Group Psychotherapy Informed by the Principles of Somatic Experiencing:

Moving Beyond Trauma to Embodied Relationship

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ABSTRACT

This article introduces the application of Somatic Experiencing® (SE™) to group psychotherapy. SE utilizes normative physiological responses to danger as a means of restoring healthy functioning of the nervous system. The authors suggest that the principles of SE, developed primarily for use with traumatized individual clients, can make the work of interpersonal group psychotherapy deeper and more effective. They respond to a clinical vignette by conceptualizing the group members from an SE perspective and discussing how the process of an SE-informed psychotherapy group would likely unfold quite differently than the vignette as presented.

SOMATIC EXPERIENCING

Trauma offers a vivid portrayal of the mind and body under threat. Developed from the study of these normative physiological responses to danger, Somatic Experiencing® (SE™) is a comprehensive set of principles and techniques for precisely attuned clinical work. Although Peter Levine originally developed SE as a treatment approach for trauma (Heller & Heller, 2001; Levine, 1997; Levine & Kline, 2006), the principles of SE are a useful framework for working with intrapsychic and interpersonal phenomena far beyond

events traditionally defined as traumatic (Heller & LaPierre, 2012; Levine, 2010; Payne, Levine, & Crane-Godreau, 2015). By paying close attention to the client's nervous system, the SE-informed therapist supports the client in the experience of greater coherence and resilience, engaging, completing, and resolving—in a slow and supported way—the body's instinctual responses. In doing so, the nervous system is reset, which restores inner balance, enhances resilience to stress, and increases vitality, equanimity, and the capacity to engage actively in life (Somatic Experiencing Trauma Institute, 2015).

Using the body's reaction to trauma as a template, it is possible to work more effectively with less-dramatic situations that have similar physiological consequences. Even in apparently minor experiences of threat, the mind and body are sent into "survival" mode, reacting in habituated ways, driven by the autonomic nervous system and the "survival physiology" it triggers. Practitioners of SE[1] find that when internal cues and interpersonal interactions are viewed through the lens of survival physiology, what previously looked like symptoms can be seen as management strategies. These patterns can be welcomed as the organism's best attempt to protect itself. They can be utilized as clues to what may have happened to require such adaptations (the event) and what didn't get to happen that needed to happen (the reaction to the event). When the full reaction to the event can be felt in the present, by slowing down and titrating these subtle physical and mental processes sufficiently that they can be noticed, followed, experienced, and survived, the person discovers—in a fully embodied knowing—that the survival-threatening situation has passed and relative safety has been found. Only then can higher-level change begin to occur. The client moves from the realm of survival to the realm of interpersonal engagement (Porges, 2011) and healing.

In a typical SE session, a practitioner helps a client discover what didn't get to happen during an event that was experienced as overwhelming. The practitioner supports the organic unfolding of the previously missing experience as it happens now, in all its emotional, physical, cognitive, and perceptual elements. With proper training, this process of renegotiating trauma is relatively easy to facilitate when working with discrete events such as motor vehicle accidents, medical procedures, natural disasters, or instances of overt violence; the body's experience is obvious (both in terms of what happened and what didn't get to happen) and the experienced practitioner can easily find creative ways to access a response, such as fight or flight, that was previously unavailable.

However, practitioners working with individual clients often have more difficulty identifying, evoking, and renegotiating the sort of chronic interpersonal patterns that lead

[1] SE is one of a number of approaches (e.g., Cohen, 2011; Kurtz, 2007; Ogden, Minton, & Pain, 2006; Siegel, 2010; van der Kolk, 2015) developed in recent decades that view the mind and body as equal (and cooperative) vectors for intervention. In discussing the integration of its principles into group psychotherapy, we do not argue that other mind-body approaches may not have equal value, but this is the one in which we are steeped and which offers a language and a comprehensive set of principles we find useful.

to equally debilitating patterns of "survival physiology"; it is far too easy to lapse into endless cognitive discussion of the patterns or to enact them in the treatment relationship. In an SE-informed group psychotherapy, such survival physiology can be re-worked *in vivo*, thus altering the interpersonal symptoms it creates.

