authors have suggested the value of Sensorimotor Psychotherapy techniques (Courtois & Ford, 2009; Ogden et al., 2006; van der Kolk, 2014), very little formal research has been devoted to studying the efficacy of this model in reducing the symptoms of trauma. To date only one research study with human subjects has been conducted on this method (Langmuir et al., 2012). This 2012 pilot study examined the use of sensorimotor techniques with 10 adult women with a history of interpersonal trauma. Subjects participated in 20 group sessions in which participants received education on body mindfulness

and awareness techniques, as well as opportunities to practice techniques and receive feedback from group participants. To determine changes in participants, the authors employed several pre- and post-test measures, including scale scores designed to capture body awareness, body dissociation, interpersonal problems and receptivity to being soothed. The findings revealed significant increases in body awareness, as well as reported improvements in somatic dissociation and soothing receptivity. These preliminary findings suggest that Sensorimotor techniques have the potential to increase body awareness and provide important inroads to reducing trauma-related symptoms.

While little formal evidence exists for sensorimotor therapy, given high dropout rates among exposure-based therapies (Mills & Hulbert-Williams, 2012; Scaer, 2001) and the difficulties associated with providing treatment for patients with complex PTSD, it is clear that alternative trauma treatments are needed. In particular, interventions that employ and engage the body are needed. As van der Kolk (2006) writes:

*Describing traumatic experiences in conventional verbal therapy is likely to activate implicit memories, that is, trauma-related physical sensations and physiological hyper- or hypo-arousal, which evoke emotions such as helplessness, fear, shame, and rage. When this occurs, trauma victims are prone to feeling that it is still not safe to deal with trauma (p. 11).*

The field of body-centered psychotherapy, including Sensorimotor Psychotherapy, offers a unique set of tools and a treatment approaches that incorporate the body and mind in trauma treatment.

Very little research has been devoted to understanding the usefulness of Sensorimotor Psychotherapy in the treatment of trauma. Therefore, it is critical to present research that

investigates the specific techniques and strategies employed by the Sensorimotor psychotherapist in trauma treatment. The research question this study seeks to answer is: what is the clinician's perspective on the body-based intervention known as Sensorimotor Psychotherapy as a therapeutic intervention for trauma? This research is concerned with illuminating how clinicians see clients with trauma histories benefiting from sensorimotor techniques.

### **Conceptual Framework**

#### **Modern Attachment Theory & Interpersonal Neurobiology**

The conceptual framework for this research is based on recent contributions to the field of attachment theory. Neurologically informed attachment theory has provided the theoretical foundation for many forms of body-oriented psychotherapy, including Sensorimotor Psychotherapy, offering a scientific evidence base for their treatment models.

Originally proposed by John Bowlby, attachment theory holds that early relationships with parental figures provide a key way that infants learn to regulate their own emotions (Robbins, Chatterjee, & Canda, 2011). The responsive caregiver (often the child's mother) provides this for the child by what Schore and Schore (2008) call "affect synchrony", in which the caregiver responds to the facial expressions, gestures and states of the child. If the two fall out of synchrony and the child becomes dysregulated, the attuned caregiver quickly responds to the infant's arousal. Thus, it is through the caregiver's attuned response that the infant learns to regulate their own emotions, having first learned this through the delicate dance of "attunement, misattunement, and re-attunement" (Schore & Schore, 2008, p. 11). It is through this transference of emotional regulation that secure attachment is formed. Bowlby proposed that the lack of this infant-caregiver mirroring in infancy could lead to severe impairments in affect



regulation, producing myriad forms of psychopathology in adulthood and perhaps permanently impairing the child's ability to form healthy relationships as she ages.

Modern attachment theory expands and deepens Bowlby's initial concepts by offering a window into the neurobiological elements involved in forming attachment relationships. Like much of the work discussed in the literature review above, these new developments are informed by emerging neuroscientific research, which provides a clearer picture of the key neurological mechanisms underlying healthy brain development. A key element of this emerging knowledge has revealed the crucial role the right brain, the seat of nonverbal communication, plays in conveying a sense of security in these parent-child interactions. Neurobiological research shows that the primary way infants develop healthy attachment is through the caregiver's subtle, nonverbal cues: loving eye contact, facial expressions, subtle variations in the tone of the mother's voice and body postures (Schore & Schore, 2008). Through these cues both the caregiver and infant learn to attune to one another.

Schore and Schore (2008) assert that this new understanding of the right brain's role in promoting attunement and safety demands that therapists utilize the subtle, non-verbal communication conveyed in therapy. Learning to harness the power of these nonverbal, unconscious cues provides a crucial set of tools for deepening the therapeutic alliance and creating a sense of safety that is beyond words. To do this requires that the therapist engage in a process of becoming "attuned" to one's own bodily-based communication, a process known within somatic therapy as "embodiment" (Shaw, 2004). As Schore and Schore (2008) put it,

*The psychobiologically attuned, intuitive clinician, from the first point of contact, is learning the nonverbal moment-to-moment rhythmic structures of the client's internal states, and is relatively flexibly and fluidly modifying her own behavior to synchronize*

*with that structure, thereby co-creating with the client a growth-facilitating context for the organization of the therapeutic alliance (p. 16).*

As we have seen, somatic therapies such as Sensorimotor Psychotherapy are based around this concept of therapeutic attunement on the physical, nonverbal level.

## **Methodology**

### **Research Design**

The purpose of this study was to gather the perspectives of clinicians on their experiences employing Sensorimotor Psychotherapy interventions with clients who have experienced trauma. To explore this topic, qualitative research methods were employed. Qualitative research methods are appropriate when a researcher desires to provide a nuanced, detailed description of a specific phenomenon or topic. Qualitative methods allow the researcher to explore the intricacies of a topic by “talking directly with people, going to their homes or places of work, and allowing them to tell their stories unencumbered by what we expect to find or what we have read in the literature” (Creswell, 2007; p. 40). Specifically, this study explored the clinician's perspectives on Sensorimotor Psychotherapy interventions for trauma through the use of semi-structured in-person interviews.

