In Search of Factors That Inform How Clients Experience Somatic Experiencing® Therapy

An Interpretive Phenomenological Analysis

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ABSTRACT

Background: While current Somatic Experiencing studies have produced impressive outcomes and biological rationales for treatment, there is a lack of client-centered research attending to the lived experience of those attending the therapy. Learning from clients about their therapeutic experience can illuminate a multitude of factors that help and hinder therapeutic outcomes in order to conceive of or reform interventions, advance our understanding of therapeutic change, and gain insight into clients' hidden processes. These might include unexpressed fear, dissatisfaction, and avoidance, as well as what they most value about the therapy.

Method: Participants were interviewed using a semi-structured schedule. Interpretive phenomenological analysis (IPA) was used to process the data. The sample size was necessarily small to align with IPA guidelines.

Findings: Two superordinate themes were abstracted: communication and pacing. Subordinate themes: Intake assessment, expectation, and psychoeducation are situated under the superordinate theme of communication.

Conclusion: Hidden processes illuminated in qualitative research of this kind can greatly benefit Somatic Experiencing Practitioners (SEPs) in better understanding how their therapeutic approach is experienced by their clients.

Keywords: Somatic Experiencing, client perspective of therapy, trauma therapy, common factors

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... important implications for practice in the realms of client safety, expectation, retention, communication, and service delivery.

The importance of finding treatments that are effective in combating the insidious effects of trauma cannot be overstated. The impact of this phenomenon can be far-reaching, and include stressful and involuntary memories of the event, chronic avoidance, and physiological hyperarousal (Breslau, 2002, Kuhfuss et al., 2021), resulting in the survivor living a tortured life, tainted by the past, which seeps unavoidably into the fabric of the society within which they live (van der Kolk et al., 1996). In the last two decades, widespread coverage in books, films, and TV has increased public awareness of trauma-related mental health to the point where the demand for accessible and effective treatment has surged (Forbes et al., 2020). Studies indicate that up to 94% of individuals seeking therapy will have experienced some form of trauma (Bride, 2004; Kilpatrick et al., 2013; Foreman, 2018) regardless of their presenting issues (Trippany et al., 2004; Bober & Regehr, 2006; Foreman, 2018). The prevalence of primary exposure to traumatic events in the general population is said to range between 70% and 90% (Breslau, 2002; Benjet et al., 2016), while others would assert that the experience of trauma visits us all (van der Kolk et al., 1996; Levine, 1997; Frazier, 2012).

Formally introduced in the seminal book *Waking the Tiger* (Levine, 1997), Somatic Experiencing (SE), is an emerging approach to the treatment of trauma that does not yet enjoy an overabundance of research, as compared to psychotherapy (Almeida et al., 2020; Kuhfuss et al., 2021). Though the current literature boasts impressive outcomes, it is not yet widely recognized in the current literature related to the accepted treatments for post-traumatic stress disorder (PTSD) (De Jongh et al., 2016; Forbes et al., 2020). However, Bisson et al. (2020) point to the increasingly robust base of evidence being developed that supports viable alternatives to pharmacological or psychological interventions for the treatment of PTSD, and include SE in their recommendations.

"Where information about meaning and value of therapy are sought, clients may be the only accurate source of information." (Elliott & James, 1989, p. 445)

Most of the current SE research is limited to therapeutic outcomes (Brom et al., 2017; Andersen et al., 2017; Almeida et al., 2020; Kuhfuss et al., 2021). Even where case studies are presented, the perspective is focused on the therapist's perception (Hays, 2014; Payne et al., 2015; Levit, 2018). Human relational variables are arguably essential to identify and include when assessing the effectiveness of any therapeutic intervention, and research that includes the client perspective can illuminate a multitude of factors that help and hinder therapeutic outcomes in order to conceive of or reform interventions, advance our understanding of therapeutic change, and gain insight into clients' hidden processes. These might include unexpressed fear, dissatisfaction, and avoidance, as well as what they most value about the therapy (Bowie et al., 2016; Levitt et al., 2016; Timulak & Keogh, 2017).

Review of the literature

Trauma definition, recognition, and treatment have had a checkered history dating back to the early 1800s (Monson et al., 2007), and have been the subject of decades of academic and professional debate (Friedman et al., 2007). The concept of shell shock, for example, was a linguistic touchstone of the scale of the First World War, and entered the zeitgeist of the early part of the 20th century (Winter, 2000, p. 7). Postwar trauma diagnosis and treatment underwent rapid shifts through World War II and beyond, in part due to political and/or military pressures (Jones & Wessely, 2006; Monson et al., 2007). Also a factor was the reconceptualization of hitherto seemingly disparate symptoms that were folded into a single definition of PTSD (Friedman et al., 2007) as part of the *Diagnostic and Statistical Manual for Mental Health Disorders* (DSM-III); American Psychiatric Association, 1980; Jones & Wessely, 2006). It was not until PTSD was included in the DSM-III that causation was linked to the traumatic event, rather than the disposition, willpower, or family history of the sufferer (Jones & Wessely, 2006). More recently, the focus has again begun to shift to a more nuanced understanding that while the event is a trigger, trauma is in the nervous system, and not in the event itself (Levine, 1997; Heller & Heller, 2004). An exponential increase in scientific knowledge that indirectly and directly informs the understanding and treatment of trauma has led to a variety of interventions being available to practitioners today (van der Kolk, 2014; Forbes et al., 2020).