SOMATIC EXPERIENCING IN GROUPS

SE-informed group psychotherapy broadens and deepens the efficacy of either SE with an individual client or group psychotherapy uninformed by the principles and practices of SE. Others have brought SE to various group settings, such as crisis response to terrorist acts or natural disasters (e.g., Parker, Doctor, & Selvam, 2008), mindfulness training, and the like. Similarly, there is much interest in the application of the principles of interpersonal neurobiology and body awareness to group work (e.g., Badenoch & Cox, 2011; Cohen, 2011; Denninger, 2011). But, to the best of our knowledge, we are the first to apply the specific principles and practices of SE to group psychotherapy per se. "SE-Informed Group Psychotherapy" is our own term for this work. To the best of our knowledge, there is no research on the use of SE in group psychotherapy. Indeed, research on SE itself is just beginning (e.g., Brom, Ross, Lawi, & Lerner, personal communication).

Many approaches to group psychotherapy utilize a focus on the here-and-now. The SE-informed group deepens and sharpens this focus by privileging—at least initially—the tracking of felt sensations. This slows down interactions and asks group members to become aware of what is going on inside of themselves before coming out to "meet" the other. They may not be able to do so, at first, but as the invitation is repeatedly offered, the group begins to recognize the various states of individual nervous systems ("am I in 'survival brain' or 'ready-to-explore brain'?") and how those states optimize or detract from the possibility of seeing or being seen. Whereas the individual SE practitioner tracks shifts in the individual nervous system, the SE-informed group therapist tracks the nervous system of the multiple levels of the group organism: in each group member, in shifting subgroups, and in the group as a whole. Within the range of resilience, the therapist supports individual group members and the group as a whole to enlarge their capacity to tolerate increasingly intense experiences without dissociating, overriding, or simply relying on habitual patterns.

One hallmark of the experience of trauma is the absence of choice ("I didn't *choose* to be assaulted by that bully on the playground!"), but in the interpersonal world of the group, the members are reminded over and over that they have choices, even about whether to take up a given opportunity or not. Moreover, not only is there a choice, but subtle signals felt in the body might usefully inform that choice ("what tells me, in this moment, that it would be ok to engage with that other group member?") rather than just forging ahead and toughing it out. Simply encouraging group members to "take the risk" of engaging—without paying conscious attention to body-based cues—leads group members to reenact old patterns that override choice, that don't allow accurate assessment of interpersonal or internal cues, the very patterns developed in earlier group

settings (such as families, schools, churches, or social circles) that participation in group therapy hopes to rework.

Working in this way, group members begin to recover their deeply felt sense of what is safe and what is not. They begin to trust that the group therapist is truly committed to protecting their right to follow their deeply personal indicators of what is safe. The group becomes a safer place—safe enough to take the risk of experimenting with new ways of managing risk. It becomes possible not just to enact "how I am" and "how you are" but to notice those patterns and consider the very real possibility of trying something new. The focus moves from content ("what happened to me") to patterns ("how I experienced that") to new possibilities ("I wonder what would happen if I followed this felt impulse, to pull away or to move towards?"). Because the relational field of the group is always alive and always changing, and because the group is always invited to slow down and notice "what's happening *now*?," there arise multiple opportunities to experience, observe, and work with old patterns, uncoupling past and present, discovering new options in real time, and healing the connection to present relational reality that history has distorted by habituating to what was once the only choice available. This healing happens in two ways: through direct experimentation by a given member in relationship to another member, the therapist, or the group; and through vicarious learning as members bear witness to, feel resonance with, or manage distress caused by what another or others are undergoing.

APPLICATION TO THE VIGNETTE

[Note: The clinical vignette to which we are responding is attached below.]

The vignette, of course, is not an SE-informed group. Three months into its development, had Dr. Newland been informed by the principles of SE, we would expect an entirely different climate and process, even with the cast of characters described. We will give a few examples of how that might have developed, and how it might now function.

Dr. Newland would likely have begun early group sessions with an explicit exercise in what we call "arriving," taking the time necessary to fully transition from where members were to where they are, inviting each member to notice:

> *Where have you come from? How was it to get here? How is it to be here? How does it feel "on the inside"—in the physiology, in images, in emotion—and how does it change, if it does, as time is taken to notice the here-and-now environment? How does the chair hold you? Where in your body is there relative tension and where is there relative calm? Then, what is it like to begin to come out from your inward focus, to notice the room, then other members, and the experience of coming back to the group? What do you remember from last time? or not?*

The invitation is to be curious about the details of the current experience without trying to change it, and from that place of awareness of self, and perhaps of other, to notice what arises that may emerge into the group. This opening experience becomes a model for

how to approach everything that subsequently happens in group. In our experience, group members very quickly begin to understand the value of such awareness, particularly of transitions, and after several sessions they take the time to fully "arrive" in group without needing explicit guidance from the therapist.

