

Integrating somatic processes into schema therapy: A theoretical and clinical framework

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Abstract

BACKGROUND: In recent decades, psychotherapy has shown increasing interest in the embodied aspects of psychological experience. This “body turn” reflects increasing recognition of the need to better understand individuals with complex trauma, dissociation, and personality disorders, for whom purely verbal approaches are often insufficient. Schema therapy, as an integrative model, offers a suitable framework for incorporating a somatic perspective.

OBJECTIVE: The aim of this paper is to provide a systematic conceptualisation of the somatic perspective in schema therapy, situate it within a broader theoretical context, and illustrate its clinical applications.

METHODS: This article is a narrative review integrating clinical experience, with an emphasis on conceptual synthesis rather than systematic evidence evaluation. Literature was searched in PubMed, PsycINFO, Scopus, and Web of Science, supplemented by key monographs and training materials. Clinical vignettes are included to illustrate practical applications.

RESULTS: The somatic perspective conceptualizes schemas and modes as complex patterns involving cognitive, emotional, relational, and bodily processes. The body may serve both as an early indicator of schema activation and as an entry point for therapeutic change. Within the conceptual and clinical literature reviewed here, integrating somatic interventions is proposed to enhance assessment, affect regulation, and experiential transformation, particularly in individuals with complex trauma and personality disorders.

CONCLUSION: The somatic perspective may represent a theoretically and clinically relevant extension of schema therapy, contributing to deeper experiential integration and improved therapeutic effectiveness. Future research should focus on mechanisms of change and specific clinical indications of somatic interventions.

INTRODUCTION

Over the past two decades, there has been growing interest in embodied experience in psychotherapy. This shift does not diminish the importance of narrative, emotional, or cognitive work; rather, it reflects clinical observations suggesting that, in patients with complex or developmental trauma, dissociation, and rigid interpersonal patterns, verbal understanding alone is often insufficient to facilitate meaningful change.

Although cognitive-behavioural approaches occupy a central place in psychotherapy, their limitations often become apparent in the treatment of complex trauma. (Rameckers *et al.* 2024). Traumatic experience is often not represented as a coherent autobiographical narrative but persists in fragmented form—as sensory traces, affective states, and autonomic responses that are activated prior to conscious processing (Borrelli *et al.* 2024). Patients may cognitively recognize a situation as safe, while their bodies respond as if it was threatening (Karimov-Zwienenberg *et al.* 2024). Both dual representation theory and contemporary somatic approaches conceptualize trauma as being encoded not only in narrative memory, but also in bodily-organized states. (Brewin *et al.* 1996; van der Kolk 1994; Ogden & Fisher 2015).

Schema therapy offers a particularly useful integrative framework for incorporating a somatic perspective, as it extends beyond a narrowly cognitive model. Early maladaptive schemas encompass memories, emotions, cognitions, and bodily sensations, while schema modes reflect their moment-to-moment activation alongside coping responses. From the outset, the model has conceptualized psychopathology as a multi-level phenomenon that includes an embodied dimension. (Young *et al.* 2003; Baelemans *et al.* 2025; Juraszek 2026).

Within schema therapy, the somatic perspective is not an external addition but a natural extension of the original model. Schemas and modes can

be conceptualized not only as cognitive-emotional constructs but also as embodied patterns of experience and response. In clinical practice, they can be identified not only through verbal content but also through posture, muscle tone, and movement quality. The body represents a functional level at which schemas are expressed, maintained, and may be modified through autonomic and motor processes. Research on bodily maps of emotions further supports the idea that emotional states are associated with relatively consistent somatic topographies (Nummenmaa *et al.* 2014).

The relevance of the body becomes even more pronounced in preverbal, developmental, and relational trauma. Early experiences are often not encoded in organized autobiographical memory, yet they persist in procedural and somatic-affective traces. The organism may learn that closeness is dangerous and that needs will not be met. In adulthood, these experiences are more likely to manifest as automatic bodily reactions—such as tension, dissociation, or collapse—rather than as explicit beliefs. In such cases, working with the body can provide access to layers of experience that are difficult to reach through verbal means alone. This perspective is emphasized in somatically oriented trauma models as well as in body-focused schema therapy (van der Kolk, 1994; Ogden & Fisher, 2015).

A key intermediary between traumatic history and schema activation is the autonomic nervous system (Corrigan *et al.* 2011; Porges 2007; Prasko *et al.* 2011; Kotianova *et al.* 2018; Nesnidal *et al.* 2025; Juraszek 2026). Clinical literature often refers to the concept of the window of tolerance—an optimal zone of arousal within which individuals can feel, think, and remain relationally engaged.

Somatic work in schema therapy does not replace cognitive work but rather complements it. Whereas verbal exploration fosters meaning and coherence, somatic attention encourages a slower, more embodied process that increases awareness of activation and supports bottom-up change. The therapist attends two parallel streams of experience: the story the patient tells, and the processes communicated through the body. Where these diverge, clinically significant material often emerges. In this sense, the somatic perspective may enhance assessment, support co-regulation, and foster the development of an embodied Healthy Adult mode (Young *et al.* 2003). Body-focused schema therapy (BFST) extends the schema therapy model by integrating somatically oriented approaches and neurobiologically informed trauma work. This style is especially important for individuals with complex trauma because it supports safety, slowing down, and the restoration of trust in internal signals (Kurtz 1990; Gendlin, 1996).

The aim of this article is to describe the somatic perspective in schema therapy and its clinical applications, and to propose an integrative four level

framework linking early experiences and needs, schemas and modes, autonomic and bodily organization, and current behavior and relational responses.

METHOD

This article is designed as a narrative review integrating clinical experience. This approach was chosen because the somatic perspective in schema therapy is a relatively recent and conceptually and methodologically heterogeneous field. The aim is not to produce a systematic review, but to offer a conceptually grounded and clinically relevant synthesis of the available evidence.

The literature search was conducted using PubMed, PsycINFO, Scopus, Web of Science, and Google Scholar. The following keywords and their combinations were used: *schema therapy, somatic, body-focused, embodiment, trauma, dissociation, early maladaptive schemas, schema modes, body awareness, regulation, and body-oriented interventions*. The search was supplemented by manual screening of reference lists from relevant articles, monographs, and book chapters in order to identify key theoretical and clinically relevant sources.

A total of 126 publications were reviewed, including empirical studies, review articles, conceptual papers, clinical manuals, and academic chapters. However, no PRISMA framework was applied. Out of these, 87 sources were included in the final synthesis based on their relevance to the intersection of schema therapy, psychotrauma, and somatic approaches. Priority was given to systematic reviews, key theoretical models, and clinically relevant studies. No formal quality assessment (e.g., risk of bias evaluation) was conducted, which represents a limitation of the present review.

In addition to published literature, the article incorporates the authors' clinical and teaching experience derived from individual and group schema therapy, supervision, and professional training. The authors paid particular attention to cases of individuals with complex trauma, personality disorders, and dissociative conditions. Their experiences are reflected in the text through anonymized clinical vignettes, which serve to illustrate the clinical application of somatic principles within schema therapy.