SE is predicated on the increasingly accepted notion that trauma is held in the body (Levine, 2015), and its treatment focus on interoceptive awareness and somatic responses is supported by a growing and persistent body of literature showing that somatic therapies have an important role to play in trauma treatment (van der Kolk, 2014; Grabbe & Miller-Karas, 2018). Despite this, the contention persists that PTSD is primarily a disorder of the mind (van der Kolk et al., 1989; Horwitz, 2018), resulting in the somatic resolution of trauma being left out of mainstream psychotherapeutic modalities (Ogden et al., 2006), despite the increasing acceptance in trauma research of the link between mind and body (Leitch, 2007), and the view that "that much of a person's traumatic past isn't accessible to verbal recall." (van der Kolk, 2009, 11:10). The client's perception of trauma resolution is consequently skewed toward talking therapies, for, as Angelo et al. (2008) point out, when people believe they have a psychological issue, they seek psychological interventions.

What is Somatic Experiencing?

SE is described by its originator Peter Levine as a resiliency-based model and "gentle step-by-step approach to the renegotiation of trauma" (Levine, 1997, p. 90). SE recognizes trauma as the result of a chronic increase in nervous system activation (van der Kolk et al., 1996; Riordan et al., 2017) that cause the overwhelmed mind and body to continue reacting long after the traumatic event has passed (Herman, 1992; van der Kolk, 2014). SE attempts to restore balance, in part, by the action of titration and pendulation (Levine et al., 2018; Levine, 1997), whereby attention is drawn to small amounts of nervous system activation while pendulating back and forth between this activation and downregulation, thus allowing the body to spontaneously restore a natural balance to the nervous system (Olssen, 2013; Payne et al., 2015). SE is consequently heavily reliant on interoceptive awareness (Winblad et al., 2018) – the awareness of internal sensations. Orienting, completion of defensive responses, resourcing, tracking sensation and involuntary movements, and therapeutic touch are among the interventions used to reintegrate traumatic experience, along with an intimate understanding of how trauma impacts the nervous system (Nickerson, 2015; Winblad et al., 2018).

Despite consistently impressive study outcomes (for example Parker et al., 2008; Leitch et al., 2009; Payne et al., 2015; Winblad et al., 2018;), SE has not found its way into the general consciousness of trauma research, as shown not only by the lack of approach-specific studies, but also by its omission in the literature concerned with the review and analysis of current treatment options for PTSD (Wampold et al., 2010; Reisman, 2016; Watkins et al., 2018; Forbes et al., 2020). This is not an indication of poor results relative to other approaches, but rather a reflection of the fact that body-oriented therapies for the treatment of trauma and PTSD are still considered revolutionary (Rothschild, 2017; Fisher, 2017).

Research that robustly attends to the effectiveness of SE is scarce, as compared to the many decades of research into psychotherapeutic modalities. Studies that explore the factors and variables that contribute to outcomes in psychotherapy have resulted in a consensus of efficacy for these approaches (Kazdin, 2009; Cuijpers et al., 2019), which has led to their legitimacy among practitioners, researchers, and the public alike (Levitt et al., 2016; Mahon, 2023). The author contends that SE needs a larger body of literature, healthy discourse, and perhaps more years in the public domain to reach the point at which consistent research is being conducted that may allow for such determinations to be made. It is hoped that this study plays a role in fulfilling that aim. Due to the scarcity of research into SE, it was necessary to look to the plethora of studies that focus on what does and does not work in psychotherapy in order to gain an understanding of how future studies could benefit from decades of critical review and public discourse.

What can psychotherapeutic research tell us?

Research into the processes that contribute to psychotherapeutic outcomes has a long history (Timulak & Keogh, 2017), producing a wealth of information that has helped broaden access to funding (Levitt et al., 2016) and inform new and more effective interventions (Elliott & James, 1989) while also highlighting poor training, practice standards, and negative outcomes (Bowie et al., 2016). While it is generally accepted that psychotherapy works (Silberschatz, 2017; Cuijpers et al., 2019), the mechanisms by which it does, and the orientations

that may deliver results, are still widely debated (Cooper, 2008; Tzur Bitan & Lazar, 2019). One such debate is between common factors (CF), elements of therapy shared by many modalities), and "empirically supported therapies" (EST) (Roth, 2005, p. 50), which emphasize more orientation-specific techniques (Mulder et al., 2017; Tzur Bitan & Lazar, 2019) aimed at the remediation of any given mental disorder (Laska et al., 2014).

