A century ago, Pierre Janet recognized the impact of trauma on the body (Janet, 1889). The significance of Janet’s contribution to the trauma field is increasingly recognized (van der Hart, Brown, & van der Kolk, 1989; van der Kolk, Brown, & van der Hart, 1989); however, his insight on the importance of working with trauma as it is experienced in the body remains neglected in the mainstream literature on the treatment of trauma. Currently, the empirically validated treatments for posttraumatic stress disorder (PTSD) do not include any body-oriented interventions (Foa, Keane, Friedman, & Cohen, 2008). Even so, there is a growing recognition of the importance of working somatically in the treatment of traumatic stress (Eckberg, 2000; Levine, 1997; Ogden, Minton, & Pain, 2006; Pesso, 1973; Rothschild, 2000; van der Kolk, 2006). In this paper, we provide preliminary evidence for the value of a body-oriented approach to working with traumatic stress.

Research suggests that trauma disrupts normal physiological responses, leading to many of the features of PTSD, dissociation and other trauma-related symptoms (van der Kolk, 1994, 2006). It has been posited that this disruption is largely because the traumatic event has been stored as procedural memory (Ogden et al., 2006). Procedural memories that are laid down as a result of trauma involve conditioned sensorimotor responses that are unconscious, resistant to decay over time, and readily evoked by both internal and external cues (Scaer, 2005). In addition, as Ogden and colleagues argue, there is a reciprocal interplay between cognitive and emotional processing, and sensorimotor processing, where each affects the other (Ogden et al., 2006). This repetitive cycle of interaction between mind and body has the effect of keeping the past trauma alive because once the procedural memory is activated, it feels as though the trauma is being reexperienced in the present moment.

Procedural memory of trauma leaves the survivor with a somatic experience that is linked to overwhelming negative emotion and maladaptive cognitions and that is readily activated by both internal and external cues. Traumatized individuals’ interpretations of their trauma-based somatic responses are informed by the negative emotional state associated with the experience and the corresponding beliefs about themselves and the world. For example, a racing heart may be associated with fear and mean that “The world is unsafe,” or “I’m a bad person.” The linking of the somatic experience with overwhelming negative emotions and maladaptive cognitions leads to a failure to process and integrate the original traumatic experience and inappropriate responses to current day experience. Thus, when memories of the traumatic experience are activated by an internal cue (e.g., a feeling state) or an external cue (e.g., a look on someone’s face or a certain sound), the survivor feels as though the traumatic experience is occurring in the present.

Keywords: trauma, sensorimotor psychotherapy, childhood abuse, mindfulness, group therapy
moment and utilizes the same defensive reactions that were used at the time of the original event, such as freezing or fighting. These responses may not be appropriate to the present-day situation, rendering the survivor incapable of effective coping with day-to-day life, and having a detrimental impact on their sense of self, their relationships, and their overall functioning in the world.

The theoretical framework of Ogden’s sensorimotor psychotherapy (SP) suggests that integrating cognitive, affective, and somatic responses to trauma may provide a missing link in trauma recovery. SP is an attachment-informed, somatic, and sensory-focused therapy for trauma survivors and may be especially helpful for clients with a history of chronic childhood traumatization who have experienced a disruption of their attachment to their caregiver, resulting in both a limited ability to modulate their own arousal and a diminished capacity for social engagement. The therapist’s attuned response to nonverbal cues, where the therapist supports and assists the client in recognizing and modulating somatic experience, allows the therapist to function as an interactive psychobiological regulator and supports the client in developing an ability to regulate arousal and establish a safe and secure relationship. SP techniques help clients modulate both hypo- and hyperarousal responses and bring arousal to a level that is tolerable, otherwise referred to as falling within the window of tolerance. SP integrates all levels of information processing—cognitive, emotional, and somatic. Because integration of cognitive, emotional, and somatic experiences is essential for processing traumatic experiences, SP offers the trauma survivor a holistic experience to heal from the effects of trauma.

The development and examination of somatically oriented interventions for trauma survivors has not kept up with the growing awareness of the impact of trauma on the body (van der Kolk, 1994). Nevertheless, in recent years there has been research on therapeutic approaches that include a body focus (Brown & Gerberg, 2005a, 2005b; Chan, Chan, & Ng, 2006; Collinge, Wentworth, & Sabo, 2005; Gordon, Staples, Blyta, Bytyqi, & Willson, 2008; Grodin, Piwowarczyk, Fuller, Bazazi, & Saper, 2008; Harris, 2007; Price, 2005, 2007). To date, there has been no empirical research to support the efficacy of SP.