THEORETICAL FOUNDATIONS OF THE SOMATIC PERSPECTIVE

The body as a carrier of psychological experience

The somatic perspective is based on the assumption that psychological experience is shaped not only by conscious thought, language, and narrative, but also by ongoing bodily processes. (van der Kolk, 2014; Price & Hooven, 2018). In this view, the body is not merely the site where psychological distress is expressed. It is an active medium of affective, relational, and implicit processing of experience (Nummenmaa et al. 2014). This is especially important for schema therapy because

early maladaptive schemas include memories, feelings, thoughts, and physical sensations (Young et al. 2003).

Bodily states often represent an early, preverbal or less verbalized level of schema activation. A patient may verbally deny feeling threatened, while the body signals withdrawal, tension, accelerated breathing, reduced eye contact, or defensive mobilization (Ogden et al. 2006). The body often conveys implicit meaning, which may be particularly relevant in trauma, personality disorders, and chronic interpersonal difficulties (van der Kolk, 1994; Ogden & Fisher, 2015).

Within the schema therapy framework, schemas can be understood as patterns stored not only in verbal form but also in bodily experience. An abandonment schema may be expressed as chest tightness, shallow breathing, and an ambivalent impulse to both move closer and withdraw. A subjugation schema is often associated with a collapsed posture, lowered gaze, and a tendency to "make oneself smaller". Defectiveness and shame may appear through hunching, breath holding, covering the body, or heightened sensitivity to the gaze of others (Young et al. 2003).

Schema modes can be understood in a similar embodied way. A mode is not only a psychological role or a pattern of thought but may also be understood as a current state of the whole organism (Briedis & Startup, 2020). The Vulnerable Child is often associated with withdrawal, fragility, trembling, or a weakened voice; the Angry Child with mobilization, forward pressure, and an impulse to confront; and the Detached Protector with reduced facial expression, diminished movement, a monotonous voice, or a sense of disconnection. Critic modes are often expressed through rigidity, holding breath, and pressure in the body. The A Healthy Adult mode is therefore not only a cognitively mature perspective, but also a relatively stable state of grounding, regulation, and internal coordination (Ogden & Fisher, 2015).

The bodily dimension is particularly evident in preverbal and early developmental trauma (Erreich, 2024). In such experiences, coherent autobiographical representation is often absent, while affective-sensory traces, defensive responses, and procedural patterns of relating to self and others persist. Dual representation theory proposes that traumatic experiences may be stored not only narratively but also as situationally activated sensory-affective memory (Brewin et al. 1996). Similarly, van der Kolk emphasizes that trauma often persists more as a state of the organism than as an organized story about the past (van der Kolk, 1994).

The body can therefore be viewed as an important component of the implicit memory system. Automatic reactions such as freezing, losing contact with the legs, averting the gaze, withdrawing, or mechanically submitting do not necessarily represent maladaptive or irrational behaviour. They may be bodily encoded survival strategies. The somatic perspective helps identify these reactions as they emerge, before the full development

of a mode and maladaptive coping response (Young *et al.* 2003; Ogden & Fisher 2015).

Neurobiological and psychophysiological models

The somatic perspective in schema therapy draws on neurobiological and psychophysiological models that help to explain the speed, automaticity, and relative limitations of voluntary control of certain reactions. In individuals with complex trauma, dissociation, and personality disorders, therapeutic change often requires work not only with meaning and relationship, but also with the regulation of arousal, implicit memory processes, and the body's defensive responses (Siegel, 1999; Brewin *et al.* 1996; Corrigan *et al.* 2011).

The hierarchical model of the brain suggests that threat responses are organized across multiple levels of processing: from primary autonomic and defensive reactions, through emotional and memory processes, to higher reflective functions (Kearney & Lanius, 2022). Dual representation theory explains why traumatic experience may not be available as a coherent narrative, yet repeatedly becomes reactivated in the form of sensory-affective states, bodily reactions, and perceptual triggers (Payne *et al.* 2015).

When a patient is in a state of intense threat or collapse, cognitive and mentalizing capacities are often significantly impaired (Harricharan *et al.* 2021). Clinically, this suggests that a basic sense of safety and regulation often must be restored before deeper interpretive work or exploration of meaning can occur (Siegel 1999).

This logic is closely related to the understanding of trauma as dysregulation of the autonomic nervous system (Porges, 2022). After complex emotional trauma, the autonomic system may shift more readily into extremes of high or low arousal. Many dysfunctional strategies may function as attempts to regulate these states. From a schema therapy perspective, coping modes can often be understood as ways of modulating or managing unbearable arousal: attack, control, and hypermobilization on one side; disconnection, self-soothing, and collapse on the other (Corrigan *et al.* 2011; Nesnidal *et al.* 2025).

Polyvagal theory offers a clinical map of the relationship between safety, mobilization, and collapse (Porges, 2007). A key concept is neuroception, the preconscious or implicit evaluation of safety or threat. A patient may react to tone of voice, facial expression, changes in distance, or silence as if facing real danger. Clinically, these reactions can be described as hyperarousal and hypoarousal. Hyperarousal includes sympathetic mobilization, tension, impulsivity, anxiety, panic, anger, and hypervigilance. Hypoarousal includes numbing, immobilization, dissociation, emotional blunting, loss of vitality, withdrawal, and collapse. Trauma is therefore not associated only with "strong emotions," but with persistent dysregulation of arousal that may be stored in bodily processes and reactivated by relational or sensory

cues reminiscent of the original danger (Corrigan *et al.* 2011; van der Kolk 1994).

The window of tolerance and affect regulation

The concept of the window of tolerance describes the range of activation within which a person can simultaneously feel, think, reflect, remain relationally engaged, and learn from new experience. When activation exceeds the upper boundary, hyperarousal develops; when it falls below the lower boundary, hypoarousal emerges. This concept links neurobiology with clinical practice and helps determine when a patient is able to process experience and when they are already overwhelmed or disconnected (Siegel, 1999; Corrigan *et al.* 2011).

In schema therapy, the window of tolerance can be meaningfully linked to schema modes. The Angry Child, some Overcompensatory modes, and Critic modes are more often associated with hyperarousal, especially when accompanied by pressure, tension, and mobilization. The Detached Protector, Detached Self-Soother, Compliant Surrenderer, and their dissociative manifestations are usually closer to hypoarousal.

Therapy therefore involves not only working with the content of thoughts, memory rescripting, and chairwork, but also the gradual expansion of the body system's integrative capacity. Patients learn to tolerate affect without hypo- or hyper- arousal states being triggered immediately. They learn to recognize these states activation early, and to use bodily, relational, and cognitive resources not to automatically shift into maladaptive coping. Affect regulation is therefore both a prerequisite for deeper change and an important therapeutic goal (Prasko *et al.* 2011; Diveky *et al.* 2012; Kotianova *et al.* 2018; Slepecky *et al.* 2017).

