# Research 101 for Somatic Psychotherapists: Cultivating a Research Mind

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Abstract

Many parallels exist between clinical practice and research practice in somatic psychotherapy, creating rich possibilities and cross-fertilizations. In this article, the authors introduce and discuss these parallels, and examine how they can be leveraged to advance emerging research interests in the field of somatic psychology.[1]

*Keywords:* body psychology, body psychotherapy, somatic psychology, research, embodiment, clinical research, psychology research

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Traditionally, somatic psychotherapists have focused on building theory as it informs, and has been informed by, clinical practice: an activity that is common across psychological disciplines that are in their formative stages of development. In this formative stage, the field also has tended to organize around theory-building via guild systems; students study both theory and practice under an identified master who is often a pioneer in the field. Under these conditions, the field often 'borrows' research from other disciplines in order to understand and identify itself (Caldwell & Johnson, 2012; Heller, 2012). As the field of somatic psychology matures, it has supported the development of university-based academic programs, institutions that devote themselves to cross-modality constructs and scholarly critiques. The activities of these programs can help pave the way for the field to build on its theoretical bases through empirical study, thereby 'fleshing out' more fully its own research interests and validating its unique perspectives, using constructs that all students of the field can access and study. This article attempts to identify ways in which clinical and research processes share common values and methods. By taking advantage of these overlaps, it is possible to increase our collective capacity as clinician-researchers to engage in scientific and critical inquiry, and potentially influence the broader culture to engage in more embodied research methodologies.

Though the particular worldview that science creates is only one way to look at and understand phenomena, it nevertheless holds some important values that can assist with the maturation of a field like somatic psychology. Science values systematic inquiry, a way of approaching problems in a methodical way. It commits to self-questioning as a way to surface and correct for implicit biases. It stresses self-correction by replicating studies and exposing them to the criticism of peers.

[1] This article is edited and adapted from an interview for Somatic Perspectives with Serge Prengel. The original interview can be found as an audio recording podcast and as transcription on the United States Association of Body Psychotherapy (USABP) website . Our thanks to Corinne Bagish for providing the interview transcription upon which this article was based.

Most importantly, it cares about understanding the individual and collective world, rather than asserting the self-interest or unexamined views of any particular individual or group (Jackson, 2008). By studying the field as a whole, research in body psychotherapy can help to create an overarching pedagogy that can support and modernize the theoretical and clinical work of its pioneers, and more fully address some of the urgent social and mental health problems of the 21st century.

The professional associations in the field of somatic psychology are comprised primarily of clinicians, many of whom feel somewhat distanced from the research agenda and activities in somatic psychology (Academic Council meeting, United States Association of Body Psychotherapy (USABP) conference, Philadelphia, 2008; Scientific Symposium, European Association of Body Psychotherapy (EABP) conference, 2012). Many members of these associations haven't been involved in any research since they finished their academic degrees. And for some, those degrees or trainings did not necessarily involve being a principal investigator of original research, or involved in any form of research. Given that research can be complicated to undertake, difficult to interpret, and experienced as inaccessible, many clinicians rightly feel under-prepared to engage with research activities and findings in an informed way. Also, given that research often dictates theory, policy and practice in psychotherapy, clinicians may also challenge psychological research as being insufficiently related to the 'on-the-ground' experience of working with actual people and their problems. Historically, there has been some understandable disconnect between the largely academic culture of research and the primarily clinical culture of body psychotherapy or somatic psychotherapy practice. As trainers, researchers, and clinicians, the authors see the intersections between the clinical perspective and the research perspective and are motivated to articulate the common ground across these areas, and to identify an attitude that can be common to both. As Jackson so aptly puts it, "What makes something a science is not *what* is studied but *how* it is studied" (2008, pp. 4).

For instance, the authors believe that there are ways of approaching both the clinical experience and the research experience that are extremely compatible. In fact, they stem from the same root. As academics, we tend to describe those roots in terms like "critical thinking" and "attitude of inquiry", and yet those same skills can be developed by working hard to become a good clinician: one who holds an attitude of curiosity and humility as a therapist. The attitudes and values of a good clinician actually parallel those of a good researcher.