Data for this study were analyzed through the use of grounded theory techniques. Grounded theory is a qualitative research design in which the researcher seeks to “generate or discover a theory” (Creswell, 2007, p. 63) through the process of research. The creators of grounded theory believed “theories should be ‘grounded’ in data from the field, especially in the actions, interactions, and social processes of people” (Creswell, 2007, p. 63), thus allowing the data to speak for themselves rather than pulling a pre-existing theory off the shelf. According to Creswell (2007), this type of research design is useful when a theory is not available to explain a

process or when a theory is needed to explain how people are experiencing a phenomenon. Because little is known about clinician's perspectives on employing somatic interventions with traumatized clients, grounded theory was an appropriate research design for the current study.

### **Sample**

The sample for this research project included four mental health practitioners licensed to practice psychotherapy within the state of Minnesota. This is a common sample size for qualitative research involving interviews, as a small sample size allows the researcher to engage in a rich, in-depth exploration of the issues brought up in each conversation (Berg & Lune, 2012). Limiting the number of participants allowed the researcher to provide a thorough, nuanced view of clinicians' perspectives on employing Sensorimotor interventions.

In order to qualify for the study, participants were required to have a current license to practice psychotherapy within the state of Minnesota. Licensure was permitted in any relevant mental health related field, such as psychology (LP), social work (LGSW, LICSW), marriage and family therapy (LAMFT, LMFT), or counseling (LPC, LPCC). In addition, all participants were also required to have completed the Sensorimotor Psychotherapy Institute Level I Training, an 8-month long course that provides the basics of Sensorimotor theory and techniques. Participants with from all training levels were welcome to participate, and those with advanced practitioner status were especially encouraged to apply. To qualify as an advanced practitioner, individuals must complete the Level III: Advanced Skills training, which provides formal certification. However, formal certification is not required in order to use Sensorimotor Psychotherapy techniques. Lastly, in order to qualify, participants needed at least one year of experience employing Sensorimotor Psychotherapy techniques with clients who had experienced trauma.

Participants were recruited using purposive sampling, a non-probability sampling method frequently used in qualitative research (Berg & Lune, 2012). In purposive sampling researchers use their judgment or expertise to select participants who possess specific qualities necessary for the research study. This technique was selected in order to locate participants who have knowledge specifically related to employing Sensorimotor Psychotherapy.

To identify an initial list of potential participants, the researcher first conducted targeted web searches for Sensorimotor trained psychotherapists in the Twin Cities Metropolitan area of Minnesota. Names were obtained from the Sensorimotor Psychotherapy Institute's web page, as well as multiple web searches for somatic therapists on Psychology Today's website. Once a complete list was compiled, the researcher then contacted potential participants by email with an initial recruitment letter (see Appendix A – Recruitment Letter). This letter included a detailed description of the study as well as contact information for the researcher. The researcher also conducted telephone calls for individuals who did not have email information listed on public web resources. A total of 19 participants were contacted – twelve via email, and seven via phone. Once a small group of participants indicated their interest in participating, the researcher then followed up with potential participants via email to confirm their participation in the study and set up an interview appointment. Five participants volunteered to participate in the study, and four participants successfully scheduled interviews. Prior to the interview each participant received a consent form (see Appendix B – Consent Form), a demographic survey (see Appendix C – Participant Demographic Survey) and a list of interview questions (see Appendix D – Interview Questions).

### **Protection of Human Participants**

Prior to contacting participants, the researcher submitted a complete research proposal to the University of St. Thomas Institutional Review Board (IRB) for an expedited review. Once IRB approval was received, the researcher began contacting potential participants. Before enrolling in the study, all potential participants received a written recruitment letter detailing the purpose and methods of the study. Once respondents confirmed their interest in participating in the study, a consent form was emailed to them for review. Participants also received an electronic copy of a short demographic survey, which they were asked to print out and complete prior to the interview. This survey contained questions related to the participant's professional training, experience and training in Sensorimotor Psychotherapy, and information regarding their current caseload. To protect participant confidentiality, this survey did not include contact information or identifying information. Each participant was given the opportunity to thoroughly review the consent form prior to the interview. At the time of the interview, the researcher obtained informed consent from each participant, offering an opportunity for participants to ask questions and address concerns related to the study. Participants were informed of the steps the researcher planned to take to keep their personal information and data confidential. Participants were informed that they could stop the interview or withdraw from the study at any time without punishment or reprimand from the researcher. The interview process began only after participants had participated in this informed consent process and agreed to sign the informed consent form.

Interviews were recorded with a digital recorder and transcribed verbatim by the researcher into an electronic word document on the researcher's computer. To protect their confidentiality, participants were asked to avoid using identifying information in their interview, such as their name or place of employment. If identifying information arose during the interview,

the researcher took steps to remove this information from the transcription and did not include this information in any excerpts included in the final written report. Once each interview was complete, audio files were downloaded onto the researcher's password protected computer and assigned a non-identifying pseudonym (such as "Participant 1") in order to ensure confidentiality. Data collected from participants was kept in a password-protected file on the researcher's computer. With the exception of consent forms, which by law must be kept for three years, all research documents such as digital records and electronic transcripts will be destroyed on or before May 22, 2016.

