

# The Somatic Post-Encounter Clinical Summary (SPECS)

*A New Instrument for Practitioners and Researchers  
to Measure the Wisdom of Somatic Intelligence*

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## ABSTRACT

In creating a research project to examine the effects of somatic psychotherapy, the authors needed a measure to gather somatic data to be filled out by therapists. After multiple iterations, and balancing clinician experience with research efficacy, we created the Somatic Post-Encounter Clinical Summary (SPECS). SPECS is a one-page tool to track and measure the process, interventions, and qualitative outcomes of somatic psychotherapy, to train somatic psychotherapists, and to structure data collection of their sessions. This paper explains the development, methodology, and usage of SPECS for clinicians as well as researchers. SPECS helps clinicians reflect on their practice and improve their skills, as well as providing a simple uniform structure for many different specialists to report on the process of somatic psychotherapy. SPECS also can be used in larger research projects for gathering data about the process and efficacy of somatic psychotherapy. We hope that it will be widely used and improved by practitioners and researchers in our field as well as adjacent and related fields.

**Keywords:** Somatic psychotherapy, somatic countertransference, training tool, trauma, body awareness, somatic intervention, mindfulness

Submitted: 28.09.2021

Accepted: 16.05.2022

International Body Psychotherapy Journal  
The Art and Science of Somatic Praxis

Volume 21, Number 1,  
Spring/Summer 2022, pp. 66–75

ISSN 2169–4745 Printing, ISSN 2168–1279 Online

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*We wanted to clarify the  
therapeutic aims, the  
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inspired in clients.*

Somatic psychotherapy has been practiced in various forms for over a century, and references to body-focused forms of healing exist throughout the ages. Despite this strong historical foundation, it is still an emerging specialization that has not fully made inroads into the wider field of general psychotherapy. One reason is that research substantiating the unique contributions of somatic psychotherapy is still sparse (Rohricht, 2009 and Young, 2010). Further, there is a tendency in the field to focus on and separate practice from research (Johnson, R., 2014). Another reason may be a continued focus on disparate approaches, rather than overarching principles (Johnson, D.H., 1995, p. xii). Due to the disparate modalities and schools of thought that make up the spectrum of somatic psychotherapeutic approaches, a large part of research in the field has been siloed and underdeveloped (Johnson, D.H., 1995; Young & Grassman, 2019).

The authors are excited to contribute to the development of the field by presenting a new measure, the Somatic Post-Encounter Clinical Summary (SPECS). SPECS seeks to support clinicians and researchers in clarifying somatic interventions applied in clinical sessions, the intentions behind these interventions, and

their observed outcomes. We will describe the context in which the measure was created, discuss how it relates to other measures, introduce its components, describe how somatically-trained clinicians received and improved it, and consider its strengths and limitations. We begin by offering a context for its development, and what led to its inception.

## The Context for Development of SPECS – Somatic Psychotherapy Study

In the fall of 2015, Theresa Silow, in her role as Chair of the Somatic Psychology Program at California Institute of Integral Studies (CIIS) in San Francisco, was approached by Denise Saint Arnault, a researcher at the University of Michigan School of Nursing, and at that time Chair of the Research Committee of the United States Association of Body Psychotherapy (USABP), regarding a possible joint research project. Several phone discussions between the two ignited interest to explore the possibility of clinicians, students, and faculty collaboratively designing a research project to examine the unique contributions of somatic psychotherapy on patient health outcomes – potentially with clients with trauma histories. They initially discussed the possibility of a somatic psychotherapy research project with CIIS faculty, and then expanded to include representatives of the two somatic psychotherapy clinics in the Bay Area. It was particularly exciting to find out that both center directors were interested in such a project. Thomas Pope of the Lomi Psychotherapy Clinic (LPC) in Santa Rosa and Stuart Gold of CIIS's Center for Somatic Psychotherapy (CSP) in San Francisco signed on to the project. Lastly, when the USABP put out a call for researchers to participate, Aaron Freedman, a CIIS graduate and research assistant at the Osher Center for Integrative Medicine, joined. The authors of this paper have come together and formed an ongoing research group. For this particular paper, the senior author, Denise Saint Arnault, contributed to the science and development of SPECS, and then stepped back from the authorship and specifics. We hope that the next phase will cover the completion of the full study, explained below.