Drawing on the principles of Ogden’s SP, we piloted a group intervention addressing the effect of trauma on the body among clients who were suffering from the psychological and somatic symptoms of childhood and adult-based interpersonal trauma. The aim was to teach clients skills that would help them to stabilize trauma-related cycles of hypo- and hyperarousal, reduce dissociation and build somatic resources. We offered this intervention in a group therapy format to provide these women an opportunity to develop and practice these somatic resources in relationship with others. The intention was to assist them in finding healthier strategies to manage relational challenges in their daily lives through giving these women an opportunity to build a supportive community and develop relational connections in the group. We posited that as clients learned how to use somatic resources (such as grounding and orienting) to increase their ability to manage hyper- and hypoarousal reactions and to counteract their tendency to dissociate, they would have opportunities to recognize and, ultimately, avoid traumatic reenactments both inside and outside the group. This paper describes a stage one, trauma-focused, 20-session group intervention informed by principles of SP, and provides preliminary data on its efficacy. All clients were assessed prior to treatment, immediately posttreatment and at 6 months posttreatment. We predicted improvement in somatic awareness and soothing receptivity and a reduction in dissociation and interpersonal problems.

Method

Participants

Participants were 10 women between the ages of 31 and 65 years old (mean \( M = 47.8 \), standard deviation \( SD = 11.05 \)) with a history of interpersonal trauma, including childhood abuse. Two were South Asian and eight were Caucasian, including three who were currently married or in a relationship similar to marriage, one was separated, and six had never married. In terms of education, one had less than a high-school education, one had attended some college, and five had completed a bachelor’s degree, one a master’s degree, and one a PhD. Two worked part-time, four worked full-time, and four were not employed. Three had a total household income of less than $20,000, three between $20,000 and $39,000, three between $40,000 and $59,000, and one had a total household income of $100,000 or more.

Regarding abuse history before the age of 18 years, 40% experienced emotional and sexual abuse, 10% experienced emotional abuse only, and 50% experienced physical, sexual and emotional abuse during childhood. All but one had received psychotherapy in the past. Mean scores on the Childhood Trauma Questionnaire were 18.30 (SD = 5.62) for emotional abuse, 19.00 (SD = 2.87) for emotional neglect, 10.78 (SD = 4.09) for physical abuse, 11.5 (SD = 2.27) for physical neglect, and 20.00 (SD = 2.72) for sexual abuse. All scores were above the 95th percentile of a normative community sample (Scher, Stein, Aasundson, McCreary, & Forde, 2001). The Life Stressor Checklist indicated that participants experienced a minimum of six life stressors to a maximum of 20. Six women indicated sexual abuse in childhood as their worst life event. The remaining women indicated emotional abuse or neglect in childhood, physical abuse in childhood, the death of someone close, and homophobia along with size oppression as their worst life stressors.

Inclusion criteria included: 1) a history of childhood or adulthood interpersonal trauma; 2) an ability to focus on the body and develop somatic awareness; 3) a desire to create new somatic resources; 4) an ability to articulate specific, realistic, and tangible goals; 5) an ability to tolerate interpersonal issues (e.g., managing conflict, setting boundaries, etc.); 6) an ability to manage distress (e.g., does not engage in acting out behavior such as self-harm; uses resources such as breathing, eye contact, etc.); 7) a commitment to keep safe with regards to suicidal ideation; 8) an ability to maintain adequate reality testing; 9) agreeing to adhere to group therapy rules and guidelines; and 10) a willingness to focus on the body. We assessed women’s ability to focus somatically by directing their attention to their body sensations, movements, and perception of their senses, and asking questions that required them to bring awareness to their somatic self. We felt it was important for women to have both a desire and an ability to focus on their bodies, as this was the predominant lens through which we would invite women to explore their experience in this group. We assessed their interpersonal skills through a face-to-face interview, during which we explored their resources. We assessed their
ability to manage distress through asking direct questions and observing their nonverbal behavior, noting if they appeared distressed (e.g., avoiding eye contact, dissociating) during the interview, and their ability to consequently regulate themselves. It was important to ascertain if the focus of this group would destabilize them and thus be contraindicated in their treatment. All women who were assessed met the inclusion criteria.