### **Data Collection**

The data collection instrument used in this study was a semi-structured interview. Each interview was conducted at a private location, such as participants' office space or home office, and lasted approximately 60 minutes. The interview schedule consisted of a mixture of open and closed ended questions developed by the researcher, as well as several informal follow up questions posed during the course of the interview. The researcher developed the question set using information compiled through a review of the literature on trauma-related disorders as well as the use of Sensorimotor Psychotherapy as a treatment for clients with a history of trauma. The interview schedule consisted of eleven questions, each focusing on different aspects of trauma and Sensorimotor Psychotherapy. The first question asks for information about the respondent's background experience using Sensorimotor Psychotherapy, including information about their caseload and the number of clients with whom they use Sensorimotor Psychotherapy. The next question focuses on the participant's experience working with trauma survivors, including types of abuse histories and common symptoms observed. Questions on the second half of the question set are focused on the use of Sensorimotor techniques in session, the arc of treatment using

Sensorimotor Psychotherapy techniques, and the participant's thoughts on what makes the model useful for trauma survivors. The question set concludes with questions regarding challenges of using the technique and clients for whom the technique would not work well. The final question asked for concluding remarks on what the participant had learned from their work with trauma survivors.

### **Data Analysis**

Findings from this study were analyzed using grounded theory methods. In grounded theory, the researcher develops a theoretical framework inductively, beginning by examining the specific word-for-word content of the data then gradually developing larger themes by analyzing the findings multiple times (Berg & Lune, 2012).

The first step in data analysis for the current study began with open coding of interview transcripts. In open coding the researcher assigns a short summary or "code" to each sentence of the transcript (Berg & Lune, 2012). During the process of open coding the researcher kept a log of detailed code notes in order to track the researcher's thought process behind each code. Next the researcher identified potential overarching categories or themes. According to Creswell (2007), open coding should help the researcher to identify core phenomena that emerge from the data. These core phenomena were identified by grouping codes that appeared two or more times into categories reflecting the tone or content of particular codes.

Following open coding and category creation, the researcher returned to the data, recoding in order to refine categories identified around the core phenomena. This second coding provided a more focused framework for the researcher to present the data in the final research report, and produced a total of five themes. The researcher chose to combine these final five themes into the three primary themes presented in the findings. To physically code the data

during both open coding and category creation, the researcher used tools in Microsoft Word to highlight units of data using different colors.

## **Findings**

### **Participant Demographics**

For this qualitative research project, the researcher interviewed four therapists licensed to practice psychotherapy within the state of Minnesota. Two of the therapists interviewed were licensed clinical social workers (LCSW), one was a marriage and family therapist (LMFT), and one was a licensed psychologist (PsyD). All four participants had completed Level II of the Sensorimotor Psychotherapy Institute's trainings, and two participants had completed the Level III: Advanced Skills training and received formal certification from the Sensorimotor Psychotherapy Institute. All four participants were currently engaged in private practice where they employed Sensorimotor Psychotherapy with the majority of their clients (80% and above). Total years employing Sensorimotor Psychotherapy with clients ranged from 5 to 12 years. The average years of experience employing SP was 9.25 years.

Participants within this sample had experience treating clients with a wide variety of trauma-related diagnoses, such as posttraumatic stress disorder (PTSD), dissociative identity disorder (DID), panic disorder, and borderline personality disorder. Additional diagnoses included addiction, depression, anxiety, and eating disorders. Participants reported that the majority of their current clients had trauma histories. Specific forms of traumatic experiences encountered by participants included: sexual, physical, and emotional abuse, rape, neglect, car accidents, torture, sudden unexpected death (suicide, murder), traumatic birth, medical procedures, witnessing domestic violence, natural disasters, cultural genocide, and parental addiction.



While all participants reported using Sensorimotor Psychotherapy as their primary theoretical framework when working with clients, additional models employed included eye movement desensitization and reprocessing (EMDR), cognitive behavioral therapy (CBT), and dialectical behavioral therapy (DBT). Alongside these primary models, participants also reported incorporating a wide variety of somatically oriented or mindfulness based trainings, such as gestalt therapy, psychosynthesis, somatic experiencing, interplay, the Hakomi Method, Hendricks body-centered model, the joy of mindfulness program, mindfulness-based stress reduction (MBSR) and mindfulness meditation.

### **Overview of Interview Themes**

Data for this research was collected through semi-structured interviews. In analyzing the data, the researcher prioritized codes and themes pertaining to the research question, which was: what is the clinician's perspective on the body-based intervention known as sensorimotor psychotherapy as a therapeutic intervention for trauma? The researcher was concerned with illuminating how clinicians see clients with trauma histories benefiting from sensorimotor techniques. Data was analyzed through this lens.

After analysis of the interview transcripts, three main themes emerged: 1) Importance of creating safety within the therapeutic relationship, 2) Use of mindfulness and somatic resourcing, and 3) Use of experiential practices.

### **Theme 1: Importance of creating safety within the therapeutic relationship**

A primary theme that emerged from the data was the importance of creating safety within the therapeutic relationship. This overarching theme was coded into several subthemes, including client choice, working incrementally, and client empowerment.

**Client choice and mutuality.** All four participants discussed how allowing the client to choose when and how to enter the body can help instill a sense of safety for trauma survivors. Participant 3 discussed how she incorporates client choice in her sessions:

*Giving them a choice I think is so helpful, asking them, you know you're saying you might wanna focus in on this today – is that the direction you wanna go? Or we could do this, we could work with this...it really gives sort of a gentle approach so that they can sort of move out of something if it feels too much, or not quite right. There's much more mutuality and dialogue.*

**Working incrementally.** Another element of building safety involved working incrementally and moving slowly when beginning to work with the body. This allows the client to slowly develop comfort with noticing their internal body sensations, without feeling overwhelmed. Several participants discussed how they are careful to allow the client to guide the pacing, which can often feel slow. Participant 2 shared:

*The talking is much more minimal. There's lots of pausing, lots of noticing. It's a whole different thing. It's slow. And when I've demonstrated it to other therapists they always go "oh it's really kind of boring to watch", because it's so slow. Somebody's sitting there for a very long time going (gestures).*