Thus, Angela's immediate opposition to Dr. Newland's opening of the group might happen as described in a very early session, but it would be unlikely at the three-month mark. If it did appear this far along in the group's development, Dr. Newland would do well to understand Angela's reaction as an incomplete fight response that needs to be encouraged and celebrated, not avoided or glossed over. This curiosity on the part of the therapist towards everything that emerges, especially the emerging self-protective responses that need to be honored, requires that the therapist pays close attention to his or her own nervous system, level of arousal and coherence, and resources for maintaining or returning to his or her own self-regulation. It is essential to monitor one's own self-regulation to respond effectively to the less well-regulated nervous systems of the group members. It also requires a tentative map of how each member manages his or her activation. Angela, for example, is quick to fight—but it doesn't always serve her well. In the group, she will need to learn to assess the actual danger in the here-and-now and to experiment with a wider repertoire of responses. When she senses danger, that's to be honored and investigated: how exactly does that register? How does she want to respond? She must first be encouraged to discover—at the body level—that she can in fact fight when necessary, and protect herself. Then, she might begin to notice when the perceived danger isn't real, and to notice how she knows the difference? Thus, when Angela challenges an intervention, Dr. Newland would be well advised to make full use of the moment, asking her to pay very close attention to how it feels to have it taken seriously. In our experience, such moments often lead to enormous shifts in clients' habitual patterns. These moments encourage them to slow down, to notice the choices available, to consider new possibilities from that awareness. Then, if they choose to try something new, they are encouraged to take plenty of time to experience the difference in both mind and body.

By three months into the group process, Dr. Newland would likely have developed a working understanding of each group member's patterns. To take another example, Betty is chronically disengaged and, when pressed, reveals an impulse towards flight from conflict (and from the group). Normalizing this strategy as a perfectly reasonable way to survive danger, albeit at a cost, opens the possibility of catching the pattern early enough for Betty to become aware of it and then to exercise the choice she has in each moment either to retreat or to begin tentatively to engage. Dr. Newland and the group must always both honor the choice to retreat as perfectly valid and also hold for Betty the certainty that there is another choice available to her. Because it will take time for Betty to know that for herself, she is far less likely to be willing to entertain it if the option of retreat is not fully supported as an ongoing option.

The larger principle is that the SE-informed group therapist actively reminds the group, that there are more choices available than each group member sees. Yet, the therapist always respects and supports the group member's right to choose how to respond in each

moment. The member is reminded of choices available and invited to make his or her choice informed by embodied impulse, to the extent possible, rather than by habit. This requires slowing down the process, mining it for incomplete self-protective responses that must be fully felt in order to know that one can protect oneself. Only then is it truly possible to engage in the kind of authentic and intimate relationship that most group members come to group therapy longing to find and which most group therapists wish to foster. Members support each other, empathize with one another, and rejoice in witnessing one another's healing. Both the hope that change is possible and the courage to take such risk increase for everyone.

Another example: Will, characteristically silent but attentive, seems to function in a state somewhere between flight and freeze. The SE-informed therapist would first acknowledge the effectiveness of that strategy for managing the threat of trying anything else. Dr. Newland might invite Will to explore the felt sense of safety when he says, for example, "No, I'm good. I'm fine listening." How does it feel to be able to set that boundary, to decline the pressure to participate, to stay safe in that way? The history that led to such a habitual response may emerge, or may not, but the focus is on the experience of it in the present. Once Will's right to protect himself in that way is validated and experienced as effective—though limiting—the invitation might be offered to try something incrementally different; and then to notice how even a little participation creates arousal in Will's system; and then to notice that the arousal is perhaps tolerable and can be integrated as mere arousal, rather than a signal of danger that must be avoided at all costs.