This can be particularly true in the current research climate, where constructivism can be honored as much as positivism (Charmaz, 2000; Denzin & Lincoln, 2011). Positivism comes from the belief that there is a particular, knowable world out there, and it can be discovered through empirical means. Positivism has fueled much of the research activity of the last few hundred years. Constructivism, on the other hand, asserts that human beings build or construct our world out of our unique experiences, experiences that are influenced by our culture and by other social forces. Positivism tends to want to find 'the truth,' while constructivism is interested in people's 'lived experience' of their world: *their* truth. Both these views can be useful, but – because a somatic psychotherapist usually wants to help empower clients to relate to their bodies as a powerful source of inner knowledge—clinicians can learn a lot through constructivist approaches.

A good 'constructivist' clinician asks questions that are genuinely curious and avoids leading questions. Not, *"Let's direct this client over here because we think we know what is best for this person"*, but instead, *"What was that like for you?"* This is particularly important when inquiring about the client's somatic experience, which is so inherently complex, subtle, and nuanced. To be genuinely helpful, a good clinician assumes that, even with very highly tuned perceptiveness and a strong

empathic connection, one is never going to know exactly what it is like to be in someone else's body, and that one does not have the right to dictate what is happening in someone else's body or how those happenings are interpreted.

This same process occurs when interviewing a research participant, particularly in a qualitative study. Qualitative methods want to get at the 'qualities' of a person's experience, rather than 'quantifying' experience by reducing it to numerical values (Denzin & Lincoln, 2011). In qualitative inquiry, for instance, researchers don't want to ask a client leading or loaded questions, nor do they want to impose an hypothesis. Like good clinicians, good qualitative researchers want to lead participants to a place of their choosing that they might not be able to get to by themselves. This facilitative role is nearly identical to therapy, where the task of the therapist is to facilitate the exploration and articulation of an experience that is meaningful to the client, rather than impose a pre-packaged analysis.

This important shared characteristic might be described as open mindedness, a curiosity and non-attachment to outcome. A significant impediment to valid research relates to wanting a particular result instead of wanting to learn something. This is also a source of difficulty in therapy. The standards of practice for both psychotherapy and research are designed to provide a framework that keeps the therapist's counter-transference (or the researcher's bias) from intruding.

Unique to research is that the articulation of an experience is understood not just to be useful to the research participant, but potentially also to others wanting to understand this phenomenon. Where a clinician might ordinarily conclude an intervention with, "*Okay, great, sounds like you just got something that's useful for you*", a researcher might wrap up with, "*Thank you! Now I need to figure out a way to frame what you've just communicated to me in a way that makes it intelligible and relevant to other people.*" In this sense, research may have a more of a parallel to clinical training.

One of the root concepts in research – one taught on the first day of any research class – is the concept of skepticism. All researchers are required to be skeptics – to refuse to accept anything without evidence, and to question everything. Another important concept in research is transparency – studies are expected to be transparent, so that others can question it. Researchers are expected to publish how they conducted the study, and to be explicit about the methodology and the analysis. Researchers want their research to survive the skepticism of their peers.

Although the concept of skepticism is central to good research, the word 'skepticism' doesn't usually translate well to a clinical context and could be counterproductive to the therapeutic relationship. Despite this, it can be very useful for a therapist to take an initial attitude of neither believing (nor disbelieving) the client's statements, but attuning to them and trusting that the mutual inquiry will yield therapeutic results. The concept of transparency is also central to the clinical supervision process; the supervisee is expected to reveal the details of their work and to critically examine ways in which it can be improved. As clinicians, we assume that we never outgrow the need to expose our work to the feedback of other professionals.

Another way that skepticism translates to clinical practice is in the examination of bias and clinical "blind spots" – therapists benefit from questioning their work in an open, curious, and rigorous way. Science offers a number of rigorous ways to examine a project, whether it's a therapeutic session or research study. These strategies always involve critical thinking, which is central to learning an academic discipline, including research methods. Critical thinking pushes back against both egocentric thinking ("This is true because I want to believe it to be true.") and sociocentric thinking ("This is true because my people have believed it for a long time"). Clinicians can benefit from this kind of rigor – training in research may be able to make us better self-reflectors, as clinicians.