Exclusion criteria included: 1) having made a suicide attempt or other expressions of being actively suicidal in the past month; 2) presently engages in self-destructive coping strategies (e.g., drugs, severe self-harm, eating disorders) that would interfere with regular attendance and participation in psychotherapy; and 3) has significant amnesia for previous psychotherapy experiences.

**Procedure**

**Recruitment and Assessments**

In November 2005, 24 women who were on a waitlist for treatment in a trauma-based hospital program were invited to participate in this pilot study. Nine women refused and one did not attend the assessment appointments. Women who refused remained on the waitlist for other trauma therapy services offered within the hospital program. Of the 14 women who were assessed, all were found eligible for the group; however, four dropped out prior to the group beginning. All participants gave informed consent to participate as approved by our institution’s Research Ethics Board.

Each potential participant first met with one of the two facilitators for an initial assessment. Participants who completed the initial assessment then met with both facilitators for a second interview to assess suitability for the group.

At the baseline assessment prior to treatment, demographic information, child abuse experiences, and other life stressors were assessed. All other questionnaires were completed at baseline, posttreatment, and at 6 months posttreatment.

**Measures**

**Demographics and Childhood Trauma**

**Demographics questionnaire.** This questionnaire inquired about demographic characteristics including age, education, race/ethnicity, employment status, and income.

**Childhood Trauma Questionnaire Short Form.** (CTQ-SF; Bernstein & Fink, 1998). This 28-item questionnaire is used to screen for a history of child abuse and neglect. It contains five scales: Physical, Sexual, and Emotional Abuse, and Physical and Emotional Neglect. Individuals rate each statement on a 5-point scale with 1 being never true and 5 being very often true. Internal consistency of the scales ranges from .66 to .92.

**Life Stressor Checklist–Revised.** (LSCL-R; Wolfe, Kimerling, Brown, Chrestman, & Levin, 1996). This self-report measure was designed to screen for the occurrence of traumatic and stressful life events. It contains 30 event items to which individuals indicate whether the event has occurred or not occurred in their lifetime. Each event has five follow-up questions assessing the age of the individual at the time of the event, the duration of the event, whether the individual believed someone could be harmed or killed during the event, whether the individual felt intense helplessness, fear, or horror, the level of distress at the time of the event, and the degree to which the event has affected the individual in the past year. An event is designated as traumatic if the participant indicated that they believed someone could be hurt or killed during the event and it resulted in intense helplessness, fear, or horror.

**Symptomatology**

**Scale of Body Connection.** (SBC; Price & Thompson, 2007). This 20-item questionnaire measures body awareness and body dissociation (response to body awareness). Individuals rate each item on a 10-point scale with 1 being not at all and 10 being all the time in reference to the previous 2-month period. Internal consistency based on the present sample was high for body awareness (Cronbach’s alpha = .97) and body dissociation (Cronbach’s alpha = .91).

**Somatic Dissociation Questionnaire.** (SDQ-20; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996). The SDQ-20 is a 20-item self-report questionnaire developed to evaluate the severity of somatoform dissociative symptoms. The items reflect somatic (sensory and motor) aspects of dissociation not included in the Diagnostic and Statistical Manual of Mental Disorders IV (American Psychiatric Association, 1994) criteria for Dissociative Disorders and which are traditionally associated with conversion hysteria. Internal consistency reliability is reported at .95 and evidence for convergent, discriminative and predictive validity. Internal consistency based on the present sample was high (Cronbach’s alpha = .93).

**Dissociative Experiences Scale.** (DES; Bernstein & Putnam, 1986). This widely used 28-item questionnaire inquires about the frequency of dissociative experiences, including amnesia, depersonalization–derealization, and absorption. For each item, participants indicate what percentage of time they have had the experience on a scale range form 0% to 100%. Internal consistency based on the present sample was high (Cronbach’s alpha = .97).

**Inventory of Interpersonal Problems.** (IIP-32; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). This 32-item measure assesses interpersonal problems based on an interpersonal circumplex. There are eight scales: Domineering/Controlling, Vindictive/ Self-Centered, Cold/Distant, Socially Inhibited, Nonassertive, Overly Accommodating, Self-Sacrificing, and Intrusive/Needy. Internal consistency based on the present sample was high (Cronbach’s alpha = .92).

**Soothing Receptivity Scale.** (SRS; Glassman, 1988). The SRS is a 27-item measure assessing an individual’s receptivity to soothing. Subscales include Physical Soothing (being soothed by physical contact), Resiliency (capacity to be soothed), Disclosure (experiencing soothing through talking to others), and Self-Soothing (able to soothe one’s self). Individuals rate how strongly they agree with the item on a 5-point scale (1 = strongly disagree; 5 = strongly agree). Internal consistency based on the present sample was high (Cronbach’s alpha = .89).