The window of tolerance is particularly important in experiential techniques and trauma work. Moving too quickly toward core affect or traumatic scenes may lead to overwhelming or retraumatizing emotional flooding or, conversely, disconnection and loss of contact. The somatic perspective therefore emphasizes the principles of titration, slowing down, and working at the edge of tolerability, and repeatedly returning to resources. Effective therapy does not aim for maximal emotional activation, but for a level of activation that the patient can integrate (Ogden & Fisher, 2015).

Somatic roots of schemas and modes

Schema therapy defines a schema as a broad pattern encompassing cognitions, emotions, bodily sensations, and memories (Young *et al.* 2003). The somatic perspective refines this assumption by asking how a schema is organized in the body and how this level can be used in assessment and treatment. Bodily sensations are not merely accompaniments to schemas; they are often the most immediately accessible component. A patient may not yet be aware of the thought "I am not safe", but may already experience stomach tightness, chest

Tab. 1. Common schema modes, typical bodily patterns, and somatic/regulatory foci

MODE	TYPICAL BODILY ORGANIZATION	SOMATIC/REGULATORY FOCUS
Vulnerable Child	Collapse, withdrawal, fragility, trembling, weakened voice, reduced support through the body	Grounding, increasing bodily support, orienting, titrated contact with affect and unmet needs
Angry Child	Mobilization, forward pressure, heightened activation, impulse to confront	Slowing down, tracking activation, boundary work, helping anger become regulated expression rather than impulsive discharge
Detached Protector	Reduced facial expression, diminished movement, monotonous voice, disconnection, numbness, absent gaze	Gentle reconnection with bodily signals, pacing, orienting, support for safe re-engagement without flooding
Punitive/Demanding Critic	Rigidity, holding the breath, internal pressure, constriction, tension	Softening pressure, increasing awareness of constriction, creating distance from the critic, supporting a more compassionate Healthy Adult stance
Compliant Surrenderer / Self-Sacrifice patterns	Collapsed posture, lowered gaze, making oneself smaller, over-adaptation, inhibited impulses	Boundary awareness, grounding through the feet, posture change, voice strengthening, experimenting with saying "stop" or taking up more space
Healthy Adult	Relative grounding, regulation, stable breathing, coordination, embodied sense of support and flexibility	Consolidating supportive posture, breath, orientation, reflective awareness, and flexible access to protection, soothing, and limit-setting

Note: This table summarizes clinically relevant links between selected schema modes and their common bodily manifestations, together with examples of somatic or regulatory focus in therapy. The table is intended as a heuristic clinical aid derived from the conceptual synthesis and illustrative material in the manuscript, not as a diagnostic typology or fixed protocol.

constriction, shoulder tension, or an impulse to withdraw (Briedis & Startup, 2020).

A mode can be conceptualized as an embodied state in which inner dialogue, emotional tone, and the overall organization of the body are altered: posture, facial expression, movement, voice, speech rhythm, breathing, vitality, and relational orientation. The Vulnerable Child, Critic modes, Detached Protector, Angry Child, and Healthy Adult often have distinct postural and regulatory qualities. The body thus functions both as an indicator of the currently activated mode and as an entry point for regulation and change (Young *et al.* 2003; Ogden & Fisher 2015).

In the Vulnerable Child mode, the bodily experience may provide access to needs that have not yet been explicitly verbalized, including safety, protection, closeness, acceptance, and respect for boundaries. Critic modes often manifest through bodily pressure, rigidity, held breath, and internal constriction. Coping modes likewise exhibit distinct bodily organization: overcompensation is often associated with expansion and forward pressure, whereas avoidant and detached modes tend to involve inhibition, reduced movement, narrowed attention, or derealized sense of distance.

Table 1 summarizes common schema modes, their typical bodily organization, and examples of somatic/regulatory focus, based on the conceptual synthesis and clinical material described above.

Somatic work helps to detect the transition into a mode before it develops into full behavioural

expression. It expands case formulation to include the level of microprocesses: tension, breathing, postural shifts, loss of vitality, mobilizing impulses, and the relational orientation of the body (Briedis & Startup, 2020). This level is especially useful in individuals with dissociation, alexithymia, pronounced shame, or rapid activation of coping strategies. Without attention to bodily organization, schema work in these individuals may remain largely at the level of cognitive or intellectual understanding.

THE SOMATIC PERSPECTIVE IN THE SCHEMA THERAPY MODEL

Top-down vs. bottom-up processing

The somatic perspective further refines the distinction in schema therapy between top-down and bottom-up processing. Top-down processes are based on language-based processing, meaning, narrative, and conscious reflection. They are essential for understanding developmental history, mapping schemas and modes, and restructuring maladaptive beliefs. Through these processes, patients can make sense of their experiences, identify recurring patterns, and develop a more coherent narrative of the self (Young *et al.* 2003).

Bottom-up processes, in contrast, originate in bodily and affective processes. They include autonomic activation, sensory impressions, motor impulses, and implicit emotional states that often arise prior to conscious awareness. These processes are particularly relevant in

trauma, dissociation, and personality disorders, where reactions are frequently rapid, automatic, and only partially accessible to reflection (Ogden & Fisher, 2015; Brewin *et al.* 1996).

Schema therapy has traditionally placed greater emphasis on relied more heavily on top-down strategies, such as cognitive restructuring, limited reparenting, and experiential techniques focused on meaning. The somatic perspective complements this approach by more systematically incorporating bottom-up processes. It brings attention to bodily markers of activation, supports regulation of arousal, and allows therapeutic change to occur not only through insight but also through the direct modification of embodied experience (Ogden & Fisher, 2015; Briedis & Startup, 2020).

This integration can be observed in moments when a patient not only understands a schema cognitively but also feels a shift in bodily state—such as a deeper breath, reduced tension, or a greater sense of grounding. These changes indicate that the intervention has extended beyond narrative understanding into the level of embodied regulation. The somatic perspective thus does not replace existing schema therapy techniques; it enhances their effectiveness by aligning cognitive insight with bodily experience (Young *et al.* 2003; Ogden & Fisher 2015).

BASIC PRINCIPLES OF BODY-ORIENTED WORK IN SCHEMA THERAPY

Mindfulness and slowing down

A core principle of somatic work in schema therapy is the deliberate slowing of the therapeutic process. This is not merely a technical adjustment of the session pace but a shift in therapeutic stance – from rapid interpretation and problem-solving toward careful observation of what is unfolding in the present moment: in the body, affect, relational contact, and emerging modes (Price & Hooven, 2018). In individuals with complex trauma or chronic dysregulation, many processes are initiated and maintained automatically. Slowing down makes it possible to notice microprocesses that would otherwise pass unnoticed: interruptions in breathing, shoulder contraction, changes in voice tone, gaze aversion, freezing, or impulses to flee or attack. These subtle shifts often mark the earliest detectable phase of schema or mode activation (Ogden *et al.* 2006; Ogden & Fisher 2015).