EST refers to specific factors within a modality that are proposed to be the initiators of change, regardless of client context (Laska et al., 2014; Mahon, 2023). While considered by proponents as more scientific, more easily manipulated for research, and easier to disseminate among practitioners, the EST approach does not purport to do away with common factors. For example, the therapeutic alliance has long been considered one of the primary catalysts of change (Rogers, 1957; Noyce & Simpson, 2018; Norcross & Lambert, 2018) and a headline factor in the CF argument. EST supporters do not deny that this is a factor shared by all psychotherapies (Laska et al., 2014). At the same time, common factors do not deny that there are "specific ingredients" that play an important role alongside common factors (Joyce et al., 2006; Wampold, 2015b, p. 270).

Wampold (2015a) posits a contextual model of "common factors" (Cuijpers et al., 2019; Wampold, 2015b, p. 270) that have both common and specific elements, but whose emphasis on the specific differs from that of the EST model. In recognition of the diversity of human beings as social creatures, the contextual model describes three pathways for psychotherapeutic benefit. They are:

- The "real relationship" (Wampold, 2015b, p. 270), where each person meets the other in congruence.
- Management of client expectations via dissemination of information regarding the client's presentation and treatment.
- The implementation of healthy strategies, where the client actively engages in something that promotes their well-being (Wampold, 2015b; Rousmaniere et al., 2017).

While the implementation of these latter strategies is considered a common factor, the strategies themselves are specific to any given approach. As alluded to above, these specific ingredients differ from techniques in EST in that the emphasis is not on treating the psychological deficit. Instead, its focus is on finding contextual, individually relevant, and acceptable interventions that create a positive and plausible expectation of healing within the client, and initiate actions that are beneficial to them (Wampold, 2015b).

Whether SE might benefit from engaging in the common factors debate is unclear. SE's interventions are predicated on the fact that nervous system responses to threat are universal (Levine, 2010a; Payne et al., 2015). The approach is replicable, easily disseminated, and manualized (Winblad et al., 2018; Almeida et al., 2020; Somatic Experiencing®, 2023), and common factors such as relationship building, empathy, and listening skills, for example, are not part of the training (Somatic Experiencing®, 2023). All would suggest a leaning toward EST. However, SE is nuanced and necessarily open to interpretation because of its suitability for integration into other approaches (Levine et al., 2018;, Levit, 2018; Blakeslee, 2023). Furthermore, a SEP can address certain elements of trauma-related symptoms without having any contextual information, which may further imply a leaning toward an EST model. However, it could also be argued that the necessity to work without context is often the result of a client who is unable to express their experience in words (van der Kolk, 2009). This would be considered a contextual factor necessitating a contextual, approach-specific intervention which would again lean toward the CF model. Regardless of where SE may sit within current psychotherapeutic frameworks, SE researchers can learn from the successes and pitfalls of such research, and one way in which to do so is to begin focusing more intentionally on how clients' experience can inform practice.

Research method

Interpretive Phenomenological Analysis (IPA) was chosen to ensure that the subtleties of the human experience were captured. It is well-suited to qualitative research, as it facilitates the expression of lived experience by a research participant (Gyollai, 2020) while explicitly acknowledging the role of researcher interpretation in the process (Smith, 2004). It is a phenomenological methodology widely used in the field of counseling and psychology (Smith, 2004; Brocki & Wearden, 2006; Eatough & Smith, 2017), and was originated for this purpose (Smith, 2004).

Participants

PA necessitates the use of purposive sampling (Rostill-Brookes et al., 2011),a deliberate choice to ensure that potential research participants have knowledge that is relevant to the study (Cohen et al., 2018). This is particularly important in IPA because the approach is characterized by small sample sizes (Smith et al., 2009). Individuals who had attended at least four SE sessions for the treatment of trauma were sampled in this way.

Procedure

Semi-structured interviews (SSI) were chosen for their suitability in generating rich data. Questions were intentionally broad to elicit authentic responses to each participant's experience of their therapy. Interviews were conducted online, and audio recorded with permission.

Analysis

Following the method suggested by Smith et al. (2009), descriptive, linguistic, and conceptual notes were made while reviewing interview recordings. Descriptive notes attend to content – what the participant is saying. On a second pass, attention is given to linguistic notes – words the participant uses, how they articulate their views, pauses or hesitations, use of metaphor, etc. Finally, conceptual notes are made, representing a wider view or interpretation of what the participant may be saying in the context of the full interview (Smith et al., 2009).

These comments were then reviewed for each interview individually, and emerging themes were noted. Each interview was then summarized under emerging themes specific to that interview. Lastly, these summaries were cross-referenced and compiled by a process of abstraction, whereby similar themes are clustered under a superordinate theme. It is these superordinate themes that are being presented in this paper.

Results

Two superordinate themes emerged from the analysis: communication and pacing. Communication encompassed three subordinate and interrelated themes; intake assessment, psychoeducation, and expectation.