**Intervention**

The present intervention draws predominantly on Ogden’s SP strategies for the treatment of trauma. It is a body-oriented,
psycho-educational and relational group, whose aim is to improve affect regulation skills. It was initially developed as part of a brief, intensive day treatment program for women with histories of chronic interpersonal trauma. Women in the day treatment program often struggled to trust their bodies’ ability to discern past from present, danger from safety, and described feeling either disconnected or overwhelmed by their physical sensations and emotions (Duarte-Giles, et al., 2007). They would regulate their internal states through unhealthy coping strategies and this group offered them healthier options for coping. The present group was then offered outside the day treatment program as a stand-alone group to address these effects on both the body and the mind. This was a women-only group, as the majority of the clients seen in the Trauma Therapy Program is female and struggle with trust issues related to men, given that their childhood perpetrators were often male. Tokens for public transportation were offered to all the women for both research and clinical visits and three utilized them throughout the group.

Clients were first taught mindfulness skills to help them notice the interplay between their thoughts, feelings, and physical experience. The therapist taught clients to become aware of the changes in their bodies by monitoring their present, somatic experience moment to moment. Clients were invited to become aware of their body sensations, their five senses, and movement, both voluntary and involuntary, and then to verbalize their felt experience. They were encouraged to notice the interplay between their posture, movements, impulses, and sensations with their emotional state and thoughts. The therapist made statements intended to help the client bring the somatic experience into awareness and to notice somatic experience that reflected their beliefs or capacities. They were then supported in completing actions or movements that encouraged a sense of empowerment and competency.

Clients were taught how to use their somatic awareness to reduce their trauma-related symptoms and bring them into the window of tolerance. Therapists recognized the state of hyperarousal through such somatic signs as pupils dilating, breath becoming short, sweating, tension in the shoulders, or involuntary movements, as well as impulsive behavior or feelings of fear or panic. Hypoarousal was identified when clients reported a sense of separateness from the body, numbness, a reduced capacity to sense or process emotions, or an inability to think clearly. Clients were in the window of tolerance when able to experience present reality while simultaneously and mindfully experiencing their somatic sensations associated with the trauma; as opposed to being taken over by the somatic response and reacting as if the trauma were still occurring.

Group Preparation

Clinical assessments included taking a trauma history and identifying presenting symptoms as well as therapy goals. Clients’ understanding of somatic awareness was assessed and any concerns about working somatically were addressed. Clients were also invited to consider what somatic or other resources were available to them in the event that they were triggered in a session. As well, we discussed how they would let the facilitators and group members know when they felt triggered and what they needed at that moment.

Group Goals

Along with individual goals that the women brought to the group, goals were set by the facilitators, which focused on helping the clients mindfully reconnect with their bodies. The intention was to help clients develop their somatic awareness and use their body as a rich source of information, strength, and pleasure (e.g., pleasures such as enjoying present sensory experiences such as a gentle touch, eating, smelling the ocean, etc.). The aim was to help the group members use their bodies as a coping skill along with their thoughts and emotions. By learning to tolerate bodily sensations and develop somatic resources, this would reduce the sense of being overwhelmed by thoughts and feelings. These group goals were introduced to the clients during the assessment phase and reinforced throughout the group sessions.

Session Structure

The group involved 20 weekly sessions and was a closed group, with no new members admitted once the group began. Ten women were eligible and two dropped out after the first group, leaving eight group members. Sessions ran 1 hour and 45 min, with each session divided into educational, experiential, and interpersonal foci. Sessions were videotaped for research purposes. There were two female group facilitators (psychiatrist and a master’s level therapist), both trained in the SP approach.

Each session began with a mindfulness exercise. The first mindfulness exercise was 1 min and expanded weekly to approximately 8 min. It was initially guided, but eventually became a silent meditation, once participants were familiar with the structure. Then, using an object (e.g., stone or musical instrument) as a “talking stick,” participants checked in somatically to their bodies, naming three sensations they were currently experiencing. After a brief somatic exercise, such as a quick stretch, so as to maintain the focus on their bodies and to keep them from orienting too cognitively to the group process, new information about somatic awareness was taught and then practiced through an experiential experience. The exercises were sometimes done alone, in dyads, or as a group. The dyadic exercises provided ample opportunity for women to offer relational support and feedback. Time was spent debriefing the impact of the exercise(s) and members were encouraged to reflect on what they had learned from each other and make suggestions for practicing new skills. The sessions ended with a brief mindfulness exercise that often focused on breath.