Participant 3 spoke frequently about how she incorporates organicity, a foundational concept within the Sensorimotor Psychotherapy model. Organicity is connected to the idea of client choice in that it implies incorporating movement and body awareness into session in an organic way, allowing whatever arises in session to happen naturally without force or coercion:

*So if somebody is sort of averse of even going into the body, I might just state something that pulls them into mindfulness even if it's for a brief moment and if they can't go there,*

*they don't. And then I just follow wherever else we go, right, instead of pushing it or making it my agenda, and so, and I think that takes me some time to work with, or to learn with people too, is like ok, I've got this way of working and I know it'll work, I know it'll be helpful, but again coming back to that organicity, like they'll be sort of ready to work with it in the amount that they can and however much, right, and then it naturally unfolds and it just starts to happen at their own pace.*

*The organicity is something that I just...truly believe in, like people come in, and be able to work through whatever level they are able to, and just letting that sort of unfold naturally is really lovely, so as opposed to just having my own agenda about what the focus should be, they know what it is, and it's where they need to be at the moment, and whatever awareness they have is sort of how it should be, and what their system can handle, I really see that time and again.*

Participant 1 shared how SP has helped her appreciate how a slowed down pacing can actually be better for clients:

*I think it's also really helped me with patience and incrementality. Just realizing that more is not better, faster is not better, that in some cases really slower or less is actually better, in terms of people staying within the window of tolerance or feeling empowered.*

**Client empowerment.** Participants described how this slow, incremental pacing helps clients to feel empowered as they begin to develop more internal resources. Participant 3 described how she sees clients increase their sense of self-efficacy as they learn to soothe and calm themselves in the face of previously dysregulating memories:

*As I work with people and they start to feel more secure [in the] relationship, and start to get more internal resources themselves, all of a sudden these connections from past things that would have previously been too dysregulating to approach start to unfold and these new connections are able to be made without you know sort of causing retraumatization. So that's a piece that I love about it.*

Participant 1 shared similar observations after clients start to develop more skills and familiarity with somatic work: “*You know I think then there is a period of feeling more empowered, just like wow I'm really getting somewhere, this is getting more manageable, I feel more sense of control, I mean that's all helpful.*”

### **Overarching Theme 2: Use of mindfulness and somatic resourcing**

Another primary theme that emerged from the data was the key role of mindfulness and somatic resourcing in helping clients begin to work with the body. Participants frequently spoke about how the body can be experienced as an unsafe place for trauma survivors, so working slowly and helping clients develop tools to tolerate strong internal sensations and emotions is always the first phase of Sensorimotor trauma treatment. All participants referred to this body awareness as *resourcing*, which is a term used in Sensorimotor Psychotherapy to refer to mindfulness and self-regulation skills that help the client notice their body and the sensations happening within it (Ogden et al., 2006). Developing these skills helps clients to soothe themselves when they become dysregulated due to trauma symptoms, and provides a safe, measured way to begin working with the body in therapy.

Participant 3 described how many of her clients do not have well developed self-regulation skills, so she spends a good deal of her time working in the stabilization and resourcing phase:

*...there's sort of an overarching model within Sensorimotor with the different phases, you know, stabilization and resourcing, developing mindfulness skills, ability to auto-regulate, internally regulate. Things like that. So I hangout in that area quite a bit with people, initially. Most of the people that come in to see me don't have much developed for resourcing, I would say most, and so we really hang out in that area for quite some time. And sort of weave in present day experience and then pulling into some mindfulness in some things, and sometimes being really deliberate about right now let's just right now practice some of those things in pulling that down and we'll do it experientially as they're talking about that thing that's either arousing or checking them out.*

Participant 1 shared that stabilization is key in order to make sure beginning treatment doesn't destabilize the client in other parts of their life:

*...you know the first stage, we think of as stabilization, so just making sure that the person's life overall is working well enough that there's not gonna be kind of a you know, avalanche of some kind if we start working on things. So there are people with whom you know I might work on stabilization for a long time cuz they're just not that stable.*

Several participants described how many trauma survivors experience the body as an unsafe place, so this stabilization and resourcing period is a necessary before any trauma processing can begin:

*I think one thing that can be challenging is that for some people, slowing down and being mindful in itself is threatening. Because again there's a lot of charge in the body and part of how they've coped is by just not going there. So people can have ways of which they are usually semi-conscious or unconscious of just avoiding getting into it. So that's always kind of a thing to work with, is like how much to draw attention to that, challenge*

*someone, invite them, versus how much to kind of just let them go with their own pace, kind of let them keep their defenses in place if they need them.*

Another participant described how mindfulness and somatic resourcing provides a way to help clients soothe the physical activation they experience when attempting to connect with their physical sensations:

*If you're going to work with the body then you really do have to work with both mindfulness and somatic resources, or all you're gonna get is activation. And that's really not fair, I think that was actually part of what I saw in the earlier work that I alluded to that didn't work, was people being encouraged to go into the body but with no real map about trauma. And then in the body is all the residue of the trauma.*

Another participant shared how disconnecting from internal experience can be a coping mechanism the client used to survive traumatic experiences, so addressing this is key to entering the resourcing phase:

*The resourcing, the focus on that internal regulating, so often for people with trauma histories, they find all kinds of strategies to disconnect from internal experience, which helped them survive, so that just happens automatically, so being able to help them relearn or even teach if the trauma was young young, ways to be with themselves in a way that doesn't cause distress. I think that feels amazing to be able to watch that happen for people, and to offer that really gentle kind of approach.*

Once clients develop fluency and begin to feel confident in their self-regulation skills, they frequently experience a sense of empowerment. Participant 1 shared this:

*So then they can actually process without getting flooded and without retraumatizing themselves. And they also feel empowered. Cuz they feel like wow I can really touch into*