## Overview of the Study

The study aims to gather detailed information about what clients and therapists regard as somatic psychotherapy interventions, and how they evaluate their impact. We intend to collect data about somatic psychotherapy clients' experiences during the course of therapy, their presenting problems, and overall lifestyle

improvement. At the same time, we want to hear from their assigned clinicians about their view on what happened in the sessions. We anticipate somatic psychology concepts overlapping since most somatic psychotherapy models have similar general aims (body awareness, emotional self-regulation, identity and agency formation, relational and attachment capacities, trauma resolution, relief of mind-body symptomatology, etc.). What emerged is a quantitative and qualitative mixed methods project that examines somatic psychotherapy as a conceptual and clinical model, and its impact on patient health.

The research proposal outlined **three specific aims**:

1. Examine the therapeutic effect of somatic psychotherapy on clients' health, symptoms, bodily awareness, and emotional regulation, while controlling for demographics and treatment expectancy
2. Describe the therapists' post-encounter analyses of their therapeutic encounters, including the type of body-oriented techniques, rationale for their use, and perception of their outcomes.
3. Examine the clients' and therapists' individual experiences with the somatic approach, therapeutic engagement, and emerging self-understanding.

To collect data from both sides of the clinical dyad, incoming clients and clinicians from both LPC and CSP are invited to participate in the research. Both centers are well established somatic psychotherapy training sites for marriage and family therapists (MFT), professional clinical counselors (PCC), and clinical psychologist trainees, associates, and interns on the licensure track. A battery of pre- and post-quantitative surveys are administered to clients, demographic and experience surveys to the clinicians, and post-treatment interviews to clients and clinicians. For example, the pre-treatment quantitative survey is administered to clients with questions about demographics; previous psychotherapy treatment and satisfaction, health and wellness (pain, vitality, social functions); depression (PHQ-9<sup>1</sup>); anxiety (GAD-7<sup>2</sup>); somatization (PHQ-15<sup>3</sup>); and interoceptive awareness (MAIA<sup>4</sup>). These questionnaires are useful in gathering information about a client's subjective experience of themselves and their therapy over time. Additionally, our goal is to track what treatments clinicians are using to address which problems, and whether they seem to work.

The study was launched at both clinics, and we have already collected a fair amount of data. Unfortunately, the project was halted by COVID-19. In March 2020, the

1. PHQ-9: Patient Health Questionnaire is a 9-item depression severity measure. See Kroenke, Spitzer, and Williams (2001).

2. GAD-7: Generalized Anxiety Disorder is a 7-item anxiety measure. See Spitzer, Kroenke, Williams, and Lowe (2006).

3. PHQ-15: Patient Health Questionnaire is a 15-item measure of the severity of somatic symptoms. See Spitzer, Kroenke, and Williams (2002).

4. MAIA: Multidimensional Assessment of Interoceptive Awareness.

clinics quickly had to shift their in-person sessions to online platforms. To add the task of ongoing data collection for the research project on top of this monumental change was too much for the clinics to manage. The plan is to re-institute data collection once psychotherapy work can return to face-to-face settings. It is now spring 2022, five years after our initial discussions, and we are still under the impact of the pandemic. Needless to say, reaching this point required commitment and dedication.

The newly developed measure, SPECS, aids practitioners and researchers by structuring the collection of clinical data after individual somatic psychotherapy sessions, and functions as a valuable training and teaching tool for therapists, supervisors, and students.

## The Need for SPECS

While we developed our research methodology, we realized that we needed a more specific instrument to track interventions employed in sessions. We needed to know which interventions clinicians used, why they used them, how well they were perceived to have worked, and what they planned to try in the next session. We wanted the instrument to be a mix between a progress note and treatment plan, with more specific attention paid to somatic interventions.