Communication

Communication emerged as a superordinate theme as a result of all participants expressing a desire for, or appreciation of, a sense of collaboration and open communication between therapist and client. This is represented by the following subthemes:

- *The value of an intake assesment*[1]

Of the eight research participants, three were offered assessment sessions before beginning weekly therapy. For these three participants, there was a general sense of their assessments having been an opportunity to discern safety and comfort with their potential therapist.

> *"It was helpful for me just to meet her first and to see whether I felt comfortable with her." (Ella)*

Having attended two other counseling assessments, at his third assessment, Noah reported breaking down in front of the therapist with whom he ultimately decided to attend regular sessions. This initial time together in the assessment was the point at which he knew the therapist was offering what he needed.

> *"I just knew that if I could let go like that in front of him then a) something was wrong, and b) that was probably the person who was gonna help me. I had to be challenged and pushed. He did both of those things." (Noah)*

While Noah needed to know that his therapist would be strong enough for him, Alex had different needs in assessing the suitability of the therapist with whom she was thinking of working. She reports a feeling of being heard and validated by her therapist during the initial assessment, which resulted in an immediate initiation of trust:

> *"There's just always something very validating about someone going, 'Gosh, that is a lot, and we can absolutely be with that.' It gave me some confidence in the therapy itself. It gave me confidence in her as a practitioner." (Alex)*

The above quotes suggest that participants appreciated the opportunity to assess, for themselves,

1. The author refers to an intake assessment as being an initial consult prior to establishing regular sessions.

the suitability of a therapist in order to ensure that they felt safe, and that their treatment expectations matched what the therapist and therapy could provide before committing to regular sessions.

There was a mix of opinions about the value of an assessment from the remainder of the participants, and not all mentioned it explicitly. However, comments made further into the interviews in relation to trust and expectation allude to issues that may have, at least partly, been resolved in an intake assessment, had it been offered. These were centered mostly around the issue of psychoeducation and goal communication.

> *"I think there was possibly an assumption that I already knew what was going to happen in the session. Going a little bit more slowly and just explaining a little bit more about the session and what to expect and how it might feel... Those types of things I think would've been helpful." (Olivia)*

Furthermore, not having asked Olivia about her intentions for therapy, her therapist made assumptions about what would be best to work on. Olivia describes how her therapist picked up on something she said while they were chatting at the start of their first session, and ran with it. This left her feeling disempowered and that she had no choice but to follow the therapist, despite being unsure about whether it was a subject she wanted, or needed, to spend time on.

> *"I don't know if that's what I wanted to talk about or not. There was not really any 'What would you like to talk about today?' It was a bit like, 'Okay, well let's work with that'... I didn't know what to expect, so I just sort of went with it." (Olivia)*

Phillip had a similar experience, which suggests that an assessment would have given the work some much needed direction. There is an audible frustration in his tone and his words.

> *"I wanted an assessment. I would've liked him to have asked me what I wanted to get from the therapy, what my goals were, what I was struggling with... I think that would've helped me to also further define what it was that I was looking for." (Phillip)*

One could argue that Phillip's desire for an assessment may be a result of an expectation based on past experiences, rather than a current need. However, listening to his tone and responses to questions further on in the interview, the lack of this initial session would appear to have led to genuine frustration and misattunement with his therapist.

> *"After the first session, and certainly at the beginning of the second session, he [the therapist] had no idea why I was there. He hadn't asked me what my issues were that I wanted to work on." (Phillip)*

Raya was keen to express her disappointment at not having been given an opportunity to address her needs and intentions for therapy at the start. She describes how this may have helped her to ease into the therapy, to get a feeling of being heard, and, much like Olivia, more information about the therapy itself and what to expect.

Had she attended an assessment, Raya feels that:

> *"I would've got the chance to express what I wanted to express in words first. And then presumably she would've explained a bit more about what SE is, and what she would likely do, and so I would've felt more comfortable because I would've known a bit more what to expect." (Raya)*

The consequence of not offering an explicit space to address questions, expectations, and uncertainties was felt by three of the participants as a rupture, and a hindrance to any further relationship with their therapist. While the lack of an assessment is not always explicitly cited, all three reported choosing to end therapy prematurely, and without feeling that they got what they needed from it.

> *I don't think I got to focus on the issue that I actually wanted to focus on... I didn't feel like the therapy was working" (Raya)*

> *"I feel like it fell short of what I needed. There was not enough sense of what we were trying to achieve" (Phillip)*

Olivia did not explicitly mention terminating therapy, but did report seeing her therapist only once before moving to another SEP, with whom she remained. Her subsequent experience was quite different from the outset:

> *"We did more of an intake. And so she was asking me about my trauma history and things like that... And also even at that very light level, there were emotions coming up talking about certain things, and there was a lot of space given for each." (Olivia)*

When asked how she experienced this assessment session with the new SEP:

> *"I think feeling a greater sense of safety." (Olivia)*

In contrast to the participants who had no intake assessment and a negative experience, Mia and Andrew report successful relationships despite having had no such session, suggesting that the assessment can initiate, but is far from a prerequisite for, an effective therapeutic relationship.