Several of the sessions focused on developing relational connections and during these groups, members were invited to reflect on what helped them feel most connected to other group members. Being able to put this into words as they experienced feeling safely connected to other group members provided an embodied sense of relational intimacy. Ongoing attention by the group facilitators to any disruption in group cohesion, such as extra group contact, ensured that a sense of group cohesion was sufficiently strong to provide a safe container for interpersonal learning. As well, adherence to the structure of the group with reminders of the group goals and redirection to the agenda of each group limited the depth of here and now discussions and processing to a manageable intensity.
Summary of Group Content

The 20 sessions were divided into topics. Group members were first introduced to basic tools to help them become comfortable with examining their somatic experience. They learned about the importance of focusing on the body, including an introduction to mindfulness and information about the “core organizers of experience” or levels of processing (cognition, emotion, and sensorimotor processing, which includes five-sense perception, movement, and inner-body sensation). We explored the impact of trauma on the nervous system as seen in symptoms of PTSD, as well as a framework for understanding the regulation of their autonomic arousal, using the “window of tolerance” (Siegel, 1999). We explored somatic resources by first examining their survival resources from childhood, as well as identifying those resources that were missing as a result of childhood trauma. We assisted the group members’ in developing somatic resources for autoregulation (Schore, 1994), using the breath, posture, containment, and movement. Around session 10, we reviewed these new concepts and practices to instill a greater understanding of them. The remaining 10 sessions included exploring boundary styles, both in theory and in practice. Clients who experience trauma can create one of two defensive boundary styles—they can either become “underboundaried” where they are passive in their struggle to set boundaries and cannot protect themselves, or “over-boundaried” where they create emotional and/or physical distance in relationships, often through angry outbursts. We examined their current orienting and defensive somatic responses to past traumatic experiences that still existed and were getting in the way of their ability to function in a healthier fashion (e.g., reaching out to others for support; living in the present; expanding the field of conscious to move away from triggers or conditioned responses). Pleasure as a “stage of triumph” (Janet, 1919/1925) or somatic resource was then explored before moving into working with relational connections and interactive regulation. The last 2 weeks of the group were spent consolidating the information and processing the ending of the group.

Data Analysis

A one-way repeated-measures analysis of variance (ANOVA) was conducted on all outcome variables. Given the directional hypotheses, all tests were one-tailed. When the ANOVA indicated a significant effect or a trend for an effect, post hoc t tests were conducted using a criterion of .05. Given the small sample size and the desire to guard against Type II error, no corrections were made for multiple testing.

Results

Table 1 presents the means and standard deviations of the symptom variables.

One-way repeated-measures ANOVA revealed a significant main effect for body awareness, $F(2, 14) = 11.52, p = .001$. Post hoc t test comparisons showed a significant improvement on body awareness from baseline to posttreatment ($t = 3.06, p = .01$), from baseline to 6 months posttreatment ($t = 4.08, p = .003$), and a trend from posttreatment to 6 months posttreatment ($t = 1.8, p = .06$). One-way repeated-measures ANOVA for body dissociation was not significant, $F(2, 14) = 1.05, p = .19$.

One-way repeated-measures ANOVA revealed a trend for an effect on somatic dissociation, $F(2, 14) = 2.54, p = .06$. Post hoc t test comparisons showed no improvement from baseline to post-treatment ($t = 1.60, p = .08$), a trend for improvement from baseline to 6 months posttreatment ($t = 1.73, p = .06$), and no improvement from posttreatment to 6 months posttreatment ($t = -1.17, p = .43$).

One-way repeated-measures ANOVA demonstrated a significant main effect for the DES, $F(2, 14) = 3.51, p = .03$. Post hoc t test comparisons found a significant improvement on the DES from baseline to posttreatment ($t = 2.07, p = .04$), a trend for improvement from baseline to 6 months posttreatment ($t = 1.78, p = .06$, and no improvement from posttreatment to 6 months posttreatment ($t = -1.14, p = .45$).

No effect was shown for interpersonal problems, $F(2, 14) = .052, p = .46$.

One-way repeated-measures ANOVA revealed a significant improvement on the total SRS score, $F(2, 14) = 3.77, p = .05$. Post hoc t tests showed a significant improvement on the SRS total score from baseline to posttreatment ($t = 2.96, p = .01$) and baseline to 6 months posttreatment ($t = 2.39, p = .03$). There was no improvement from posttreatment to 6 months posttreatment ($t = -0.21, p = .42$).