Many somatic psychotherapy interventions are intuitive and felt responses to clients' somatic presentation, and their engagement in the therapeutic dyad and environment. It seemed necessary to devise an instrument that would make some of these implicit processes more explicit. We wanted to clarify the therapeutic aims, the somatic interventions, and the healing mechanisms inspired in clients. Most psychotherapeutic measures look at outcomes; however, we wanted to create a measure used by clinicians to evaluate their sessions, and to describe their most common practices. Additionally, it was essential that the instrument be brief so that it wouldn't add much time to the normal session documentation.

A particularly important criterion was that the instrument should be useful to the clinicians as well as the researchers. This valuation of research participant experience is in alignment with a more collaborative and social justice-oriented framework of research (Caldwell & Johnson, 2012), as opposed to mining the data of clinicians or clients with minimal improvement of their own experience. The prioritization of clinician experience was ultimately essential for encouraging participation from the clinicians.

We briefly reviewed some existing literature and instruments available to address our aims. If an existing instrument could be found that closely approximated our goals, it would be preferable to fold our data into the context of other similar research with psychometric validity and functionality. Unfortunately, none of the existing options were able to fully fit our needs. In the

following section, we will present some of the existing literature on somatic instruments.

## Evaluation of Existing Research Tools

Our need for instruments that particularly addressed somatic interventions and somatic work focused our search. Our initial exploration included the European Association of Body Psychotherapy's Bibliography. A cursory search there provided helpful meta-reviews, such as *The Effectiveness of Body Psychotherapy* by Bloch-Atefi and Smith (2015), May (2005), and Rohricht (2009). Mehling et al. (2009) reviewed 39 body awareness instruments, and found two with high reliability and four with validity. Many of these studies were focused on client outcomes, and were difficult to adapt for a training clinic model. On the shoulders of that review, we continued to look for more nuanced instruments that could capture the wholeness of a therapy session in a brief and usable instrument.

Another criterion for inclusion was an instrument that touched on somatic countertransference. This is a core aspect that separates somatic psychotherapists from other psychotherapists; the unique attunement to the physical experience of being with a specific client. There are various case studies and theoretical approaches to somatic countertransference that highlight its importance, but they haven't yet led to creating validated measures. Vulcan (2009) provides an excellent overview in this area, but no somatic countertransference measures are mentioned. A few studies that explore the clinical experience of somatic countertransference include Gubb (2014), Forester (2007), and Stone (2006). These all explore the qualitative therapeutic experience, but do not translate into quantitative research. A key concern for our research to plug this gap would therefore be to use mixed methods. For that purpose, we focused our continued search on somatic tools with mixed methods capabilities.

The best tool we found was Egan and Carr's (2005) *Body-Centered Countertransference Scale* (see Booth et al., 2010), which does specifically address somatic countertransference in session with clients on a quantitative scale. However, the timeline was limited to "the past six months." For our purposes, we wanted clinicians to reflect right after a session on that immediate session, and to use those reflections on the interventions and content of this session to inform future treatment planning.

The most in-depth, somatically-oriented instrument is the *Multidimensional Assessment of Interoceptive Awareness* (MAIA) (Mehling et al., 2012). This is a thoroughly scientifically validated instrument for dealing with the somatic concept of interoception and bodily awareness. This instrument helps users assess themselves for concepts such as self-regulation, emotional awareness, and body listening, among others. The instrument is thoroughly psychometrically validated, and has been

translated into over 20 languages (Mehling et al., 2012, p. 8). Unfortunately, the MAIA does not capture clinicians' experiences during sessions, and is neither specific enough to inquire into the therapeutic relationship, nor broad enough to integrate multiple types of somatic interventions and therapeutic goals.

After this brief review of the options available, we realized that none of the existing instruments fully met our needs. It became apparent that creating our own tool for our research, with an eye on the possibility of it being generalizable for others in the future, was necessary. Thus, we decided to create a new, user-friendly measure for somatic psychotherapy interventions (SPECS).