Events from outside the group are handled with similar slow and sensitive curiosity. Thus, when Diane speaks of putting herself at risk with a "random guy" after drinking too much, Dr. Newland and the group would be interested in the story but would slow down the telling of it to notice—in Diane and in others—what happens during the retelling. What danger signals does Diane notice in herself as she tells about what happened? How did she override those signals, or how might she feel the impulse to follow them, now, and see what might happen that's different than the old pattern? What resonance do others feel for Diane? What can that resonance make available for them, or for Diane? SE believes, in accordance with much of the more recent work on interpersonal neurobiology, that embodied moments of new possibility create new neural pathways and thus new opportunities for living differently. The SE-informed therapist is constantly normalizing behavior that may look maladaptive but makes sense for the "survival brain," and then pointing out the possibility that other options are available. But those options are only authentically available after the ability for self-protection has been demonstrated, welcomed, and experienced. Only when we know that we can protect ourselves if necessary, can we risk trusting the (relative) safety of new kinds of interpersonal connection.

Over time, in an SE-informed group, the interpersonal process of the group itself supplies triggers to identify and rework activation patterns and interpersonal dynamics. We see this clearly with Ned, who wants attention and tries to find his place in the group by refocusing the group on his own flirtations, compared to Diane's. When the process

proceeds at its regular, unexamined pace—as in the vignette—his ineffective bid for attention is met with criticism, and he aggressively defends himself. But if Dr. Newland and the group were to greet his fight response as a signal to slow down the process and pay close attention to what's happening within each nervous system, Ned would likely feel more met than he ever has before.

The challenge is to attend to Ned without dropping other group members. This is done by alternating between them, validating them each, and utilizing other members of the group to hold one while overt attention is on another—rather than having group members simply battle it out and repeat old patterns. This might look like the kind of good process work done in any well-managed group therapy, but informed by the principles of SE, it is likely to soothe the deeper survival needs of the autonomic nervous system, which then allows higher-level attachment needs to be met through new behaviors not previously available. Ultimately, Ned would become much more able to offer a genuine empathic response to others and to notice when his narcissistic needs have a chance of being met rather than always maintaining his vigilance to when they are not.

How long does it take to develop such a group culture? Being "tuned in" to oneself and to others is something that most of us don't do as a general rule. Most of us have lost touch with our bodies and our nervous systems. We are not aware of what happens moment to moment and we have often developed strategies to ward off what our bodies want to tell us. It can take time to develop the capacity to pay attention to these things. Group members joining an SE-informed group must at least be willing to be curious, to be open to making new discoveries, to befriend their bodies. In some cases, the body has become the enemy, so this is a particular challenge—and may in fact be the critical shift towards healing. But patience is required and the group therapist must normalize the challenge and titrate the invitation, so as not to overwhelm individual group members or the group as a whole.

The goal is to develop a capacity in each group member, and in the group culture, to track experience at multiple levels, to gather information from all the subsystems and from the overall group system, and to make appropriate use of it. "Coherence" (as the term is used in SE) is the state in which all the physiological and psychological subsystems of the individual are working effectively and collaboratively to respond effectively to present circumstances. Broadening that to the group field, we suggest that this understanding of coherence should refer to all the subsystems within and among group members (from each member's physiological subsystems, to the capacity for each individual to access appropriate self-protective and socially-engaged responses, to member's ability to accurately "read" the state of others, to subgroup functioning, to group-as-a-whole activation and settling cycles) and including, of course, the group therapist and the larger culture in which the group functions.

As the SE-informed therapist so often does, working "bottom up" and "from the inside out," we seek coherence initially in each individual member, actively supporting the recovery (or discovery) of those subsystems that are less available (such as body sensations, impulses, emotions, mindfulness, and the like). Attention is then paid to those

group interactions that demonstrate coherence at the group level. As the group begins to experience this new way of being with one another, a holding environment is created, alleviating the sort of "pin-ball" discordance illustrated in the vignette. In the SE-informed group, fewer issues are brought up, with slower and deeper exploration of those that are; the group focuses on resolution and healing rather than telling stories. Conflict is welcomed as information about habitual survival strategy rather than managed as bad behavior. As the therapist and the group focus on individual and group-level activation and settling cycles (that is, on the "music" of the group, rather than on the "words" of individual group member's stories), multiple experiences are addressed at once: the commonality of human nervous system experience becomes the unifying theme, and the details of stories are utilized as a route towards seeking each body's truth in the here-and-now, rather than as a venting of past grievances.