Skepticism might also translate to a clinical context via the suspension of judgment. A good clinician is discriminating, but is also capable of suspending judgment, until he or she has enough evidence to be able to say, "*I'm reasonably certain that this is what's going on*," or waiting until session three or four before saying, "*You know, based on what you've said and what I've heard and what we've talked about, I feel reasonably certain that this may be one of the things that's going on here. What do you think?*" In research, investigators often hold a 'working hypothesis,' which means holding an idea about what is going on while still gathering more data before feeling confident. Postponing certainty is central for both good researchers and good clinicians. In therapy practices, for instance, it is often noted that the more certain a therapist feels about something in a clinical environment, the more likely it is that they are in a state of countertransference (Martin, 2000). Both in clinical practice and in research, it is important not to impose pre-conceptions on methods or interventions.

There is a parallel practice in research that strengthens a research study's outcome, when the researcher goes back to participants in a qualitative research study and says, "*Did I capture what you told me? Does this description fit your experience*?" Additionally, co-researchers may each analyze the same data to find congruencies and affirm findings: "*This is how I analyze the data. When I analyze the same data that you gathered; I get very similar results. The themes that I identified when I looked at your data are the same themes that you've identified.*" This "inter-rater reliability" establishes some degree of confidence that not just the principal researcher asserts a set of findings, but others do as well. In a parallel process, clinical peer supervision gives us inter-rater reliability in a therapy context.

**Developing Research Skills**

Clinicians may become intimidated by research when they assume that research requires large, sophisticated studies involving laboratories and complex equipment. In reality, there are many simple studies that make important contributions without the need for machines or complex statistical analyses.

Three central concerns of science are to describe behaviour, predict behaviour, and explain behaviour. By doing this, science can help society to solve problems. Therapists are also interested in these three elements, but they tend to focus on studying behaviour in an individual or group as a way of facilitating the healing of just that individual or group. As noted above, there are three basic types of research methodologies. The one that tends to be the most familiar to the public is the explanatory method. This method uses experiments to determine cause and effect between variables. This method can also be called outcomes research. This method would answer the question, "*Did this treatment method cause a beneficial result in a certain number of clients, and does that benefit persist?*" This research can be complicated and difficult to do well, because it requires the researcher to control everything in the study in order to make sure that some other variable isn't the one causing the result. To use a clinical example, a therapist can test a client in various ways to see if they improved as a result of being in therapy, but if the client was simultaneously taking yoga class while in therapy, it isn't possible to say that yoga wasn't the cause of the improvement. Clinically, it is often impossible to control the variables in a person's life such that it is possible to assert that the salient ingredient in their improvement was psychotherapy. Research has developed strategies for addressing this problem, such as extremely controlled conditions, large sample sizes, and random assignment to treatment groups, but few clinicians have the time, money, training, or will to engage in such controlled environments. Although this type of randomized controlled trial (RCT) is required to 'prove' whether a treatment (like a new drug or a therapy) works or not,

there is active debate as to how appropriate this type of 'medical' research is when applied to the field of psychotherapy (May, 2012).

The second type of research method is called relational or predictive. In this method, one searches for a relationship, a correlation between two things, but doesn't attempt to establish which one causes the other, or whether the two things are caused by a third variable. Correlations can be either positive or negative. In positive correlations when one variable goes up, so does another, such as ice cream consumption going up when temperatures rise. In negative correlations, when one variable goes up the other goes down, as in the correlation between increased education for women and a decrease in infant mortality. In predictive studies you don't necessarily need a control group, and this can make the study easier and less costly. This can be important for research that involves therapeutic interventions, because withholding treatment (from a control group) is considered unethical in some situations.

The third form of research is descriptive. In this type of study, you are seeking to simply describe phenomena, either in a natural setting, or in a laboratory. You might observe non-verbal communication, for instance, or interview someone about their experiences of therapy. Here is where you might do a clinical case study, because you are seeking to just describe the effect – on a particular person – of a course of treatment. Surveys tend to be descriptive as well, as they report the trends in people's answers to a certain set of questions or statements. Descriptive research studies can be a lot easier to set up and run. It doesn't take a lot of money or equipment to do a case study, for instance. But a note of caution – it can be easy to do these methods, but hard to do them well. The important issue is to apply 'the research mind' to any project that you undertake. That way, even a modest, simple study can contribute to the field, and be a credit to the field, because it is done with intellectual rigor, systematic thinking, examination for possible error or bias, good methodology, transparency, and ethical actions.