> *"I just felt that she was really with me, and understood where I was without any kind of judging... I think that's what made it feel really safe." (Mia)*

> *[She was] "one of my favorite therapists that I've ever had." (Mia)*

Andrew felt that over time, an allegiance with his therapist grew. He describes it thus:

> *"There's an allegiance here, we're in this together. It felt like a joint exploration. It was more than just relational... there's a sense of going on that journey together." (Andrew)*

- *Role expectations: Am I talking too much?*

An uncertainty arises for participants that is seemingly a result of previous experience in talking modalities, or the public perception of SE not being a talking therapy. Consequently, Phillip, Raya and Ella express unease around how much or how little talking was expected, or allowed, in their sessions.

> *"I remember reading [that] this is not talking therapy. And so that was always in my mind... am I talking too much?" (Ella)*

Despite her uncertainty, her therapist embraced Ella's need to talk about issues, resulting in a long-standing and successful therapeutic relationship. However, as much as her therapist may have been able to hold the way in which Ella chose to use her sessions, what she had read about SE made it hard for her to believe that she was engaging in the therapy correctly.

> *"So, there were times I would end up just talking more or telling a story... She listened really well, but there was just something in me that was telling myself that I was doing it wrong." (Ella)*

A similar disquiet around talking was also expressed by Phillip and Raya, which indicates their need, and perhaps their expectation, of talking being integrated with SE:

> *"I didn't know how much talking was involved with SE. I think probably my impression was that there was not a lot of talking in SE at all because it wasn't talking therapy. So I almost kind of apologetically said, 'I feel like I need to tell you my story.'" (Phillip)*

Raya's experience illustrates how one's presuppositions can lead to disappointment and disengagement from the therapy. While she knew that SE was largely body-based, she felt that there would be more integration with talking therapies, despite knowing that her practitioner was not a counselor or psychotherapist.

> *"It [the therapy] was very strictly body-focused, and there wasn't any room for actually having a conversation about the thing that I felt caused my body to react in the way that it did." (Raya)*

Unfortunately, after four sessions, Raya reports, through tears, feeling like a failure despite really wanting the therapy to work for her. Ultimately, she ended the sessions.

> *"[I] just felt like I was failing because I didn't feel like the therapy was working, or [I] wasn't able to connect with it." (Raya)*

Finally, Phillip succinctly illustrates the need for "role induction" (Swift et al., 2012, p. 55), the intentional act of establishing the role of both client and therapist early in the relationship.

> *"I think I got the sense in the first session that I had to lead it in some ways, certainly at the beginning, because there was no kind of offering of explanation of how things would work ,and what his [the therapist] expectations of me were." (Phillip)*

- *Process expectations*

For some participants, the contrast between previous talking therapy and their experience of SE facilitated a new understanding of how positive therapeutic change can be achieved. Both Alex and Ella were pleasantly surprised with their experience of SE. It showed them how different these sessions can feel as compared to previous counseling experiences. With less talk, they felt they could drop the need to make meaning, and focus almost exclusively on their senses.

> *"There's like a freshness and a sense of aliveness I think that comes from it. … The process itself just leads to less grip on finding meaning." (Alex)*

> *"I could just stay with what was happening in my body, and just felt really understood as that being an important part of my experience." (Ella)*

Despite having worked on his trauma experiences with multiple counselors, Noah reports having no prior knowledge of SE. He states that at first he was resistant to doing body-oriented work, and when asked to spend some time with his internal sensations he was not keen.

> *"To start with, I didn't like it. I think I tried to resist what was going on." (Noah)*

Noah may have experienced here what Andrew expresses in his interview when talking about his therapist making observations about his body language. It speaks to a vulnerability that is needed on the part of the client to be willing to follow difficult sensations, and allow the body to speak about what the mind is not necessarily ready to reveal:

> *"In talking therapy you can hold back what you want to say for as long as you want to until you trust them [the therapist]." (Andrew)*

Alex describes the way in which somatic work took her in unexpected directions. The fluidity of the work was experienced as a benefit, not as something to be feared.

> *"We ended up kind of working in quite a dynamic way where we had this overarching intention to work with the trauma. We started there and sort of diffused some of that. But then other things came in, and some of the other things that came in were actually really profound things to work with." (Alex)*

Ella has a similar view. She approached SE therapy not for specific trauma work, but as a result of having done a short workshop that she found helpful in settling her nervous system. She soon realized that the process of regular somatic work allowed her to see where the issues were that she needed to work on.

> *"It was through the process of SE that I even really figured out what the trauma was." (Ella)*

Expectation and psychoeducation are closely linked, with the latter having a potentially significant influence on the former.

- *Psychoeducation*

In support of the assertion that psychoeducation can help to normalize one's somatic responses (Parker et al., 2008), Ella reports a feeling of relief at understanding her internal biological processes.