*this, but I can also pull back if it's too much, you know I can touch in with it and I can manage to stay with this as long as I don't go too far too fast. So they really start to have some sense of control, which is a lot of what the trauma has taken away. So I think all those things are really effective.*

### **Overarching Theme 3: Use of experiential practices**

Another strong theme that emerged from the data was the central role of experiential practices within Sensorimotor Psychotherapy. Engaging the client in mindfulness and movement practices within the session is a major element of every SP session. One participant shared how the goal of engaging the client in experiential exercises, whether it be body tracking through mindfulness or the physical movements SP is known for, is to help clients develop the ability to use the mindfulness skills on their own:

*Ideally what you want is to be training the client to notice themselves, otherwise you're not really doing it. You're doing physical therapy or something, if you're just telling somebody, try standing up straight. What you're asking somebody to do or training them to do is to notice themselves, does your body like standing up straight? You want them to be noticing it, and for it to be coming from inside, like oh I like that part.*

Participants described a wide variety of techniques they might use in session to engage the client in movement. For clients who are nervous about working with the body, this might be done in very small ways, such as Participant 2 described:

*So on this end, it might only be 2 minutes out of the hour. And the rest they're talking. But if we're just a minute I may say, "so it seems like you're really angry and you've got a fist going, go ahead and try just hitting something soft. Go like that (hits pillow). And*

*they go “well that feels kind of good.” But then that’s about all they wanna do. So it’s just a little slice. So they respond positively. But they’re normally quite reluctant.*

One participant described how she would guide a client to notice the present moment as a way to begin working with movement in a session:

*So then I’d have them come in and pay attention to their body. And then I switch to present moment. What are you noticing in your body right now? I keep trying to steer them back to the present if they wander. Does your body wanna make that movement now? Or I see your hands are already moving, would you like to follow that...then they’re following that. We’re working organically. Eventually they get to something that feels good. Then I emphasize that. And then in the last third of the hour there’s something new that’s happened.*

Another participant described guiding a client to imagine what certain actions might feel like:

*And another thing with the body, if they’re talking about, when they’re in the midst of talking about the trauma, and I say ok what does your body wanna do? I just wanna kick that guy. I say “do it.” And I have them imagine, I say feel it in your body, you’re gonna kick this person, to get them off you or something. Anything that they can – they can talk about it, they can feel it, but by golly the body is the last thing to let it go. You can change a thought, you can change a feeling, but it takes longer for the body to let go of it.*

Another participant shared the importance of tracking defensive movements, and using these as a way to help clients explore movement:

*There also might be defensive movements, or kind of the impulse towards defensive movements, you know movements that maybe the person doesn’t even know, yeah, she*



*wants to turn, or she wants to block, or she needs to push, or do this, or you know, and often that isn't full blown, sometimes it is, sometimes a person's like "oh I just need to do this" but sometimes it's more like, oh I just feel a lot of tension in my shoulders. And so then I'll say, you know, is there some kind of impulse to move. Well I kind of feel like doing this. Ok well why don't you do that, go ahead and do that more. Well I really just wanna do this. Ok, so then sort of letting the whole thing follow until the whole defensive movement has come out. And that's part of the nervous system kind of completing the memory, is getting to do what it didn't get to do to protect itself. So we go all the way through the memory til it's done.*

### **Discussion**

This study sought to understand the clinician's perspective on the use of Sensorimotor Psychotherapy as a therapeutic intervention for trauma. The researcher was concerned with illuminating how clinicians see clients with trauma histories benefiting from Sensorimotor techniques. The following section will present an overview of findings supported by the literature. Implications for practice, implications for future research, as well as strengths and limitations of this study will also be explored.

### **Findings Supported by the Literature**

**Client-therapist partnership.** A number of this study's findings are consistent with the literature on therapeutic work with trauma survivors. The importance of an active client-therapist partnership in establishing safety when working with trauma survivors is a major theme that emerged in the data. According to participants, a large part of experiencing trauma has to do with loss of control. They stated that returning a sense of control to the individual who has experienced the trauma is identified as a crucial aspect of establishing a climate of trust and

safety when working with individuals who have experienced traumatic events. They shared that this is accomplished by allowing the client to direct the session, selecting the level of intensity, or determining the nature of activities used to address the trauma. The importance of client-therapist partnership was supported in the literature reviewed by the researcher. For example, Ogden et al (2006) assert that like all traditional psychotherapeutic models, good therapeutic alliance is a crucial aspect of Sensorimotor Psychotherapy. Strong therapeutic alliance is additionally important within Sensorimotor Psychotherapy because the therapist assumes the role of somatic guide, noticing subtle changes within the client's posture or body language and providing entry points for the client to access undischarged defensive responses (Ogden et al, 2006). The role of the Sensorimotor trained therapist is to provide attunement to the client in understanding their physical sensations and connecting them to the thoughts and feelings associated with the bodily experience.

**Mindfulness.** Another major theme that emerged in the data was the use of mindfulness as a tool for calming the nervous system and creating safety. Participants frequently stressed the importance of directing the client's attention to their immediate physical experience and surroundings as a way to calm the nervous system when the autonomic stress response starts to kick in. This technique of using mindfulness as a way to "resource" the client and calm the body's stress response is directly supported by the literature. Mindfulness techniques such as these are an important part of Sensorimotor Psychotherapy, but are employed across a wide range of treatment modalities such as mindfulness-based stress reduction (MBSR) and yoga interventions (Cukor et al., 2009; Emerson & Hopper, 2011). Research indicates that mindfulness techniques are an effective treatment in improving scores on Mindfulness Skills and Acting with Awareness scales (Cukor et al., 2009). Cukor et al. (2009) found that at least three

clinical studies supported the use of mindfulness as a method for reducing trauma related stress and staying in the present moment.