## Intention and Development of SPECS

SPECS seeks to clarify somatic interventions applied in clinical sessions, the intentions behind these interventions, and their observed outcomes. SPECS' wider purpose is to support researchers and clinicians in understanding, integrating, and advancing the practical efficacy and unique contributions of somatic psychotherapeutic approaches in encouraging client health. Therefore, the data collection – and especially *how* the data are collected – needs to be palpably felt as one link in a chain of helping and healing. In the spirit of congruency, the motivating and ongoing evaluative prompts during creation were: How does a clinician's relationship with SPECS contribute to the learning and service of healing? And are the questions we are asking, as well as *how* we are asking these questions, inviting the clinician into the very somatic realm we are studying?

In order to center clinicians' experience, and harmonize with the project's valuing of collaboration, when it came time to test SPECS in the field as an instrument in the larger research project, MFTs, PCCs, and clinical psychologist trainees, interns, and associates at both LPC and CSP participated in two pilot studies inspired by the following inquiries:

- What are your experiences of the instrument's ease of efficiency (design, flow, organization)?
- In what ways has using SPECS benefited both your clinical understanding and your treatment formulation of your case-work?
- In what ways have you noticed clients' therapeutic process benefiting by using SPECS?

Each pilot study occurred over a two-week period, and included the participation of approximately ten MFT/PCC and clinical psychologist trainees, interns, and associates from both clinic sites. The following is a summation of the clinicians' experience of completing SPECS after every session.

Clinicians responded positively to SPECS' ease of use and practical flow, while also suggesting a consistent format of "Check all that apply," as well as a layout that provided more space for narrative write-ins. This was

crucial for having quantifiable data as well as narrative, qualitative data. Additionally, there was, and continues to be, an energetically voiced desire to integrate SPECS into the required standard clinical case progress notes.

The clinicians found the instrument's content helpful for providing options and reasoning when considering somatic psychotherapeutic interventions. They also found it supported their self-observation, as well as articulation of explicit and implicit clinical dynamics, and it helped them create a thread from one session to the next. The instrument's fields that were most influenced by the clinicians' reflections were the "Interventions Used," its immediately related "To Promote" section, and the area focused on the "Therapist's Experience in the Session." (See SPECS below for reference.)

The "Somatic Resonance/Countertransference" and "Self-Care" categories were fleshed out to underscore their clinical value, and to encourage clinicians' mindful consideration of their own subjective presence. Recognizing the profound clinical significance of multiculturalism and intersectionality embodied by both client and practitioner, "Embodiment of Culture" was emphasized to explicitly promote clinicians' careful awareness of and active attention to the central presence of self-identities within therapeutic relationship dynamics.

The following is a list of specific themes and feedback that emerged:

- The language of SPECS helped clinicians clarify their intentions to themselves, their colleagues, and their clients, and created an increased sense of safety in the therapeutic process.
- The long list of somatic interventions encouraged clinicians to reflect on the modalities they routinely use, and stimulated novel approaches.
- The connection of recent client outcomes to future session planning helped maintain the arc of treatment continuity.
- The opportunity to consider clients' somatic states with a deepened level of regular detail enhanced the potential of appreciating substantial shifts happening slowly, and helped clinicians maintain awareness of all that happens nonverbally and intuitively.
- The steady invitation for clinician self-reflection increased therapist/client attunement and awareness of somatic countertransference, and further emphasized and contextualized the beneficial influences of the clinician's somatic bearing and actions within each session and throughout the course of treatment.

We appreciatively took this feedback and continued to revise and fine-tune the sections until we came up with the final one-page instrument. The following is a comprehensive look at each section, and is offered as an informal user guide with general definitions and suggestions.

**Somatic Post-Encounter Clinical Summary:** Therapist Code: \_\_\_\_\_ Client Code: \_\_\_\_\_ Session Date: \_\_\_\_\_ Session #: \_\_\_\_\_

**1. Presenting PROBLEMS or areas of exploration this session:** *(check all that apply)*

- |  |   |
|--|---|
| <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Medical Issues/Physical Pain       |
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Employment/Economic/Housing Issues |
| <input type="checkbox"/> Trauma          | <input type="checkbox"/> Relationship Issues                |
| <input type="checkbox"/> Grief           | <input type="checkbox"/> Family Issues                      |
| <input type="checkbox"/> Sexuality       | <input type="checkbox"/> Drug/Alcohol Use                   |
| <input type="checkbox"/> Gender Identity | <input type="checkbox"/> Socio-Cultural Issues/Oppression   |
| <input type="checkbox"/> Other: _____    |   |