> *"When she did explain things, that helped me feel less alone in what I was experiencing. 'Oh, it's just a normal nervous system response to that experience'… There was just a relief in that." (Ella)*

One gets the sense that this work, without an explanation of what is happening, and why, leads to discomfort in being in the dark about somatic responses.

> *"Just doing the body bit would've been like, 'Well, I don't know what's going on.' The talk and the body need to happen together so that you have an understanding of it." (Noah)*

Process expectations seem to be interwoven with psychoeducation, with some of the participants reporting unease at not knowing what to expect from the therapy itself. Both Phillip and Raya suggest that more education around what was happening in their sessions, both preemptively and at the time, would have increased their level of comfort with the therapy itself. Speaking about what he may have needed, Phillip suggests:

> *"More openness about what they're [the therapist] doing, why they're doing it, and when they're doing it. Not all the time, but just like a preemptive thing. Like the first session, or an assessment session going, 'This is what it's about, or why we'll be doing these things,' etc." (Phillip)*

Raya similarly expresses unease with not understanding the reason for doing certain things in the therapy, and speaks to a general disquiet with, and difficulty in, connecting with the therapeutic process:

> *"When somebody says we're gonna do this, this is what it's likely to look like, and this is why, then you understand the benefit to yourself of doing it." (Raya)*

> *"If you don't know why that's important, then it does feel more like you're performing for them, because they hold the cards, they have the knowledge in their head of why that might be good for you, or where they might go with that, but you are left not knowing." (Raya)*

Here, Raya introduces a powerful example of how an imbalance of knowledge and power in a relationship can be difficult for a client to navigate. The use of the phrase "holding all the cards" and the word "performing" suggests that Raya may have felt subjugated as a consequence of the therapist's lack of communication. While there is no evidence that another participant, Ella, felt subjugated in what she describes as a collaborative process, the use of the phrase "I could get this wrong" suggests a concern about the potential consequences of not engaging in the therapy correctly:

> *"The SE practitioner knew what the process was and I didn't, even though actually it was always a collaborative process, but just a belief somewhere in there that she knows what's happening. I don't, and I could get this wrong." (Ella)*

The following quote could reveal the perceived consequence that Ella is concerned about when she suggests that getting it wrong would mean she would not benefit from the treatment. This concern is also shared by Raya.

> *"I'm gonna do this really well, and I'm going to heal myself and fix myself and get this right." (Ella)*

> *"I suppose I just felt like I was failing because I didn't feel like the therapy was working, or I wasn't able to connect with it, and therefore I wouldn't get better." (Raya)*

- *Pacing*

Six participants mentioned the pace of the therapy as an initial source of frustration, either too slow or too fast. While the pacing of SE stood out for Phillip, it was not something that bothered him at first:

> *"The slowness I think stood out for me. There was a part of me that appreciated the slowness of it. It was quite nice, and curious and interesting, to kind of drop into body and go, 'Okay, what's happening there?'" (Phillip)*

After several sessions, however, Phillip's annoyance with the lack of communication and psychoeducation collided with this slower pace, and became a source of frustration.

> *"There was not enough forward motion. There was not enough sense of what we were trying to achieve." (Phillip)*

Andrew notes that he found he had to adjust his expectations to meet the pace of the therapy, and that his initial desire to do more was replaced by an appreciation of the nuances of SE:

> *"I think maybe I adapted my expectations as we were going along. I think I maybe had quite high expectations to begin with. Over time, I think my experience was that even the small things that we did do – grounding, resourcing, saying, okay, 'Let's take a pause there,' or 'What do you notice now?' – an easily be missed. It did give me an appreciation of how much value there is in those really simple things." (Andrew)*

Andrew speaks further to adjusting to the pace of therapy, and how trust can grow over time. He also touches on letting go of his role expectation, and allowing the therapist to bring to his awareness anything that he might have missed.

> *"I started to feel more comfortable in knowing what we were doing... letting my body just do whatever it wanted to do and knowing that that was okay, and if there was something interesting there, that she would pick up on that and we might follow it." (Andrew)*

Andrew was not alone in frustration eventually turning to appreciation. Mia reports her first few sessions feeling disjointed. Living her life at speed, she found these first sessions too slow and frustrating. However, over time, the slowness became a source of comfort and safety, ultimately allowing more vulnerability in the process.

> *"I sort of started to know what to expect. I think probably as she [the therapist] began to understand my nervous system and I began to understand the therapy, it just started feeling like something that was really safe and reassuring. And it actually let me go a little bit deeper than I think I would've if I'd had counseling." (Mia)*

The pacing was challenging in opposing ways for the participants, with those already mentioned feeling that they wanted to go faster at first. However, one participant recalls their therapist not going slowly enough. Recounting her first session, and alluding to previously mentioned issues that may have been alleviated by an intake assessment, Raya speaks about diving into somatic work before establishing a connection with the therapist, or the therapist knowing anything about her personal history.