Not only do clients receive direction on how to do this in session, but the Sensorimotor therapist also works directly with the client to ensure they can practice these skills on their own. As each of the four participants emphasized, teaching clients the ability to self-regulate when they become dysregulated helps to empower the client. As the client develops more “resources”, they become more confident in their ability to tolerate the strong physical charge and emotions accompanying trauma memories. This finding is supported by other research focusing on the effectiveness of Sensorimotor Psychotherapy. In their study on the use of Sensorimotor Psychotherapy in group work, Langmuir et al. (2011) observed: “as clients strengthened their ability to use somatic resources they were more successful at identifying the antecedents of flashbacks and other dissociative symptomology and eventually improved their ability to stay present in the here and now” (p. 219). Participants in the present study noted similar observations as they watched clients become more aware of their own triggers following practice with mindfulness and somatic resources in session. Similarly, participants noted that this mindfulness training and use of self-soothing techniques serves as a way to prepare clients to do more in-depth trauma processing. This finding provides an important clue towards why Sensorimotor Psychotherapy is beneficial for trauma survivors – other trauma therapies do not focus so extensively on creating safety prior to entering trauma memories.

For example, Scaer (2001) notes that while exposure techniques used in cognitive behavioral therapy have been shown to reduce arousal symptoms in individuals with PTSD, the flooding or dissociation that may accompany such techniques has the potential to be deeply retraumatizing for clients. Scaer (2001) warns: “intense arousal and re-experiencing may

duplicate the original traumatic experience, and without a concomitant internal and external environment that incorporates a sense of safety and empowerment, the victim may move immediately into freeze response” (p. 162). As the findings from this study revealed, the extensive period of safety, stabilization and somatic resourcing characteristic of Sensorimotor Psychotherapy treatment may be a key reason this modality can be potentially effective for use with trauma survivors. Participants shared that Sensorimotor Psychotherapy is unique in the extensive emphasis on resourcing the client with mindfulness and self-regulation skills prior to any trauma processing. All four participants in this study spoke of how this first phase of stabilization may be much longer in Sensorimotor Psychotherapy than in other therapies. This finding suggests that this extended stabilization period may be an important missing piece in other trauma therapies.

### **Implications for Social Work Policy & Practice**

This research suggests a number of important implications for social work practice. As documented in the literature review, current research regarding rates of traumatization has been shown to be quite high among the general population (Felitti et al., 1998; Perrin et al., 2014; Straussner & Calnan, 2014). Given these statistics, clinical social workers currently practicing in the field are likely to encounter clients with trauma histories. It is therefore crucial that institutions devoted to social work education and training, such as undergraduate and graduate social work programs, include the most current research regarding symptoms, assessment, and treatment of trauma. Because many clients who have experienced trauma are resistant to therapy or drop out of trauma treatment (Mills & Hulbert-Williams, 2012; Scaer, 2001), this education must include not only well-documented treatment models such as CBT and EMDR, but also lesser-known, alternative therapies such as Sensorimotor Psychotherapy. In order to make these

treatment modalities more accessible to clients, policy mandating the inclusion of alternative trauma therapies of this kind should be included in nationwide standards regarding social work education, such as the National Association of Social Workers and the Council on Social Work Education.

However, before these policies are implemented, clinical social workers who work with highly traumatized populations, such as domestic violence survivors and sexual assault survivors, can begin to incorporate many of the mindfulness and body-awareness techniques described in this study into their individual and group work practices, offering clients a unique set of tools previously lacking in the literature regarding trauma treatment.

### **Implications for Future Research**

As mentioned previously, very little is known about the effectiveness of alternative trauma therapies such as Sensorimotor Psychotherapy (Langmuir, et al., 2012; Fisher & Ogden, 2009). While many trauma researchers and practitioners have noted the importance of studying the efficacy of alternative trauma therapies, very little work in this area has occurred (Cukor et al., 2009). The preliminary findings of the current research study indicate that body-awareness and mindfulness techniques may provide excellent resources for traumatized clients to process traumatic memories and begin to tackle the unconscious physical arousal and somatic symptoms that accompany traumatic experiences. Further research into the techniques and theory behind Sensorimotor Psychotherapy is needed to better understand the mechanics of this emerging technique. Future research should concentrate on clinical trials in order to establish an evidence base to prompt greater use of the technique, as well as encourage further funding for this modality.

Additional research is also needed regarding what factors contribute to client readiness for working with mindfulness and body-based therapies. Participants in this study spoke of the many barriers traumatized clients experience when they begin to approach body-based work, and more research is needed to understand why some clients are able to approach body-based work and others are not. Similarly, more research is needed exploring how clients who are highly averse to entering the body might begin to learn techniques such as those employed by the participants in this study. This is a crucial area of study, as this treatment model is not available to many clients because of this aversion.

### **Strengths and Limitations**

**Strengths.** One of the primary strengths of this study is that it gathered the nuanced perspectives of clinicians working in the field with clients who have experienced trauma, an area that is currently unaddressed in the literature concerning Sensorimotor Psychotherapy. The use of in-depth interviews allowed the researcher to capture the voices of clinicians in their own words, documenting their beliefs and perspectives on their work with a richness and depth that is impossible to provide with quantitative data. Documentation of practitioners' perspectives and experiences using body-based therapies with clients who have experienced trauma is notably missing from the current literature regarding Sensorimotor Psychotherapy and trauma-focused therapies. Similarly, the use of a semi-structured interview provided the researcher with enough flexibility to follow participants towards important concepts and revelations, regardless of whether it was specifically related to a planned interview question or not.

As mentioned in the literature review, emerging understanding of trauma's impact on the brain has created a new framework for the treatment of traumatized individuals. While somatic psychotherapies such as Sensorimotor Psychotherapy have emerged as a proposed synthesis of

existing clinical skills and theoretical knowledge, very little research has been devoted to understanding clinician's application of this model. The current study is aimed at exploring the myriad ways somatically oriented clinicians are integrating this developing theoretical knowledge into their practice. Despite the small sample size of the current study, the use of purposive sampling allowed the researcher to select individuals with vast practice experience in the field of Sensorimotor Psychotherapy, providing important insights into this developing area of practice.