**2a. Somatically-oriented INTERVENTIONS used this session:**

- ☐ Somatic Psychoeducation
- ☐ Focus on Breathing
- ☐ Body Sensation Tracking
- ☐ Focus on Gesture/Posture/Muscular Tone
- ☐ Spatial Proximity
- ☐ Gaze/Orienting
- ☐ Vocal Tone/Volume/Prosody
- ☐ Use of Therapist's Own Body (Posture, Tone, Gaze)
- ☐ Mindfulness/Meditation
- ☐ Props
- ☐ Touch (Client-Self Touch or Therapist Hands On):  
(specify) \_\_\_\_\_
- ☐ Movement: (specify) \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

**2b. To PROMOTE:** *(check all that apply)*

- ☐ Awareness/Insight of
  - ☐ Inner Landscape
  - ☐ External Environment
- ☐ Emotional Regulation
  - ☐ Up-regulating: Enhancing/Opening/Express
  - ☐ Down-regulating: Calming/Soothe/Contain
  - ☐ Centering/Grounding
- ☐ Relationship Skills
  - ☐ Communication
  - ☐ Intimacy/Connection
  - ☐ Boundary Articulation/Individuation
- ☐ Other: \_\_\_\_\_

**3. OUTCOME of the session (include both client's words and somatic clinical observations):**

\_\_\_\_\_  
\_\_\_\_\_

**4. THERAPIST'S Experience in session:** *(check all that apply)*

- a. **General Sensation:** ☐ Comfort ☐ Discomfort ☐ Neutral/Numb
- b. **Bodily Awareness:** ☐ Shallow Breaths ☐ Deep Breaths ☐ Hypotonic ☐ Hypertonic ☐ Energized ☐ Lethargic
- c. **Somatic Resonance/Counter Transference:** ☐ Ease ☐ Engaged ☐ Off Balance ☐ Overwhelmed
- d. **Self Care:** ☐ Grounding ☐ Centering ☐ Orienting ☐ Posture ☐ Breath ☐ Other: \_\_\_\_\_
- e. **Embodiment of Culture:** ☐ Similarities to Client ☐ Differences ☐ Other: \_\_\_\_\_

**General Description:** \_\_\_\_\_

\_\_\_\_\_

**5. Somatic GOALS for next session:**

A.

B.

**6. Planned Somatic INTERVENTIONS to address these Goals (see "INTERVENTIONS" above for suggestions):**

A.

B.

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## SPECS Specifics

SPECS was designed using a distillation process. The authors identified broad categories of interventions and the intentions for their use. Also included is the subjective experience of clinicians that informs the process of somatic psychotherapy. This distillation aims to allow clinicians from a variety of different schools of training to be able to document broad categories of interventions and methods. The following is a more in-depth look at the anatomy of each section.

At the top, SPECS has space for the therapist's and client's code for identification and for confidentiality. The session date and session number help situate the data in the larger course of treatment.

Here are descriptions of each section:

**Section 1. Presenting Problems:** This section shows the client's issues being addressed in the specific session and in the therapy. A wide variety of common clinical issues are listed. This information is important to show that specific interventions are used to target particular problems.

**Section 2a. Interventions:** This section captures which interventions are being used. While many non-somatic interventions are used in most therapies, this list attempts to focus on the broad types of somatically-focused interventions used in the field.