Slowing down may help protect the process from premature intellectualization. Mindful pausing creates space in which experience can be explored rather than simply acted out. This is especially relevant in shame, anger, helplessness, or dissociative tendencies, where even a brief gap between stimulus and response may open the possibility of a new response instead of repeating an established coping pattern (Siegel, 1999; Corrigan *et al.* 2011; Ogden & Fisher 2015).

This stance is closely linked to the language of mindfulness. Somatic work tends to use fewer “why” questions and more observational language: “Notice what happened when you said that”, “Can we stay with this for a moment?”, “What do you feel in your body right now”, “Is there any impulse?”. Such language reduces performance pressure, fosters curiosity, and supports a shift from evaluation to exploration and self-compassion. This is particularly important for individuals with histories of intrusive or shaming relationships (Gendlin, 1996; Kurtz, 1990).

Attunement and co-regulation

Another key principle is attunement and co-regulation. The therapist is not only an observer or interpreter but also becomes part of an interpersonal regulatory system. Their presence, tempo, facial expression, tone of voice, rhythm of speech, capacity to hold affect, and quality of contact all influence whether the patient's nervous system moves toward safety or toward mobilization or shutdown (Porges 2007; Schore & Schore 2008). This extends the schema therapy concept of limited reparenting into the bodily and affective domains: the therapist repairs relational experience not only through words but through how they are physically and emotionally present (Young *et al.* 2003; Schore & Schore 2008).

Affective regulation develops primarily in early interpersonal contexts, and the therapeutic relationship can provide a new regulatory experience. For individuals with developmental trauma, attachment disruption, or chronic dysregulation, it is crucial that the therapist remains stable, non-intrusive, predictable, and at the same time genuinely present. This creates conditions in which the patient can begin to notice and regulate bodily states without immediately shifting into defensive responses (Schore & Schore, 2008; Porges, 2007).

Patients respond not only to the content of what is said but also to the overall quality of the therapist's presence. Tone of voice may soothe or trigger defense; eye contact may feel inviting or intrusive; tempo may support or overwhelm; distance may feel safe or invasive. From a polyvagal perspective, many of these cues are processed at the level of implicit neuroception, a preconscious evaluation of safety or threat. Even well-intentioned interventions may fail if delivered too quickly, too sharply, or at a moment when the patient's system cannot register them as safe (Porges, 2007; Schore & Schore 2008, 2012).

Emerging empirical evidence supports the clinical importance of nonverbal co regulation. A recent meta-analysis of 11 quantitative studies reported a substantial association between nonverbal synchrony and the therapeutic relationship from the patient's perspective across treatment modalities, whereas associations with outcome were less consistent (Gregorini *et al.* 2025). These findings are compatible with the view

that nonverbal attunement represents a transtheoretical process supporting affective and collaborative aspects of the therapeutic alliance. This is consistent with the idea that the therapist's bodily presence serves as a regulatory tool before any specific spoken intervention.

Somatic work also places demand on the therapist's self-regulation. If the therapist responds to the patient's mobilization with their own activation, hyperarousal may escalate; if they respond to collapse with pressure, disconnection may deepen. Slowing down and mindfully observing one's own bodily signals may help regulate therapists' arousal. Attunement, therefore, does not mean simply mirroring the patient's state but perceiving it clearly without being absorbed by it. It requires a balance of empathy, boundaries, stability, and flexibility—core qualities of the Healthy Adult mode (Schoore & Schoore, 2008; Ogden & Fisher, 2015).

Safety and boundaries

Safety and boundaries represent fundamental preconditions for somatic work. The body is where early experiences of violated boundaries, neglect, intrusion, or abuse are encoded but also where experiences of safety, protection, and respect can be restored (Harricharan *et al.* 2021). Boundaries are therefore not only a psychological construct but also a bodily-based capacity to distinguish between “self” and “not-self”, safe and threatening proximity, contact and withdrawal, acceptance and rejection (Ogden & Fisher, 2015; Ciaunica *et al.* 2021).

Work with boundaries may involve experiential and often subtle experiments with distance, gaze direction, chair positioning, or awareness of personal space. In other cases, boundaries are explored through hand gestures, posture, grounding through the feet, a firm vocal “stop”, or noticing how the body signals that “this is too much”. The aim is not primarily behavioural assertiveness training but restoring an embodied capacity for self-protection, recognizing one's needs, and distinguishing what is acceptable from what is not. This is particularly important for individuals with histories of boundary violations, submissive or self-sacrificing modes, or chronic over adaptation at the expense of bodily awareness (Sansone & Sansone, 2004; Svaldi *et al.* 2012).

The use of touch requires caution. Although some somatically oriented approaches use touch, within schema therapy and trauma work it must remain exceptional, fully consensual, transparent, culturally sensitive, and continuously reflected upon. For many patients, even well-intended touch may activate experiences of helplessness, shame, confusion, or intrusion (Svaldi *et al.* 2012; Kobeleva *et al.* 2014). In most cases, it is sufficient and safer to work with the body without direct touch—through movement, support, orientation, breathing, distance, or imagery (Ogden & Fisher 2015; Barahmand *et al.* 2026). Sometimes, to help people maintain a connection with their therapist and to help

them feel grounded, the therapist suggests holding a scarf together (Briedis & Startup 2020).

Cultural and individual factors also shape the experience of safety. Perceptions of the body, personal space, touch, emotion, authority, and boundaries are not universal. For some patients, a somatic focus is relieving; for others, it may initially feel unfamiliar or shame-inducing. Safety does not arise solely from the technique itself but from how it is introduced, paced, and adapted to the patient's preferences (Kabat-Zinn, 2013; Ogden & Fisher, 2015).

Working within the window of tolerance

Working within the window of tolerance represents an integration of the previous principles into a practical regulatory framework. The goal is not to keep the patient within a state of constant comfort nor to suppress all intense affect, but to help them remain within a range of activation where they can feel, perceive, reflect, and learn simultaneously. The therapist therefore monitors whether the patient stays in contact with experience or shifts into hyperarousal or hypoarousal and adjusts the pace, depth, and form of intervention accordingly (Siegel, 1999; Corrigan *et al.* 2011; Ogden & Fisher 2015).

Key strategies include titration, pendulation, and stabilization. Titration refers to the gradual introduction of experience in small, manageable increments. Instead of directly entering highly activating or traumatic material, the therapist helps the patient approach it gradually, track bodily signals, and pause before overwhelm occurs. Without titration, somatic work can become too intense and counterproductive, especially in individuals prone to panic, anger, or dissociation (Ogden & Fisher, 2015; Levine, 2010).

Pendulation describes a rhythmic movement between activating and stabilizing resources. The patient briefly touches a bodily experience of threat, then returns to stabilizing elements—breathing, contact with the feet, connection with the therapist, or orientation in the room—before approaching the activating experience again. This rhythm allows the nervous system to learn that strong affect does not inevitably lead to overwhelm or complete withdrawal. In schema therapy, pendulation is particularly useful when working with the Vulnerable Child, traumatic memories, or intense shame, where repeated reconnection with the Healthy Adult and bodily resources is necessary (Levine, 2010; Ogden & Fisher, 2015).