In a sense, clinical work involves all three types of research. Therapists engage in descriptive research when they ask clients to describe their somatic experience, and describe the client's postures, gestures, or expressive movements to them. They engage in correlational research when they support a client to experiment with the relationship between their breath and their anxiety. Therapists engage in informal explanatory research when, over time and repeated trials, the client finds that moving as they feel an emotion causes them to feel more empowered than when they freeze during an emotion.

One difficulty that arises for many clinician/researchers is the need for permission from an institutional review board (IRB) when doing any kind of human subjects research. In order to ensure that the participants in a study are not harmed as a result of their participation, it is necessary to have a proposed study reviewed by a trained group of researchers who will determine whether or not the study obeys ethical guidelines centered around making sure participants are at choice, protected from harm, and fully informed. While all universities and research institutes have IRB Boards, they are difficult to access by private clinicians. This gives the field of somatic psychology one more reason to support the continuance of the field in academic environments, as the research that helps us investigate what we do will need to involve academic or governmental partnerships.

**Future Directions**

What does it take to build on our clinical mind and generate more of a research mind? Below are some recommendations:

- All good research begins with looking at the literature relevant to the research question, and

having a good grasp of what others have already done in this area, before you attempt to do something new. One way to develop research skills is to read the research literature in topic areas that are of interest, and becoming familiar with the methods used, and how the data was analyzed. Don't just read books on a topic, read the actual research articles that the books are based on. This also requires certain technical skills: learning how to use online databases, and library searches.

- Pair up with a colleague who has done research before, and do a project together. Or pair up with a researcher who wants to do research on some (of your) clinical patients: though both of you will need to ensure that the research does not interfere with the therapy.
- Don't count on grant monies. Grant monies tend to flow to people who already have an established history of research publication. Unless you can pair up with someone who has respected research credentials, it is best to:
- Start small, with a modest number of participants and modest research questions. Construct a project that you can do with little or no money, and that won't take years to accomplish. This will likely be descriptive or correlational research.
- When you do publish your results, make sure it is in a proper, peer-reviewed, scientific, psychology-based journal, ideally one that is fairly mainstream, with a citation index. It is probably best to ask someone familiar with research publications to 'mentor' you through the technical aspects of presentation, lay-out, format, etc.
- Don't attempt a research method that you don't have the resources or know-how to do properly. A project using an experimental method will not get published if you did not control all the variables and remove all possible alternative explanations, even if the results are interesting.
- Educate yourself on emerging research methods that are more culturally competent, consistent with the practice of psychotherapy and especially those that value the voice of those whose voices have been marginalized. These can include participatory action research, arts-based research, feminist-based research, indigenous-based research, and any method based in critical theory (Caldwell & Johnson, 2012; Chambers, 2008; Clifford, 1994). We don't need to buy into only engaging in positivistic research methodology, especially since those methods have in some cases been used to exploit and harm the people they study.
- Use research strategies that honor and privilege somatic experience (Todres, 2007), such as embodied reflexivity in research (Finlay, 2005; Hein, 2004), embodied data transcription (Brooks, 2010), embodied data analysis (Chadwick, 2012), embodied writing (Anderson, 2002) and embodied data presentation methods (Denzin, 2003; Spry, 2001).

**Conclusion**

Good research is essentially about developing a 'research mind,' which is highly related to a 'clinical mind.' More than anything, it involves an attitude of curiosity, open-mindedness, skepticism, self-monitoring, and thinking systematically and critically. The actual research methods follow from these. For instance, several currently successful therapies like Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT)[2] started by having therapists giving their clients questionnaires before and after sessions that asked about what worked, and what didn't, and why: another name for that process is 'pre-test' and 'post-test'.

[2] DBT combines standard cognitive-behavioural techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness, largely derived from Buddhist meditative practice (Linehan and Dimeff, 2001).

Over time, because they were willing to modify their work in response to feedback, their research became more elaborate and extensive and funded by grants, to the point where these therapies are now considered 'evidence-based'. Somatic psychotherapists can also start simply – taking courses in research, working together, supporting the work of university-based training programs, and by familiarizing ourselves with cutting-edge methodology that centralizes social justice issues and does not need a lot of resources beyond our embodied, clinically-informed, research-minded selves.

## BIOGRAPHIES

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