> *"I think it just dipped into it too quickly for me. I think I would've liked to have had some time to chat and feel like I had a kind of cognitive connection with the therapist, rather than straight away just being about me and my body, because my body is what I have a problem with." (Raya)*

> *"Within the first three or four minutes, she asked about putting her feet on my feet and I found that really uncomfortable, and she sensed that... I did say I didn't find that comfortable, and then she didn't try and do anything like that again." (Raya)*

Further exploring what she felt she might have needed instead, Raya again touches on her desire for a better connection with her therapist, and for more opportunities to communicate her issues before beginning the somatic work.

> *"It would've been nice for it to just have been a bit more of a relaxed entry into the room... it was literally, we didn't have a conversation at all. Immediately we were into something. There wasn't a kind of conversation about what SE is, and what she was likely to do in the session, and why, and that sort of thing." (Raya)*

Discussion

Communication with its three subordinate themes, emerged as a powerful factor in client retention for three of the study participants, and nonetheless essential for the remaining five, who appreciated the results of good communication with their therapists. These findings show the importance of sharing information with clients through psychoeducation to normalize somatic responses, and alleviate any uncertainty about role or process expectations. Psychoeducation is effective and common across a variety of trauma treatments (Schnyder et al., 2015; Mahoney et al., 2019) including SE (Kuhfuss et al., 2021), and the study's findings support this. This is especially important as SE is relatively new to the field of PTSD recovery, and differs from generally accepted treatments (see Forbes et al., 2020). The consequent comparison, specifically with talking therapies, had an impact, both positively and negatively, on the expectations of all participants.

Role expectation refers to the behaviors that are expected of both the client and therapist during sessions; their role in therapy (Wang et al., 2022). The uncertainty that arises around role is illustrated by the unease expressed by almost half the participants with how much talking is involved in the approach. Process expectations refer to presumptions made by clients as to what may occur during sessions (Tzur Bitan & Abayed, 2020). Most participants were pleased with their experience of SE, but it did take time and a willingness to trust in a largely unknown process to get to a point where they were comfortable to fully engage with it. This is arguably true of most, if not all, therapeutic approaches, but the findings do suggest that this unease may have been partly alleviated by better communication, be it through psychoeducation, management of expectations, or intake assessments.

Intake assessments which in these findings were shown to precipitate trust and safety, have been shown elsewhere to considerably influence a better connection and stronger alliance between therapist and client in subsequent sessions (Hilsenroth & Cromer, 2007). However, findings also show evidence of a strong, longstanding relationship developing over time for some participants who were not offered an intake assessment. This suggests that the relationship and/or alliance is not exclusive to those who attend these sessions. Therapy can be successful and even flourish without the need for assessments. The findings do suggest, though, that there are elements, such as expectation and goal setting that, if not discussed early in the relationship, can have a detrimental impact on client retention. Furthermore, while assessments are opportunities for a therapist to assess a client (Hilsenroth & Cromer, 2007), Alex and Ella show how they are also opportunities for the client to assess the suitability of a therapist, ensuring that they feel safe and that their treatment expectations match what the therapist can provide.

The intentionally slow pace of SE is central to creating an experience in the body that is counter to the experience of trauma (Levine & Kline, 2011; Olssen, 2013; Levine et al., 2018), which overwhelms the body's ability to effectively respond or cope with the demand on it (Olssen, 2013; Payne et al., 2015). Six participants mentioned the pacing of the therapy as an initial source of frustration, be it too slow or too fast. For all those who found it too slow, a strong appreciation was later felt for the positive impact of pausing to allow their sensory experience to be part of the healing process. Conversely, when

the pacing was too fast, and the focus on the body was initiated too soon, a sense of unsafety, shame, and overwhelm was reported. This experience is supported by Levine (2010b, 37:35) who states:

> *"Traumatized people come to view their bodies as the enemy. Any sensation in the body becomes a harbinger, a trigger, for the overwhelming helplessness and terror and shock that they experienced. So you gradually have to bring the people to their body sensations… If you do it too fast then the person can easily become overwhelmed."*

While there were elements that may have initially made them uncomfortable and may not have met their expectations, five of the eight participants had a positive overall experience of SE therapy, and a subsequent effective and longstanding therapeutic relationship. For the three who terminated their therapy early, the gap between expectation and reality, often not bridged by sufficient communication, expectation management, or attention to pacing, made the process unsustainable. However, there was no indication that they had lost their faith in SE as an effective approach, with two of them going on successfully to other therapists and training professionally in the modality themselves. The remaining participant, Raya, a non-therapist, remains open to SE in the future, and her experience may simply illustrate the fact that finding the right therapist is not always straightforward:

> *"(I'd) still be willing to try SE again with another therapist if I knew that the therapist worked in a different way. It's not like I've totally sworn off SE forever [laughter]. I could still see the value of it. I just didn't… I felt uncomfortable with her, I think." (Raya)*

Ethics: Protection of human subjects

Ethical approval was granted by the Bath Spa University research ethics committee. Interview questions were deliberately broad, and the participants were told ahead of time that they would not be asked to, nor should they, share personal trauma history or the content of what was discussed in their therapy sessions. It was stipulated that the study was only concerned with their experience of the therapy, and not with any session content or therapeutic outcomes. Pseudonyms have been used to maintain participant anonymity. Participants were recruited for their relevant experience in accordance with the aims of the research, and not for any other characteristic such as ethnicity, age, religion, or gender.