Stabilization includes interventions that bring the patient back to a more regulated state, such as grounding, prolongation of exhalation, orienting in space, increasing bodily support, adjusting distance, changing posture, modulating the therapist's voice, or shifting to a safer topic. Stabilization is not a retreat from deeper work; it is a condition for it. For individuals with traumatic experiences, repeated practices of safely returning from activation may be a key mechanism

of therapeutic change (Corrigan *et al.* 2011; Ogden & Fisher 2015)

CORE SOMATIC SKILLS OF THE THERAPIST

Observing the body

Observing the body involves the deliberate tracking of what is happening in the patient's organism. This includes breathing, posture, muscle tone, movement impulses, micro-expressions, voice, eye contact, spatial orientation, and overall vitality or shutdown (Bentley *et al.* 2023). These signals often precede conscious verbal awareness and help identify hyperarousal, hypoarousal, dissociation, mobilization, withdrawal, or protective detachment (Ogden *et al.* 2006; Ogden & Fisher 2015).

Breathing is one of the most sensitive and clinically informative markers of regulation. Breath-holding is often linked to Critic modes, shame, or affect control; rapid, shallow breathing to mobilization, anxiety, or anticipated threat; and minimal breathing to shut down, disconnection, or dissociation (Bentley *et al.* 2023). These changes guide the intervention—whether to downregulate activation or to support reconnection with the body and vitality (Ogden *et al.* 2006; Corrigan *et al.* 2011).

Posture may reflect the procedural organization of modes. Collapse and protective closure are typical of the Vulnerable Child; rigidity, expanded chest, and forward pressure often accompany the Critic or Overcompensatory modes; reduced movement, flattened expression, and an absent gaze are common in the Detached Protector. Posture is not merely descriptive—it reveals learned patterns of regulation, defense, and relating (Young *et al.* 2003; Ogden & Fisher 2015).

Micro-expressive shifts—narrowing of the eyes, lip tension, gaze aversion, skin color changes, freezing, restlessness, or subtle avoidance—may signal emerging mode activation before it becomes fully expressed. Clinically, the point of transition is particularly important. It offers a window for intervention before defense, outburst, or disconnection unfolds (Ogden *et al.* 2006; Schore & Schore 2008).

Attunement

Attunement refers to the therapist's capacity to perceive the patient's bodily and affective processes and respond in a way that supports safety, contact, and co-regulation. It extends beyond empathy for verbal content. It involves tracking rhythm, intensity, direction, and the overall organization of experience. Nonverbal and right-hemispheric attunement are considered central mechanisms of regulation in the therapeutic relationship (Schore & Schore 2008; Porges 2007).

Embodied empathic responding does not mean imitation. The therapist adjusts pace, tone of voice, eye contact, quality of silence and offers gentle naming

of observed processes while maintaining a regulated presence (Vyskocilova *et al.* 2011). Statements such as “I notice you withdrew slightly just now” or “I notice some tension in your body at the moment” create a bridge between implicit and conscious experience. For individuals with histories of neglect, invisibility, or abuse, being accurately perceived in this way may have a potentially reparative effect (Ogden *et al.* 2006; Espejo-Siles *et al.* 2020).

Attunement depends on the therapist's own regulation. The therapist remains aware of the patient's state without being pulled into it: not meeting mobilization with a counter-attack or agitation, nor responding to collapse with pressure or disengagement. Effective attunement integrates empathy, boundaries, and internal stability. In this way, the relationship itself becomes regulating even before any specific technique is applied (Schore & Schore, 2008; Porges, 2007).

Focusing

Focusing involves the deliberate narrowing of attention to a specific bodily phenomenon and staying with it long enough for its meaning to unfold. It draws on the concept of “felt sense”, a bodily held, initially vague sense of meaning related to a situation (Gendlin, 1996; Vanhooren *et al.* 2022). In schema therapy, focusing helps shift from a diffuse narrative to a concrete experiential node: tension in the chest, pressure in the abdomen, constriction in the throat, coldness, a hand impulse, or a tendency to “shrink”.

Focusing should not become a form of pressure on the patient's bodily experience. The therapist and patient select a phenomenon that is both clinically relevant and within the window of tolerance. It is often more useful to work with a small, repeatable, observable signal than with the most intense experience. Focusing prevents fragmentation of the process and links bodily experience with schema, mode, and need (Ogden *et al.* 2006; Briedis & Startup 2020).

Awareness-guided dialogue

Awareness-guided dialogue supports the development of focused bodily experience without premature interpretation. The therapist uses questions such as: “What do you feel in your body right now?”, “Where is it strongest?”, “What happens if you stay with it for a moment?”, “Is there any impulse?”, or “If this sensation could express itself, what might it say?” These questions connect body, affect, imagery, cognition, and need, allowing implicit experience to become more accessible (Gendlin, 1996). This form of dialogue requires slowing down and restraint. Through the intervention the patient not only understands but also experientially recognizes what is happening and what is needed. This is particularly important for individuals who have learned to ignore bodily signals, emotions, or needs over a long period of time. (Kabat-Zinn 2013; Gendlin 1996).

Somatic experiments

Somatic experiments translate awareness into small, specific, and observable bodily actions. The therapist does not assume what is therapeutically “correct” but explores with the patient a subtle change in posture, breathing, movement, distance, gaze, gesture, voice, or the completion of an impulse (Schwarz *et al.* 2016; Dugas *et al.* 2022). The effect is evaluated in terms of experience, regulation, mode activation, and access to the Healthy Adult. Procedural patterns are modified not only through insight but also through corrective embodied experience (Ogden *et al.* 2006; Ogden & Fisher 2015).

The experiment may be intentionally minimal: sensing the feet more clearly while setting a boundary, maintaining eye contact briefly instead of looking away in shame, placing a hand on the chest when connecting to the Vulnerable Child, prolonging the exhalation under stress, or leaning back for support. Even a small shift can alter the organizing principle of a mode and change the sense of competence, safety, or boundary (Ogden & Fisher, 2015; Briedis & Startup, 2020).

Somatic experiments may also support the generalization of therapeutic gains beyond the session. When patients discover that a particular bodily organization supports access to the Healthy Adult, they can apply it in real situations—during conflict, criticism, shame, or boundary setting. The experiment becomes a bridge between insight and behavioural change, especially for patients who know what they “should” do but whose organism reverts to habitual patterns under stress (Young *et al.* 2003; Ogden & Fisher 2015).

These somatic skills form a coherent clinical sequence: observation of the body, attunement, focusing, awareness-guided dialogue, and experiment. This is not a rigid protocol but a flexible process that integrates assessment, regulation, and change within the schema therapy model (Ogden *et al.* 2006; Gendlin 1996).

TYPES OF SOMATIC INTERVENTIONS

Working with bodily resources

Working with bodily resources may strengthen the patient’s regulatory capacity, allowing them to remain in contact with experience without becoming overwhelmed or disconnected (Harricharan *et al.* 2021; Thurner *et al.* 2022). A resource may be defined as anything that supports safety, grounding, competence, vitality, or relational availability: breathing, grounding, centering, bodily support, contact with the floor or chair, orientation in space, simple movement, or vocal expression.

