Somatics as Information, Not Modality

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ABSTRACT

Somatic attention in psychotherapy is widely treated as belonging to a specific family of treatment modalities, so that a therapist practicing outside those modalities may reasonably conclude that bodily information falls outside the scope of their work. This conclusion rests on a category error: whether the body is clinically informative and whether a therapist should conduct a somatic intervention are two different questions.

Embodied behavior changes measurably during psychotherapy, verbal report and physiological or behavioral state can diverge in ways a clinician cannot always predict, and bodily signals resist simple decoding across different bodies and histories. Together these findings support a further and more consequential claim: because therapeutic change proceeds across several channels at once, tracking the conversation alone cannot tell a therapist whether an intervention has landed as intended. Embodied change offers continuous feedback on the effect of the therapist's own preceding action, a channel of information available nowhere else in the room. Somatic observation, on this account, is not a specialized technique. It is part of the clinical reasoning available to any therapist, regardless of theoretical orientation, the moment attention to the body enters the therapist's field of observation.

1. SOMATICS IN THE CULTURE

A September 2026 feature in The Atlantic profiles Sybil Ottenstein, a Brooklyn therapist whose clients often arrive able to narrate their own psychological history in detail and still feel no better for the telling. What Ottenstein offers instead is somatic psychotherapy, an approach that asks clients to slow down, locate sensation in the body, and let whatever arises there move through them, framed explicitly as a shift from a “top-down” model of talk therapy toward a “bottom-up” model that starts in the body. The article traces this approach through Peter Levine's development of Somatic Experiencing, the surge in popularity of Bessel van der Kolk's The Body Keeps the Score, and the spread of somatic language across Instagram and TikTok, where an online trainer teaches followers to release grief through the hips.

The article treats somatics with more care than the trend pieces around it, and it earns that care. It acknowledges that many components of somatic practice draw on real evidence, that interoception carries genuine relevance to well-being, and that movement, breath, and attention to bodily sensation can meaningfully ease distress. It is equally willing to name the trend's overreach, noting that some of the field's central claims, that trauma sits in the body as a fixed residue waiting to be

discharged, rest on metaphor stretched past what the evidence supports. The account is fair to a practice that has both earned and outrun some of its enthusiasm.

What the article documents, and what it also inadvertently reinforces, is a framing worth examining. Somatics, in this rendering, names a family of interventions: techniques a client and therapist do together, deliberately, to move stored material through the body. While the framing holds truth, it is incomplete.

When somatics becomes synonymous with a modality, a set of things a therapist does, it becomes easy to assume that attention to bodily information belongs only to clinicians who do those things. A psychodynamic therapist, a cognitive-behavioral therapist, or a strictly verbal analyst can reasonably conclude that the body sits outside the scope of their work, since they have no plans to direct a client's attention toward sensation or teach anyone to discharge anything. This conclusion rests on a category error. Two distinct clinical questions have been collapsed into one. The first: is bodily change clinically informative? The second: should the therapist use a somatic intervention? A therapist can answer no to the second question while the first question remains fully alive, because the two are separate questions rather than one question wearing two names.

2. BEFORE THE INTERVENTION, THE OBSERVATION

Suppose a client is describing something relationally painful. Her sentences remain grammatical, her account stays coherent, and she answers each question the therapist asks. At the same time, her breath has become shallow, her shoulders have risen, and her responses have grown shorter without becoming less articulate. The therapist, following the content, asks a more detailed question, and the client answers it.

The session flows normally and nothing appears to go wrong. The therapist notices that the client remains verbal and continues to follow the content. However, something in the client has changed and the exchange of words themselves does not reveal the shift because the coherent and responsive speech itself was never the measure that would detect it.

Somatic work, understood as a set of deliberate techniques, is one thing a therapist might choose to do. Somatic observation, the act of registering what the body is doing while the conversation continues, is a different thing entirely, and it comes first. A therapist decides whether to intervene somatically only after noticing that something in the body has changed. When a clinician does not track bodily change through the session, pieces of clinically important information are not on the table for noticing and responding to. .

A moving foot, a flattened voice, a shift in posture: each is a fact about what the body did. Anxious, shut down, defended: each is a conclusion about what the fact means. A moving foot can indicate anxiety, restlessness, physical discomfort, or nothing of clinical significance. The observation

belongs to the clinician the moment it happens. The interpretation is a hypothesis, worth holding loosely until more evidence arrives.

3. MULTIPLE CHANNELS, ONE CONVERSATION

Psychotherapy proceeds across several channels at once: what the client says, what the client feels, how the client relates to the therapist in the moment, and what the client's body is doing. These channels are four aspects of a single conversation, available to a clinician who is tracking more than words.

Embodied behavior changes measurably during psychotherapy. Research on nonverbal coordination between client and therapist has found that movement synchrony runs measurably higher in genuine therapeutic interactions than in matched control conditions, with different forms of synchrony relating differently to process and outcome (Ramseyer & Tschacher, 2011, 2014). A more recent meta-analysis across thirteen trials found no significant overall association between synchrony and outcome, though synchrony in physiological measures showed a positive association while synchrony in vocal pitch showed a negative one (Gregorini et al., 2025). The honest summary is not that the body speaks one legible signal. It is that something measurable is happening in the body throughout a session, and that whatever is happening there varies by channel rather than moving as a unit.