In summary, the SE-informed therapist's art is found in the balance of two perspectives. One is the complete certainty that nervous systems respond in predictable and understandable ways to situations of overwhelm, stress, trauma, and interpersonal risk. Such situations are the norm in society, in families, in workplaces, and in our therapy groups; and they are certainly seen in the clinical vignette to which we have responded. How our clients behave is evidence that they have nervous systems doing what's possible within a range constricted by earlier experiences, which leave our clients not as effectively spontaneous and responsive as they could be. The group setting can be an environment in which members discover or recover a capacity for optimal self-regulation and the full range of possibilities that are their birthright.

The other perspective that must be held at all times is the certainty that we are inviting a nervous system to find its *own* way back to regulation. We are the holder of that possibility but not the author of the story. We confidently invite our clients to try something new even as we know little or nothing of the particular experiences—often nonverbal, pervasive, and profound—that they have suffered and survived. Particularly in dealing with individuals of backgrounds and experiences different than our own (i.e., what is commonly referred to as "diversity"), we must maintain enormous humility in what we think we know, and enormous gratitude that living organisms are as resilient as they are. We are doing no more and no less than creating, as best we can, a group field in which each participant discovers or recovers the fluidity necessary to respond appropriately to the challenges that will inevitably arise in the course of being fully alive.

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This article is one of eighteen, invited by the International Journal of Group Psychotherapy to mark the 75th anniversary year of the American Group Psychotherapy Association in 2017, which compare and contrast clinical approaches to a clinical vignette. The vignette and the context for discussion we reprint below is excerpted with permission from:

Joseph J. Shay Ph.D., CGP, LFAGPA. (2017). Contemporary Models of Group Therapy: Where Are We Today? *International Journal of Group Psychotherapy*, *67:sup1*, S7-S12.

Dr. Shay's full article is available online at http://www.tandfonline.com/10.1080/00207284.2016.1238749.

We begin with a clinical example to which we have asked a number of senior clinicians to respond. The example is drawn in an exaggerated way to make it easier for our respondents to comment broadly on the members and the group. Although there are six group members in the group, clearly more could have been described. We have limited the group size to make the task more manageable for our respondents.

The point here is not to learn from therapists exactly what they might have said in response to precisely this kind of group member, but to be taken backstage by the clinicians to hear how they are conceptualizing the situation and how their interventions might derive from this conceptualization. For our clinicians to respond to the questions below in the limited space allotted to them, they will, of necessity, be reduced to generalizations, but hopefully ones that can be mapped by the readers onto their own clinical work. Essentially, the respondents will be trying to illuminate the DNA of their theoretical model and of their interventions that will transcend the specific response to the specific patient.

Here then are the members of the group who have been brought together because the referring clinician, often also their individual therapist, thought they would profit from interactions with and reactions from others. Based on this description and a brief transcript of a group session, our respondents will describe how they understand the situation and what they would do with this collection of members.

The group comprises 6 members, all between 30 and 55 years of age, who have been meeting for three months and therefore have gone through the general introductions of who they are and what they are struggling with. Group members are characterized very simply in order to allow a broader response from our numerous authors:

Angela is typically critical of people in her universe and also of people in the group, including the therapist.

Betty is rarely attentive to group members when they speak and typically scans the bookshelves as though bored and when making comments, states, "I don't know what I'm supposed to be getting from this group."

Diane takes the group hostage with her stories of dangerous social interactions and life-endangering behavior, forcing them to respond to her presentation.

Otto is very talkative, albeit with limited eye contact, and can be counted on to fill space, but his narratives are full of circumstantial detail without a clear point to be addressed.

Ned takes the floor whenever there is a lull to bring the conversation back to something he is reminded of by the prior speaker, but he rarely makes an empathic connection or seems to care about the distress of others.

Will is characteristically silent though notably attentive but is rarely able or willing to offer a reaction, observation, or personal association, let alone introduce a topic of his own.

The therapist is Dr. Pat Newland, a well-trained individual therapist, but a novice at group therapy. (Respondents have been told they can assign the gender of the therapist in the context of their comments.)