Grounding may be particularly important in dissociation, “drifting away”, chronic shame, and high mobilization. Contact of the feet with the ground, pressure of the back against the chair, or awareness of body weight can support presence and reduce chaotic shifts

between modes (Rabellino *et al.* 2016). Centering shifts attention toward the inner axis of the body and helps patients tolerate affect without losing contact with themselves. Resources, therefore, do not merely calm the patient; they create the internal organization needed for change work (Ogden & Fisher 2015; Engelhard *et al.* 2021; Kearney & Lanius 2022).

Breath work

Breath work is relatively accessible, yet clinically sensitive. Its effect depends on context, timing, and the patient’s regulatory capacity. Respiratory rhythm is closely associated with autonomic regulation and can be used both for calming and for gentle activation (Bentley *et al.* 2023). Slow conscious breathing with a longer exhalation has been associated with increased parasympathetic activity, reduced stress, and improved anxiety regulation, although effects vary according to technique, context, and patient characteristics (Porges 2007; Morgan *et al.* 2024; Yau *et al.* 2021).

In schema therapy, breathing should not be understood as a universal relaxation technique. The therapist observes which mode “controls the breath”: critical constriction, anxious mobilization, detached minimal movement, or a more regulated rhythm. For some patients, a longer exhalation is stabilizing; for others, focusing on the breath may increase anxiety or activate helplessness. Breath work should therefore not be imposed but explored in terms of what supports safety, contact, and further therapeutic work (Ogden & Fisher 2015; Morgan *et al.* 2024).

Diaphragmatic breathing promotes engagement of the diaphragm, a relieved exhalation, and reduced reliance on an upper-chest mobilizing breathing pattern (Bentley *et al.* 2023). Reviews suggest that breathing exercises may reduce subjective stress and anxiety and, in some studies, influence autonomic regulation. However, methodological heterogeneity calls for caution in generalization (Hopper *et al.* 2019; Morgan *et al.* 2024; Yau *et al.* 2021; Lanius *et al.* 2025).

In some contexts, breathing can also support activation. In hypoarousal, shutdown, or disconnection, more energetic breathing, sound, greater bodily verticality, or a more active inhalation may help (Bentley *et al.* 2023). The aim is not technical perfection but greater regulatory flexibility while maintaining contact with bodily experience (Austin *et al.* 2007; Porges 2007; Grossman 2023; Grossman 2024).

Working with movement

Movement work is based on the assumption that trauma, schemas, and coping modes may involve inhibited or stereotyped action tendencies (Liang & Bryant, 2024). Under threat, the organism activates defensive tendencies such as fight, flight, immobilization, or seeking protection. When these responses remain incomplete, they may persist as patterns of chronic tension, unexpressed impulses, rigid postural patterns, or repetitive

procedural tendencies. Sensorimotor psychotherapy, therefore, emphasizes mindful work with movement, impulses, and the completion of defensive responses, including the so-called “act of triumph” (Ogden *et al.* 2006; Fisher 2019; Kleinlooh *et al.* 2021).

In BFST, the therapist explores what the body wants to do when the Vulnerable Child, anger, shame, or Critic mode is activated: push away, hide, withdraw, raise the hands, straighten up, clench a fist, or seek support. When approached slowly, with grounding and within the window of tolerance, recognizing bodily impulses can support a sense of boundary, self-protection, autonomy, or contact (Briedis & Startup, 2020; Ogden & Fisher, 2015).

Movement can be used both for stabilization and for change. In hypoarousal, it can restore energy and presence (Meekums *et al.* 2015); in hyperarousal, it gives form to mobilization. In schemas of subjugation or shame, movement may allow the patient to embody actions such as “I take up space”, “I support myself”, “I stop this” or “I put my hands in front of me”. In controlling modes, movement can expand the repertoire from rigid holding toward greater flexibility, relaxation, and spontaneity (Young *et al.* 2003; Ogden & Fisher 2015; Majore-Dusele *et al.* 2021).

Working with boundaries

Boundaries can be understood as both psychological and embodied. Individuals with developmental trauma, neglect, abuse, or chronic subjugation may struggle to recognize when something is overwhelming or intrusive, when they need more space, or when their body is shifting into intrusion or withdrawal. Somatic boundary work therefore begins with space, distance, position in relation to the other, gesture, support, gaze direction, and voice (Ogden & Fisher, 2015).

Experiments with space may include changing the distance between patient and therapist, sensing a personal “bubble”, working with a circle on the floor, approaching and stopping, or noticing bodily signals that someone is too close or too far away. Diagnostically, such experiments show how automatically the patient adapts, how late discomfort is registered, or how strongly the body withdraws instead of actively expressing a boundary (Briedis & Startup, 2020).

Changes in gesture and voice can strengthen the sense that one can influence the situation and act actively within it. Raising a hand, pushing away, straightening the torso, finding firmer support through the legs, or saying “stop”, “no” or “I do not want this” are not only communicative acts. They are forms of embodied self-protection. Some patients first need to discover the bodily preconditions for such expression: support, breath, verticality, and contact with their own strength. Boundary work thus integrates behavioural rehearsal, somatic experiment, and corrective emotional experience (Young *et al.* 2003; Ogden & Fisher 2015).

Voice and sound

Voice and sound may be used for affect regulation and mode work. The polyvagal perspective highlights the role of prosody in signaling safety and activating the social engagement system (Thurner *et al.* 2022). Rhythm, melody, intensity, and vocal quality carry both meaning and regulatory effects. The therapist’s voice can stabilize and slow the process, whereas a sharp, rapid, or tense tone may mobilize defensive responses (Porges 2007; Deits-Lebehn *et al.* 2020; Porges 2022).

For the patient, voice work can support contact with affect, vitality, and modes. Interventions may include sighing, prolonged exhalation with sound, a firmer tone when setting a boundary, vocal accompaniment of breathing, or a shift from constricted expression toward fuller vocalization. Sound may serve as a regulated bridge to the Vulnerable Child or to anger when used as a controlled means of accessing suppressed experience, rather than as an uncontrolled discharge. BFST also uses breath and sound to “give voice to modes” and to support ventrally regulated contact.

A shift from the Critic mode to the Healthy Adult is often reflected in movement from a tense, sharp, or mechanical tone toward a firmer, more compassionate, and grounded voice. In the Vulnerable Child mode, the voice may be quiet, broken, or almost absent. The aim is not to increase volume mechanically but to find a vocal expression that corresponds to the emotional experience while remaining within regulation (Porges 2022; Briedis & Startup 2020).

Somatic imagery

Somatic imagery links schema therapy experiential techniques with a focus on bodily organization. In imagery rescripting, the focus is not only on the image and its meaning but also on where the patient feels the experience in the body, which breathing pattern, posture, movement, or impulse accompanies it, and how the body changes during rescripting (Young *et al.* 2003; Arntz 2012; Arntz 2025).