4. WHEN THE CHANNELS DIVERGE

The channels available to observation do not move in lockstep, and the gap between them is often where clinically important information sits. Research on the discrepancy between self-reported affect and autonomic arousal, sometimes called verbal-autonomic response dissociation, has found that individuals can report one thing while their physiology indicates another, with theorists proposing that the gap reflects reduced attention to internal cues rather than the absence of the underlying state (Thayer, 1971; Schwartz, 1990). In trauma populations, high-dissociating individuals have shown inconsistent arousal patterns rather than the uniform suppression a simple "shutting down" model would predict, with some studies finding elevated arousal alongside dissociative presentation (Nixon & Bryant, 2005). Verbal report, autonomic arousal, and dissociative presentation can each move independently of the others.

The same bodily signal means different things across different bodies. Expression varies with pain, illness, medication, disability, cultural display norms, and neurological difference; recent research comparing facial expression production between autistic and non-autistic adults found that autistic individuals rely on different facial features and produce more variable expressions, a difference in expressive register rather than a deficit. A clinician who reads bodily signals as a fixed, universal code will misread some of the people most in need of accurate reading. The corrective is to hold

every inference as provisional, checked against context, history, and the individual person, rather than applied as a rule.

5. WHY FOLLOWING THE CONVERSATION IS NOT ENOUGH

If verbal report can remain stable while regulatory, relational, or psychological organization shifts underneath it, then tracking the conversation, however closely, cannot by itself tell a therapist whether the treatment is proceeding the way the therapist believes it is. A client can continue speaking coherently after curiosity has narrowed, after flexibility has diminished, after contact with immediate experience has receded. The words carry on but something else has already changed. A therapist whose observational field stops at the sentence has no way of knowing this has happened, and no way of knowing it matters until it surfaces in a form language finally registers, often much later and at greater cost.

6. THE BODY AS FEEDBACK ON THE THERAPIST'S OWN ACTIONS

If embodied change can reveal that something has shifted in the client, it can just as usefully reveal what shifted it, including the therapist's own preceding action. A therapist offers an interpretation, asks a question, or increases relational intensity and subsequently, something in the client changes. That change is evidence about both the client and the intervention.

This connects directly to a body of research on what William Stiles and colleagues have termed responsiveness: the finding that therapist behavior is, and should be, continuously adjusted in light of emerging information about the client's state rather than delivered according to a fixed plan (Stiles, Honos-Webb, & Surko, 1998; Stiles, 2009). Appropriate responsiveness depends on a therapist's ability to register what actually happened after an intervention, beyond whether the client voiced agreement with it. Two clients might both say “that makes sense” after the same interpretation. One becomes more spontaneous and elaborative afterward. The other becomes more polite, more still, more cognitively organized. Agreement sounds identical in both cases. Bodily and behavioral information can distinguish an intervention that increased openness from one that produced compliance, exceeded the client's current capacity, or intensified shame, sometimes well before the client has words for any of it.

This reframes what embodied observation is for. It is not only a richer picture of the client, gathered for its own sake. It is continuous feedback on whether the therapist's own actions are landing as intended, feedback that exists nowhere else in the room. A therapist who cannot see this feedback is missing a primary channel through which the session reports back on the therapist's own work, session by session, intervention by intervention, in something closer to real time than a client's retrospective account of how the week went could ever supply.

> *Embodied change offers continuous feedback on the effect of the therapist's own preceding action, a channel of information available nowhere else in the room.*

7. SOMATIC OBSERVATION BELONGS TO CLINICAL REASONING, NOT ONE MODALITY

The relevant distinction, then, is not between somatic therapists and everyone else. It is between clinicians whose observational field includes embodied change and clinicians whose observational field does not. A therapist need never conduct a somatic intervention, direct a client's attention inward, or ask anyone to discharge anything. But if that therapist cannot detect that a client has become less available, more compliant, more constricted, more activated, or differently organized while the words continue uninterrupted, a clinically significant change can occur without ever entering the therapist's reasoning.

Many experienced clinicians already track some version of this, noticing rhythm, posture, breath, and vocal change without describing the noticing as somatic work at all. Naming the practice does not compete with that tacit skill. It gives the skill a place in supervision, in case formulation, and in the ordinary moment of deciding what to do next, where an unexamined impression and a checked observation can otherwise look identical from the outside.

Somatic tracking, in this sense, is not a modality. It is part of knowing what is happening: what the client is bringing, what the room contains beyond the sentence being spoken, and what the therapist's own last action actually did. A clinician who leaves the body outside that reasoning has not stayed theoretically neutral. The clinician has narrowed the field of information available before the first hypothesis is even formed.

Related CEI Training: *Somatics as Information: A Cross-Orientation Training in Clinical Observation*

This training teaches clinicians to use somatic observation as clinical data, not to practice somatic therapy. Built for any theoretical orientation, it teaches participants to distinguish observation from inference, track embodied change without converting it into a fixed decoded meaning, and read bodily and behavioral shifts as real-time feedback on their own interventions rather than only as information about the client. No somatic technique, touch, or directed attention to sensation is required to use any of it. The training gives clinicians a place to put what many already notice but rarely name, so it becomes something they can use, teach, and examine in supervision rather than something they carry as an unexamined impression.

https://www.sarahozolshore.com/somatics-as-information

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