Discussion

This pilot study provides preliminary evidence that a SP group whose aim is to help clients reconnect with their bodies and use their body as a source of information about their thoughts and experiences is effective.

Table 1: Means and Standard Deviations at Each Assessment

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline M, SD (N = 10)</th>
<th>Posttreatment M, SD (N = 8)</th>
<th>6 months posttreatment M, SD (N = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBC body awareness</td>
<td>5.55, 2.06</td>
<td>6.25, 1.22</td>
<td>6.63, 1.43</td>
</tr>
<tr>
<td>SBC body dissociation</td>
<td>5.52, 1.91</td>
<td>4.97, 1.49</td>
<td>4.76, 2.04</td>
</tr>
<tr>
<td>SDQ</td>
<td>35.60, 13.55</td>
<td>28.00, 7.01</td>
<td>28.25, 8.61</td>
</tr>
<tr>
<td>DES</td>
<td>24.96, 22.74</td>
<td>18.21, 15.73</td>
<td>18.35, 15.88</td>
</tr>
<tr>
<td>IIP</td>
<td>60.35, 20.06</td>
<td>62.50, 19.27</td>
<td>61.00, 21.78</td>
</tr>
<tr>
<td>SRS</td>
<td>57.05, 12.46</td>
<td>58.88, 7.59</td>
<td>59.50, 9.52</td>
</tr>
</tbody>
</table>

Note. SBC = Scale of Body Connection; SDQ = Somatic Dissociation Questionnaire; DES = Dissociative Experiences Scale; IIP = Inventory of Interpersonal Problems; SRS = Soothing Receptivity Scale.
feelings may be effective in increasing body awareness and reducing trauma-related symptoms in trauma survivors. The results showed a significant improvement in body awareness, dissociation, and receptivity to being soothed. There was also a trend toward improvement in somatic dissociation.

A main goal of this intervention was to improve trauma survivors’ ability to reconnect with their bodies. The intervention taught a range of skills for enhancing body awareness such as mindfulness. It provided information about the impact of trauma on the body and opportunities to practice what they had learned. The increase in body awareness suggests that this approach was effective in meeting its goal. Anecdotally, clients also reported to the therapists their greater awareness of body sensations.

By increasing survivors’ ability to be aware of and more comfortable with their bodies, we expected that this would also reduce their use of dissociation. Learning to improve their somatic awareness was also expected to lead to a reduction in dissociation as was found on the DES. The reduction in dissociation was consistent with our clinical impression that as clients strengthened their ability to use somatic resources they were more successful at identifying the antecedents of flashback and other dissociative symptomatology and eventually improved their ability to stay present with the here-and-now. Over time, we found there was less need to interrupt group discussions to check in with clients who appeared distracted or acknowledged having flashbacks and that clients reported a lessening of their somatic flashbacks.

The clients’ improved capacity to be soothed was shown on the Soothing Receptivity Scale. Clients developed a greater capacity to be aware of their here-and-now experience and to communicate to one another about that experience. This facilitated relational connections by enabling them to notice how they were impacting one another and provided opportunities to experience intimacy within the safety of the group container. It is possible that as clients experienced an increase in somatic awareness and greater relational connectedness, their receptivity to soothing improved. Having an opportunity to experience a safe relationship in the group may have strengthened their ability to use relationships as an opportunity for auto and interactive self-soothing.

There are a number of limitations to this study. This was a pilot study utilizing a small sample and no control condition. Although we noted changes over time, without a control condition there is no way of knowing whether these changes are due to: treatment; the assessment process, which in itself may have raised somatic awareness; the passage of time; group support; attention; regression to the mean; or some other variable. It is possible that participants were already positively disposed to doing somatic work and this may have increased the chance of a placebo or expectancy effect. Also, this study does not enable us to determine whether improvement in body awareness mediates improvement in other trauma-related symptoms. This was not a randomized intervention. A manual is being developed based on the experiences of this pilot study.

This study provides preliminary evidence that, drawing on the principles of SP, a somatically informed group intervention for trauma survivors may be effective in increasing somatic awareness and reducing trauma-related symptoms. This study suggests that a group intervention based on the principles of SP may be effective for survivors of interpersonal trauma.

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Received October 27, 2009
Revision received January 24, 2011
Accepted February 7, 2011