- **Somatic Psychoeducation:** Explanation to clients about the process of somatic psychotherapy and the benefit or purpose of specific interventions in addressing the relevant issues and problems.
- **Focus on Breathing:** Increased awareness or active engagement of the client's experience of breathing.
- **Body Sensation Tracking:** Tracking the moment-to-moment flow of sensations of the ongoing felt-body experience.
- **Focus on Gesture/Posture/Tone:** Identifying and exploring gestures and postural stances, patterns of formation, as well as momentary bodily expressions. Identifying and exploring tone, ranging from hypotonic to hypertonic.
- **Spatial Proximity:** Exploring the physical distance in the room between client and therapist, and the associations and ramifications that emerge in the contact process.
- **Gaze/Orienting:** This may include therapist/client eye contact, the client's use of their eyes to orient in the moment, or any other conscious use of visual perception.
- **Vocal Tone/Volume/Prosody:** Shifting volume, tone, patterns, and rhythms of speech and voice, implicitly without comment, or as an explicit invitation for client exploration.
- **Use of Therapist's Own Body (Posture, Tone, Gaze):** Conscious or unconscious shifts of posture, muscu-

lar tonicity, use of gaze, gesture, stance, etc., of the therapist.

- **Mindfulness/Meditation:** Use of client's attention to the range of experience in the moment, especially of sensations and feelings, and associated thoughts. Training clients to pay attention and tend to themselves, in the moment.
- **Props:** Pillows, blankets, toys, chairs, clay, baseball bats, exercise equipment etc. used to aid the therapeutic exploration.
- **Touch:** Use of touch in the therapeutic process, including client's self-touch or the clinician's use of touch.
- **Movement:** Any type of guided movement when sitting, lying down, or standing, either subtle or large movements, internal or external.
- **Other:** There is room for the clinician to add any other interventions not mentioned above.

**Section 2b. To Promote:** This section tracks the purposes for which the interventions are used. It encourages clinicians to make the connection between the interventions they are using, and why they are using them. It is used to reflect on which interventions work best for which outcomes with each client. (We considered using lines to connect the interventions and reasons, but ultimately decided that would be too time-consuming for clinicians, and speculative from a research perspective.)

- **Awareness/Insight** is aimed primarily at a client's conscious awareness of their *internal landscape* or *external environment*, and is a primary focus of many therapies.
- **Emotional Regulation** consists of 1) "Up-regulating," which increases healthy psychophysical sympathetic nervous system state activity and emotional expression, with the ability to open to and enhance experience; 2) "Down-regulating" increases the parasympathetic nervous system functioning and helps reduce overstimulating or hyperarousal states; and 3) "Centering/Grounding" helps a client connect to a solid base, and bring them back to being in the present moment. Together, these create emotional functionality, flexibility, and range.
- **Relationship Skills** include 1) "Communication," both verbal and nonverbal; 2) "Intimacy/Connection," which includes physical or emotional vulnerability and feeling close to others; and 3) "Boundary Articulation/Individuation," which allows one to maintain a sense of self within relationships. Together these skills address relational wounds, repair relational ruptures, and open to an embodied sense of vitality in connection.

**Section 3. Outcome:** How did the session go? What were the effects of the interventions, and did they achieve the goals intended? This is the clinician's perspective on the main takeaways, including the client's reported experience.

**Section 4. Therapist's Experience:** The therapist's subjective experience is part of the therapeutic process, and informs the treatment. We break this down to five categories, which are generally self-explanatory. The goal is for the therapist to reflect on what was unique about this session, and to differentiate this from their personal state before they started the session. "General Description" allows a more qualitative and creative way to reflect on the clinician's intersubjective experience of being with the client.

**Section 5. Somatic Goals:** This section is an aid in developing the overarching goals of the therapy, and in connecting one session to the next. It helps keep the larger somatic treatment plan in mind, encouraging ongoing conceptualization of the course of treatment from the somatic lens.

**Section 6. Planned Somatic Interventions:** Clinicians consider specific interventions from the list in 2a., or their own, specifically to address the goals outlined in number 5 above. This encourages them to make a specific plan that they could revisit before the next session. In the future, researchers or clinicians could track how many of these interventions were actually used in the next session. Pilot feedback has been that these last two sections have been very helpful in thinking about what needs addressing in the therapy, and how to achieve the goals that the client and therapist collaboratively have set. These sections can help bridge from the current session to future ones in a coherent fashion.

In the spirit of collaboration, SPECS is a living and adaptable document. We hope it will change as it is used, and as the field develops. We encourage modifications, and we request notice by emailing [specs@ciis.edu](mailto:specs@ciis.edu) if you intend to use it or tailor it for your work, so that we can track and continue developing the tool.