Limitations

Due to confidentiality held by practitioners, participants were sourced through social media channels that were largely frequented by mental health professionals. Consequently, six of the eight participants were mental health or holistic therapists themselves, and had a basic understanding of SE. This doesn't appear to have compromised their ability to remain objective about their experience. However, if further research is undertaken, members of the general population with little knowledge of SE or other therapeutic approaches would provide responses that may more accurately represent most service users.

Further research

The SE research that exists boasts impressive outcome statistics, and the neurobiological mechanics of the approach are being attended to with some regularity (Levine, 1997; Nickerson, 2015; Reoch, 2017), though this could be improved upon (Payne et al., 2015). This author contends that more, and larger, studies of the lived experience of those attending SE therapy would help in determining the non-biological elements involved in the success or failure of the approach.

It was not the author's intention, or one of the stated research aims, to situate SE within a recognized theoretical framework from which efficacy can be assessed. However, the author would be remiss not to explore SE's suitability to either the CF or EST framework, as elements thereof have emerged unexpectedly from the findings. Alignment with either of these frameworks may assist in future research efficacy. The body reacts to external stressors in relatively predictable and well-understood ways (Levine et al., 2018), and SE's interventions aim to take advantage of the fact that one's natural biological resources, embodied by the nervous system, are universal (Levine, 2010a; Payne et al., 2015). This may suggest that it could be a one-size-fits-all approach to the treatment of trauma, which would fit comfortably within the EST model that emphasizes specific treatment

protocols aimed at remediating any given mental health issue, regardless of client context (Laska et al., 2014; Tzur Bitan & Lazar, 2019). The findings, however, suggest that there are enough similarities with Wampold's (2015b) CF model to posit, at the very least, a connection, and to suggest the possibility of further research. The participants' desire for, or appreciation of, bilateral communication, role induction, expectation management, psychoeducation, and trust within a therapeutic relationship align with the CF model. Furthermore, SE is a holistic modality that recognizes the importance of the context around which a traumatic event occurred, as well as the unique resilience and nervous system capacity of each individual. As use of pacing considers these individual circumstances and actively supports the resolution of trauma (Levine and Kline, 2011; Riordan et al., 2017), it could be considered a modality-specific intervention; the last of the constituents of the contextual model.

Implications for practice

Although the sample size is necessarily small to align with IPA guidelines, this study provides valuable insight into what Elliott (2008) describes as "covert processes" (p. 239), and what Blanchard and Farber (2016) refer to as "secrets" (p. 91) that may not otherwise be expressed, if not for studies like this. Role and process expectations detailed here may be examples of hidden processes whereby a client's expectations of their role in the therapy, and what may happen in the sessions, remained unspoken. The clients were consequently left to navigate these things on their own. Secrets are things that, in this study, hide shame, frustration, and a sense of failure that were not expressed to the therapists themselves, but which resulted in some participants terminating therapy prematurely.

For all participants, an opportunity early in this relationship to sense safety through questioning, learning, and personal resonance with the therapist was, or would have been, helpful. The author suggests that SE practitioners may need to help clients and potential clients understand what they might expect from sessions, express their needs, collaborate on their goals, and help them find their role in the therapy before they begin.

Conclusion

This study's primary aims were to facilitate the expression of the subjective voices of those who have experienced SE therapy, and to better inform therapists about elements of the approach that may and may not work for clients, and the human variables that may impact outcomes. The findings have important implications for practice in the realms of client safety, expectation, retention, communication, and service delivery. Studies of the lived experiences of those attending SE therapy could help in determining what non-biological elements are involved in the success of the approach, and what, if any, common factors are shared with psychotherapeutic modalities, e.g., the working alliance or therapeutic relationship. Alignment with a recognized theoretical framework, such as CF or EST, may assist in future research efficacy. Perhaps this shared experience, and a language more familiar to those for whom psychological concerns are more highly rated, will allow SE to enter the fold of accepted trauma therapies.

SE is considered to be a complimentary modality, with many ways to interweave the wisdom of the nervous system, be it through psychotherapy, dance therapy, life coaching or teaching, for example (Blakeslee, 2023). This study has shown the importance of listening to and acting upon the hidden processes present in the client experience of SE, regardless of the modality within which it is practiced. We cannot change what we are not aware of, and so this research, and others that attend to the client perspective of SE, will hopefully help inform best practice, creating, over time, a strong foundation upon which an already proven-effective modality can rely.

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