Here is a transcript of a segment of the most recent group:

Therapist:	Hello. Anyone want to begin today?
Angela:	Why can't you just let us start the way we want to start? We'll begin if we want to begin?
Diane:	I'm happy to begin. This weekend, I didn't want to work on my dissertation so I went to a party and had too much to drink. And then some random guy thought I was flirting with him and began to pressure me to leave with him, and I began to leave with him until I thought, is this really a good idea? I was remembering when I did this before and wound up in a lot of trouble. Still, I went with the guy and he took me to my place and then left in the middle of the night. With my credit cards.
Ned:	That kind of thing happens to me a lot. Women come up to me, talk to me, flirt with me, and then assume I'm going to pressure them for sex or something. That's not my fault.
Angela:	What are we talking about anyway? I thought we were supposed to focus on what's happening in the room?
Ned:	You don't get to decide that, Angela. If I want to talk about my life, I'll talk about it any way I want. Right, Dr. Newland?
Therapist:	I'm wondering whether we can include Will and Otto in this discussion.

Will: No, I'm good. I'm fine listening.

Otto: I wanted to understand something we were talking about last week. When I told the group I was applying for a new job, I don't think I made clear what kind of company the new company was. It's a technology services company and my job would be to respond to what we call "tickets" from anybody in the company who is having computer problems. The reason we call it "tickets" is because…

Angela: I don't care about that, Otto. Who cares why you call it "tickets"? Last week, you took up a lot of time and I didn't find it that interesting. Pat, we've now wasted 5 minutes and we're not talking about anything at all.

Diane: What are you talking about, Angela? I was talking about my weekend and how I could have been raped.

Angela: But you took the guy home, Diane.

Diane: Are you blaming me?

Dr. Newland: Hold on, everyone. Let's try to find one theme and stick with it or else it will be hard to focus the session. Betty, what's going on with you?

Betty: Nothing. I'm just listening.

Dr. Newland: Anything more?

Betty: Okay, then. I have been thinking about leaving the group because I'm not getting anything out of it. I came because I don't have many friends and my therapist thought it would be a good idea. But there's a lot of arguing in here and I'm not sure what the purpose is?

Dr. Newland: Well, the purpose is for each of you try to learn about how you come across to others and what gets in the way of your living more satisfying lives.

Ned: I'm all for that. I felt I was making progress this week because I was able to get back to working on my novel because I stopped worrying about the criticism my readers had made of the writing.

Angela: I wish I could let criticism roll off my back.

Will: You said it!

Diane: What do you mean, Will?

Will: I'll pass, but thanks.

Otto: Criticism is very hard for me too.

Ned: Not for me. People who criticize are often just jealous so I'm not going to let it get to me.

Dr. Newland: There are a lot of issues being discussed. Angela's frustration with the group; Diane's risky weekend; Ned's relationships with women and with criticism; Otto's wish for the group to know more about his job;

and Betty's frustration with the group. So, maybe we can decide as a group which direction to take?

Angela: That doesn't strike me as a good idea at all.

Diane: You're always criticizing Pat.

Angela: You're always defending Pat.

Betty: See what I mean about how we're always arguing.

Dr. Newland: I'd like to say a few things. We've been meeting for three months and some of you seem to feeling confortable enough to share your anger and frustration, which I see as a good thing. However, we need to be able as a group to stick with someone's issues long enough for that person to feel heard and understood. I want to recommend then that we turn to Diane and try to help her work through the issues from this weekend. And each group member can reflect on what her story stirs up for you, and then we can take a look at that. Diane?

The respondents from 18 models were asked to address the following questions:

1. Does your model work with this population of members? (If it does not, or if this description is foreign to how you think, please respond to the following questions with respect to how you do think, trying to address the same questions from your perspective.)
2. What are the goals of your model for the group? That is, when you are leading a group, what do you count as success for each meeting or sequence of meetings and for a member's readiness to terminate?
3. What does your model view as the change agent(s)? That is, of the various change agents present in group therapy, which would your model most privilege?
4. What are the core elements of your model regarding etiology and treatment?
5. What are some typical interventions of your model? Please address directly what you might say and why you might say it with a group such as this one.
6. How does your model address multicultural issues?
7. What is the research support for the model?
8. What are the drawbacks of the model with respect to suitability of patients or other considerations?