A key example is the exercise of the embodied Healthy Adult. The patient is not asked solely to imagine this part cognitively but to explore its bodily correlate: how it sits or stands, how it breathes, what support it has, and what gesture or movement emerges when it becomes more present. In this way, the Healthy Adult becomes a state that can be evoked in the present moment, especially in patients who can speak about it but struggle to experience or use it in demanding situations (van Donzel *et al.* 2026).

The same principle can be applied in rescripting. When entering a traumatic or wounding scene, the therapist observes what happens in the body at the moment of threat and supports an embodied change: more support, movement toward the child, a protective gesture, stronger boundaries, fuller breathing, a different tone of voice, or completion of a movement that was not possible at the time. Imagery rescripting

Tab. 2. Body-oriented interventions in schema therapy: mechanisms and clinical targets

INTERVENTION	MECHANISM OF ACTION	TARGET MODE / PROBLEM	CLINICAL EXAMPLE
Slowing down and mindful attention to the body	Increased interoceptive awareness	Detached Protector, dissociation	The patient notices chest tension during avoidance
Breath regulation	Modulation of the autonomic nervous system	Anxiety, panic, hyperarousal	Slowing the breath during activation of the Vulnerable Child
Grounding	Stabilization of attention and bodily experience	Dissociation, derealization	Contact of the feet with the ground during “disconnection”
Postural work	Shift in implicit emotional organization	Submissiveness, shame, helplessness	Straightening the body during Critic mode activation
Completion of a defensive response	Release of motor inhibition	Trauma, freeze response	Symbolic “pushing away” in imagery
Bodily boundaries	Strengthening the sense of control and safety	Vulnerable Child, trauma	A “stop” gesture when threat is activated
Touch, limited and clinically indicated	Regulation through interpersonal contact	Deprivation, abandonment	Offering support in a safe context
Movement	Activation and regulation of energy	Hypoarousal, depression	Active movement during shutdown
Somatic imagery	Integration of bodily and emotional representations	Trauma, schemas	Imagining a “safe place” in the body

Note: Table 2 summarizes key somatic interventions used in schema therapy, their proposed mechanisms of action, and typical clinical targets. These interventions operate primarily through modulation of autonomic and bodily processes and may indirectly influence schemas and modes.

affects emotional and memory representations of early experiences; the somatic perspective adds that change may be deeper when the bodily level is included (Arntz 2012; Semeniuc *et al.* 2023).

Taken together, somatic interventions form an integrated system. Bodily resources support safety and regulation; breathing modulates state; movement completes action tendencies; boundaries restore autonomy and self-protection; voice regulates affect and makes modes more visible; and somatic imagery links the body with corrective emotional experience. Their shared mechanism is a shift in the patient's relationship to bodily experience—from automatic and defensive toward more conscious, regulated, and therapeutically usable (Ogden & Fisher, 2015; Arntz, 2012). Table 2.

SOMATIC WORK WITH TRAUMA IN SCHEMA THERAPY

Somatic work with trauma is based on the premise that trauma is not stored solely as a narratively accessible memory but also as a bodily and affectively organized state that may be reactivated in the present (Eilers *et al.* 2023). In some patients, it may manifest as constriction, collapse, hypervigilance, impulses to escape, disconnection, shame, or somatic re-experiencing without a clear autobiographical memory. The somatic perspective may make it possible to track how these activations are expressed through modes such as the Vulnerable Child, the Critic, and Coping modes, and to work with

them in both a regulatory and transformative way (van der Kolk 1994; Brewin *et al.* 1996).

Within schema therapy, many modes can be conceptualized as relatively rigid attempts to cope with what was once adaptive but has become maladaptive. The Detached Protector may reflect an incomplete escape response; the Angry Child may reflect blocked mobilization; and surrender may reflect a failure to establish boundaries. Somatic work, therefore, focuses on exploring what action was inhibited and how it can now be safely completed, thereby reshaping the bodily organization of experience (Young *et al.* 2003; Ogden & Fisher 2015).

A second level concerns implicit memory. Dual representation theory suggests that trauma may be stored both as a verbal memory and as sensory-affective representations that return in bodily states and images (Brewin *et al.* 1996). Bessel van der Kolk describes the difficulty of integrating such experiences into autobiographical memory, while in Janet's terms they appear as “subconscious fixed ideas” recurring outside their original context (van der Kolk & van der Hart, 1989). Somatic work accesses this layer through bodily phenomena rather than relying solely on conscious recall (Brewin *et al.* 1996; van der Kolk 1994; van der Hart *et al.* 1989).

In practice, this work is often integrated with imagery rescripting approaches. This technique modifies both the meaning and emotional organization of early experiences, and studies support its effectiveness—as well as that of EMDR—in treating PTSD

following childhood trauma (Arntz & Weertman, 1999; de Haan *et al.* 2020).

Somatic work with trauma integrates three levels: implicitly organized bodily memory, schemas and modes shaping current functioning, and corrective experience emerging through the regulated completion of previously blocked action. Trauma can, therefore, be understood as not only a memory but also a state of dysregulation and an unfinished bodily response. Therapeutic work may allow what was once merely survived to become symbolized, integrated, and, to some extent, completed (van der Hart *et al.* 1989; Fisher 2019).

CASE VIGNETTES

All case vignettes are composite; only fully anonymized and non-identifiable patient data are included. They are not intended as representations of individual patients, but rather as illustrative clinical examples of the somatic perspective in schema therapy. They show how bodily signals, autonomic regulation, and action tendencies can be linked with the conceptualisation of schemas and modes.

Case vignette 1: Trauma and dissociation

History

Lucie, a 34-year-old administrative worker, entered therapy because of episodes of disconnection, a sense of “being dead inside”, emotional shutdown, and relationship difficulties. During conflict or when someone raised their voice, she felt “as if everything left her”; afterward, she would agree mechanically and later feel flooded by shame, helplessness, and exhaustion. She grew up in an emotionally unpredictable family, with an impulsive father and a passive, overwhelmed mother. She repeatedly described having to “disappear in order to not to be hit”. The clinical presentation was consistent with developmental trauma with dissociative features, complex PTSD, and activation of abandonment, emotional deprivation, mistrust, and subjugation schemas.

Conceptualisation: schemas and body

The dominant modes were the Vulnerable Child, who felt unprotected, lonely, and helpless, and a strong Detached Protector activated by threat cues. A mildly Punitive Critic appeared after dissociative episodes with statements such as: “You failed again. You are weak.” Bodily, when difficult material emerged, her voice slowed, her shoulders collapsed forward, her gaze drifted away, her breathing became minimal, and she lost contact with her legs. The dissociative sequence was recurrent: brief sympathetic activation, tension in the jaw and chest, a rapid shift into hypoarousal, disconnection, and loss of presence. This organization corresponds to trauma-related dysregulation and protective detachment described in the literature on structural dissociation and sensorimotor psychotherapy.