Another key strength of this study is the sheer amount of practice experience with Sensorimotor Psychotherapy participants in this study possessed. All participants in this study had at least five years of experience using Sensorimotor Psychotherapy with clients. In addition, all four participants used Sensorimotor Psychotherapy with the majority of their clients and considered it their primary theoretical orientation. Given that Sensorimotor Psychotherapy is a relatively new treatment model, and advanced practitioners are uncommon due to the length of training and small size of training institutes, it is remarkable that all participants in this study had such extensive experience employing this model with clients. This vast experience provided participants in this study with a wide variety of client experiences and contributed to the depth of the data presented.

**Limitations.** One potential limitation of the study is that the researcher targeted therapists who are currently employing Sensorimotor Psychotherapy techniques with clients. The use of purposive sampling, while providing richness in qualitative data, may also indicate a potential bias towards employing body-based techniques over other forms of trauma therapy.

Another limitation of this study is that all four participants currently practice Sensorimotor Psychotherapy with clients in private practice settings. Participants lacked

experiences using this technique with clients in additional settings, such as inpatient and outpatient clinics, residential facilities, and group settings. Additionally, participants practiced exclusively with adult clients. Further research exploring the use of Sensorimotor techniques with child, adolescent, and elderly clients is needed to illuminate the usefulness of this model.

An additional limitation of this research is lack of generalizability due to the small sample size. Because the sample is quite small, it is not possible to generalize the results of this study to the larger study of trauma and trauma treatment.

### **Conclusion**

The impact of traumatic experiences on the human mind and body has become an important and well-defined area of clinical research. Considerable innovations in the field of trauma research have contributed to a growing body of trauma treatments that aim to alleviate the distressing symptoms of traumatic memories. First line therapeutic treatments for trauma such as CBT and EMDR have provided important inroads towards alleviating some of the most distressing symptoms of trauma. However, as Sensorimotor Psychotherapy founder Ogden, et al. (2006) notes, “the body, for a host of reasons, has been left out of the ‘talking cure’” (p. xxvii). Therapeutic interventions that incorporate the body are necessary to address the full range of trauma symptoms. This study provides promising new evidence regarding the use of Sensorimotor Psychotherapy as a therapeutic treatment for trauma. Data collected for this study revealed the myriad ways Sensorimotor trained clinicians are bringing physical movement, mindfulness and somatic resourcing into their work with trauma survivors, offering promising new paths towards healing for these clients.



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## Appendix A

### Recruitment Letter

Hello! My name is Sarah Lazarewicz and I am a graduate student in the Clinical Social Work program at the University of St. Thomas (UST), in St. Paul, MN. I am conducting a research study as a requirement for my master's thesis, under the advisement of Dr. Courtney Wells in the Department of Social Work at the University of St. Thomas.

My study is designed to explore clinician's perspectives on the use of Sensorimotor Psychotherapy as a treatment for trauma. I am currently seeking mental health practitioners with experience using sensorimotor techniques to participate in the study. I'm reaching out to you because you are listed as one of the graduates of the Sensorimotor Psychotherapy Institute Level 1 training in the Twin Cities area (ALTERNATIVE: I found your information on the Psychology Today website, which indicated that you have training in Sensorimotor Psychotherapy). I am specifically seeking practitioners who have experience using this technique with clients with a history of trauma for at least 1 year. If interested, your participation in this study will consist of a single, audiotaped interview lasting no more than 60 minutes that will take place in person. During that interview, I will be asking questions related to your training and experience using sensorimotor techniques with clients who have experienced trauma, your thoughts on the utility and unique elements of Sensorimotor Psychotherapy, as well as the specific benefits of utilizing this technique with trauma survivors.

There are no direct benefits to this study. Risks may include possible emotional distress and recalling traumatic or distressing memories shared by clients in past therapeutic sessions. No data collected by the investigator will contain any identifying information that will link the data back to you or your participation in this study. If you are interested in participating in this study, or if you would like more information, please respond to this email with your questions. I am also happy to discuss the study over the phone.

Thank you in advance for your response! Please feel free to respond to this email or if you prefer to speak on the phone, I can be reached at: (413) 320-7791

I look forward to hearing from you!

Best,  
Sarah Lazarewicz

## Appendix B

### Consent Form



UNIVERSITY of ST. THOMAS  
MINNESOTA

#### *Embodied Healing: Clinician's Perspectives on Sensorimotor Psychotherapy and Trauma*

**IRB Tracking Number: 860295-1**

You are invited to participate in a research study about Sensorimotor Psychotherapy as a treatment for trauma. You were selected as a possible participant in this study for the following reasons:

- You are a licensed mental health professional in the state of Minnesota
- You have completed the Level 1 Practitioner Training conducted by the Sensorimotor Psychotherapy Institute
- You have experience using sensorimotor techniques with trauma survivors for at least 1 year

The following information is provided in order to help you make an informed decision whether or not you would like to participate in this study. Please read this form before you arrive for your interview. At the time of the interview we will discuss this form and you will have the opportunity to ask any questions before you agree to participate.

This study is being conducted by Sarah Lazarewicz, a graduate student at the School of Social Work, University of St. Thomas/St. Catherine University, supervised by Dr. Courtney Wells. This study was approved by the Institutional Review Board at the University of St. Thomas.

**Background Information:** The purpose of this study is to gain insight on the perspectives of clinicians on their experiences using Sensorimotor Psychotherapy methods and theory with clients who have experienced trauma. Very little formal research has been devoted to studying the efficacy of Sensorimotor Psychotherapy in reducing the symptoms of trauma. In conducting this study, my intention is to produce a nuanced description of clinician's experiences employing sensorimotor interventions with trauma survivors, thus contributing to the knowledge base regarding this modality.