## Future Developments

We acknowledge that SPECS has limitations, and we hope that it can be improved with input from the researchers and clinicians who use it. The instrument is limited to the subjectivity of the user, and would benefit from wider acceptance and agreement of terms. SPECS includes the biases that clinicians have toward their own sessions, and encourages them to reflect on their patterns and habits. It is currently in paper form. We are currently working on a digital version for future use for large-scale research, and a standardized process for implementing adaptations and changes, which we intend to publish through *IBPJ*. In the meantime, please email any feedback to [specs@ciis.edu](mailto:specs@ciis.edu). Further, we need to test SPECS' cultural relativity.

There are inherent biases within the concepts of SPECS that come from the social, cultural, and racial context from which it originates (Freedman et al., 2020). The authors are all white, and practice in the Bay Area of California, which is steeped in a particular therapeutic

culture. Regional and international feedback will help improve the tool, and can bring the field into dialogue across cultural differences.

SPECS highlights the relational experience of therapy, and validates subjective and objective observation. A future adaptation of SPECS could be a client-centered instrument, which could be used for research and also to encourage clients to review each session, and note important insights and experiential learning. There are many other potential versions of SPECS, but beginning with the clinician's perspective seems the most fruitful for coalescing the interventions and gathering larger data.

We hope that our work over these past years will provide the reader with an opportunity to review their own practice, and inspire them to use SPECS to dialogue with other clinicians and researchers. SPECS is intentionally generic and simple so it can be used in many settings and adapted at will, with notice to the authors. Every participant will help contribute to developing the field of research, as long as there is dialogue. This growth is vital for our field to thrive. Cruz and Koch (2015) have noted that quantitative and evidence-based research may be difficult to engage, but serves to strengthen the foundation of the field, and vastly improves client care.

## Conclusion

Our intention is that SPECS contributes to the growing body of research in somatic psychology. For that to happen, it must be used widely, improved upon, and debated by researchers and practitioners alike. The techniques that it describes are often more art than science, and as such are difficult to operationalize. By beginning with a measure that casts a wide net and integrates descriptive data, we hope to provide a starting point for further clarifying and codifying terms and techniques across various modalities within the somatic specialization (Mehling et al., 2011). We want to help address the difficulties that disparate limbs of specialized modalities have in communicating with each other. As Dr. Barnaby Barratt notes: "The only way to transcend this problem is for us to have articulate research by which we can compare and appreciate our different theories and methodologies, thus empowering us to communicate better with each other" (2019, p.17).

SPECS can function as a therapist training tool, a research instrument, and as an addition to clinical documentation. It can be applied by brand new and experienced clinicians, as well as mixed methods researchers. We acknowledge that SPECS is not intended to become psychometrically validated or to prove efficacy. But it can help move the field of somatic practice towards becoming evidence-based. This instrument adds a tool to somatic psychotherapy so that researchers can further the knowledge base in the field. We must train clinicians to be able to reflect on and explain their work – wheth-

er those colleagues apply the same somatic discipline, come from a different somatic perspective, or are general practitioners without somatic training.

Having researchers and clinicians who are more embodied, reflective, and able to evaluate the benefits of somatic psychotherapy will improve client experiences. We need ongoing financial support and collaboration between member organizations such as the USABP,

EABP, universities, and training organizations to create research that validates the benefits and mechanisms of all interventions being used. This can be done only as a collective effort, and is more and more important as dominant cultural trends continue to drag us toward dissociation and disembodiment (Leder, 1990; Van Wolputte, 2004). SPECS is a roadmap toward the ongoing goal of illuminating somatic psychotherapy and its integrating and healing contribution to the world.



### Acknowledgment of Support:

California Institute of Integral Studies, faculty and staff in the Somatic Psychology program, clinicians at the Center for Somatic Psychotherapy and Lomi Psychotherapy Clinic, United States Association of Body Psychotherapy, University of Michigan, and Phoenix DeLeon.



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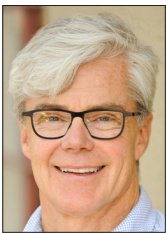
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