**Procedures:** If you agree to participate in this study, I will ask you to participate in one 1 hour interview. At the time of the interview, before beginning I will review this consent form and offer an opportunity for you to ask questions and address concerns related to the study. You will be informed of the steps I will take to keep their personal information and data confidential. If you find the agreement satisfactory and agree to sign the informed consent form, the interview process will begin. The interview will be recorded with a digital audio recorder and will last no more than 1 hour. During the course of the interview, I will ask questions related to your experience using Sensorimotor Psychotherapy with trauma survivors. You will be able to skip any question you would like and can stop the interview at any time. Two weeks after the interview, I will follow up with you by email to provide a space to answer questions and check-in about the interview process.

The goal of this research is to provide real world recommendations on best practices for the treatment of trauma. The researcher intends to conduct individual interviews with 5-8 therapists. The output for this research will be a formal research paper and a presentation at the University of St. Thomas MSW Clinical Research Program Symposium on May 16, 2016.

**Risks and Benefits of Being in the Study:** Risks of this study include: Possible emotional distress while recalling traumatic memories discussed with clients during past therapeutic sessions.

There are no direct benefits to participating in this study.

**Privacy:** Your privacy will be protected while you participate in this study. You will be provided with a choice of locations where the interview may be conducted. Examples may include your private office or home, as well as an enclosed, private room in a public library. You will be asked to avoid using identifying information in your interview, such as your name or place of employment. If identifying information arises during the interview, I will take steps to remove this information from the transcription and will not include this information in any excerpts included in the final written report. Once the interview is completed, the audio file will be downloaded onto the researcher's password protected computer, and will be assigned a non-identifying code and date in order to ensure confidentiality. Each audio file will be transcribed solely by the researcher in an electronic Word Document stored in a password protected file on the researcher's computer. Digital audio files and electronic transcripts will be destroyed on or before May 22, 2016. In keeping with national research regulations, your consent forms will be destroyed 3 years following the date of completion of your interview.

**Confidentiality:** The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include: digital audio recordings of your interview, a written transcript of your interview, a code book listing themes and categories from compiled interviews, and a master list of each interview with de-identified codes assigned to each participant. Digital audio recordings and transcripts will be viewed, transcribed and coded only by the researcher. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

**Voluntary Nature of the Study:** Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with your place of employment or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used in the final research report. You can withdraw by indicating your desire to withdraw to the researcher either during the course of the interview or following the interview. This can be done by phone, email or in-person. You are also free to skip any questions I may ask.

**Contacts and Questions:** The researcher conducting this study is Sarah Lazarewicz at the University of St. Thomas. You may ask any questions you have now and any time during or after the interview. If you have questions later, you may contact me at (413) 320-7791 or [sarah.lazarewicz@gmail.com](mailto:sarah.lazarewicz@gmail.com). My research adviser's name and contact information is: Courtney Wells, [well7613@stthomas.edu](mailto:well7613@stthomas.edu). You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or [muen0526@stthomas.edu](mailto:muen0526@stthomas.edu) with any questions or concerns.

## Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

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

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**Signature of Study Participant**

**Date**

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**Print Name of Study Participant**

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**Signature of Researcher**

**Date**

## Appendix C

### Participant Demographic Survey

#### Embodied Healing: Clinician's Perspectives on Somatic Interventions for Trauma

##### Professional Training/Licensure:

- Social Work (LSW, LISW, LGSW, LICSW)
- Counseling (LPCC, LPC)
- Marriage and Family (LMFT)
- Psychology (LP, LPP, PsyD, PhD)
- Psychiatry (MD)
- Other (*please describe below*)

##### Sensorimotor Psychotherapy training

Please check which Sensorimotor Psychotherapy Institute trainings you have completed:

- Level I: Training in Affect Dysregulation, Survival Defenses, and Traumatic Memory
- Level II: Training in Emotional Processing, Meaning Making, and Attachment Repair
- Level III: Level III: Training in Advanced Skills/Certification
- Complex Trauma Training
- Other SP workshops or trainings (*please describe below*)

##### Other somatic/body-oriented training

Please list any other body based or somatically oriented trainings or workshops you have attended:

Are you currently using sensorimotor principles and techniques with clients?

- YES  NO

- 1) If so, how long have you been using these techniques?



- 2) How many clients do you currently use Sensorimotor Psychotherapy with?
  
- 3) Of the clients you use Sensorimotor Psychotherapy with, how many of them have experienced trauma?
  
- 4) Please describe what forms of trauma these clients have experienced.

## Appendix D

### Interview Questions

1. Tell me about your background and experience using Sensorimotor Psychotherapy techniques.
  - a. Who are your typical clients?
  - b. What is your typical caseload?
  - c. How many of your clients do you use SP with?
  - d. When do you choose to use SP with your clients?
2. Tell me about your experience working with trauma survivors. How do you see trauma impacting your clients, somatically and otherwise? Please be specific.
  - a. types of trauma/abuse histories
  - b. common symptoms
3. What other modalities do you use when working with trauma survivors?
4. Walk me through a typical session using Sensorimotor Psychotherapy. What specific techniques might you use, and what is each technique designed to achieve?
5. Please describe the arc of treatment using sensorimotor techniques.
6. What drew you to Sensorimotor Psychotherapy? What training and experience do you have employing this technique?
7. What do you think makes sensorimotor techniques effective intervention for trauma survivors?
8. What patterns do you see in clients as they progress through the trauma healing process? How do sensorimotor techniques aide in this process?
9. What is challenging about employing this technique with clients? How do you overcome those obstacles?
10. Are there any clients who this technique would not work well for? What do see as the limitations of this technique?
11. What have you learned from using sensorimotor techniques with trauma survivors?