Course of therapy

In the initial phase, it was not appropriate to open traumatic memories too quickly. Lucie wanted to “finally say what

happened”, but as soon as she approached painful situations, she rapidly lost contact. Therapy therefore focused on mapping bodily markers, the window of tolerance, resources, and early signs of disconnection. Gradually, she identified a sequence: pressure in the jaw, coldness in the arms, loss of support in the legs, and a sense of being “behind glass”.

Therapist: “When you talk about yesterday’s phone call with your supervisor, I noticed that you became quiet for a moment. What was happening in your body then?”

Lucie: “I don’t know... probably nothing.”

Therapist: “Let’s slow down for a moment. What is your breath doing now?”

Lucie: “It’s weaker... almost as if I don’t want to hear it.”

Therapist: “And your legs?”

Lucie: “I can hardly feel them now.”

Therapist: “Is this the moment when you start to go away?”

Lucie: “Yes. That’s it. Right now I would like to disappear.”

Rather than continuing to explore content, the therapist shifted to grounding: back support, feet on the floor, orientation to the room, gentle head movement, and finding the safest place in the body. Lucie remained present; for the first time, she did not “go away completely”.

In the second phase, imagery and somatically expanded rescripting were introduced. In this form of imagery rescripting, attention is paid not only to the image and its meaning, but also to bodily experience—breathing, posture, muscle tension, and impulses to act—and these bodily responses are actively included in the transformation of the scene. In a key image, Lucie remembered herself as an eight-year-old standing in the kitchen while her father shouted and she could not move.

Therapist: “As little Lucie stands there, what does her body want to do?”

Lucie: “It wants to step back. And raise my hands. But it couldn’t.”

Therapist: “Can we try that now, very slowly, just a little? Feet on the ground, breathing, and allow your hands to move only as far as feels safe.”

(Lucie very slowly raises her hands in front of her chest and takes a small step back.)

Lucie: “I couldn’t do this then.”

Therapist: “How does it feel to do it now?”

Lucie: “As if I’m suddenly here. Not just hidden inside.”

Somatic interventions

The interventions followed a gradual sequence. First, therapy focused on mapping early signs of dissociation: identifying Lucie’s individual bodily signals that preceded disconnection, such as changes in breathing, loss of support in the legs, bodily contraction, or the “behind glass” feeling. This was followed by grounding and spatial orientation, including conscious awareness of the feet, back support, looking around the room, and naming present reality. These procedures helped restore contact with here and now. Gentle breath work was also used, especially slowing and deepening exhalation without performance pressure. Somatic resourcing involved identifying bodily states associated with greater safety, stability, and control. These resources then served as support when approaching more difficult material. Later, somatically expanded imagery rescripting was introduced. In addition to changing the image, the therapist worked with

bodily responses, especially impulses to move—stepping back, raising the hands for protection—that could not be completed in the original situation. These movements were carried out slowly and in a regulated state, shifting not only the meaning of the memory but also its bodily component.

The work also included completing small defensive movements in the present, such as leaning into support, strengthening posture, or gently increasing distance. These actions enhanced the experience of safety and capacity to act. In parallel, the embodied Healthy Adult was developed through specific bodily parameters: support in the body, a more upright posture, steadier breathing, and simple protective gestures. These supported regulation, boundaries, and inner support.

These procedures are consistent with phase-oriented treatment of complex trauma and dissociation, where stabilization, co-regulation, and gradual work with implicit memory are central.

Outcome

After nine months, Lucie remained sensitive to conflict, but episodes of complete disconnection were shorter and less frequent. She could recognize the onset of disconnection earlier and work with her body before the protective mode fully developed. In relationships, she began to communicate overwhelm sooner and agreed automatically less often. She summarized the change as follows: 'Before, I disappeared. Now at least part of me stays and knows what is happening.' This vignette illustrates how, in trauma related dissociation, therapeutic work may need to focus not only on past events but also on restoring presence in the body and in the relationship.

Case vignette 2: Borderline personality disorder

History

Veronika, age 28, was referred because of relational instability, intense fear of abandonment, episodes of self-harm, outbursts of anger, and rapid shifts in her perception of herself and others. She previously had several brief hospitalizations after suicidal crises. She grew up with an emotionally unstable mother and a largely absent father; her needs were invalidated, and her history included physical punishment. The clinical presentation was consistent with borderline personality disorder, with abandonment, instability, emotional deprivation, mistrust, and defectiveness schemas.

Conceptualisation: schemas and body

The dominant modes were the Vulnerable Child, Angry Child, Detached Protector, and Punitive Critic. The Vulnerable Child carried the fear that she would be abandoned and that her needs were "too much". The Angry Child was activated by signs of rejection and led to attack, accusation, and affective escalation. After conflict, the Detached Protector brought emptiness, numbness, and sometimes self-harm as self-stimulation.

Bodily, she shifted rapidly between two extremes. When abandonment or shame was activated, her breathing accelerated, tension moved into her shoulders and arms, her voice became sharper, her gaze intensified, and her body moved forward. This escalation was followed by hypoarousal: her shoulders dropped, her gaze became detached, her speech flattened, and she engaged in mechanical scratching or pressing of her hands. This

sequence may illustrate oscillation between hyperarousal and hypoarousal in BPD, expressed through the language of schema modes.

Course of therapy

The first months focused on mode awareness and building a co-regulatory therapeutic relationship—that is, a relationship in which the therapist's stable, predictable, and emotionally attuned presence helps the patient regulate affect and bodily activation. Veronika reacted intensely to silence or uncertainty in the therapist. The somatic perspective made it possible to detect activation before a full affective outburst.

Veronika: "You're silent now. I'm annoying you again. I knew it."

Therapist: "Before I tell you what I think, let's notice what is happening in your body right now."

Veronika: "I don't want to notice my body. I want to know what you think."

Therapist: "I can see how intense this is for you right now. Your shoulders are high and your hands are clenched. Let's observe it together for just ten seconds."

Veronika: "It's like I have to attack before you throw me away."

Therapist: "That sounds like a very fast protection. And underneath it?"

Veronika: "Underneath, I feel that you don't want me."

The bodily focus appeared to facilitate a shift from Angry Child mobilization toward the need of the Vulnerable Child.

Later, work with boundaries and voice was introduced. Veronika oscillated between passive clinging and aggressive pressure as she lacked experience with regulated boundaries.

Therapist: "When you are afraid someone will leave you; your body moves forward and attacks. Let's try another option. Put your feet on the ground. Raise your hand in front of you just a little. And say: 'Stop, I am scared.'"

Veronika: "That sounds stupid."

Therapist: "Yes, because you are used to going into attack or collapse. This third option is new."

(Veronika raises her hand; her breathing is initially fast.)

Veronika: "Stop... I am scared."

Therapist: "What does your body do?"

Veronika: "It's strange... it's not weak. It feels... firmer."

This experiment appeared to support the emergence of a new organization: boundary without attack, contact without fusion. In BPD, such somatic experiments can offer an alternative to switching between extremes.

In the next phase, somatically expanded imagery work was used with a memory in which Veronika's mother called her childhood crying "hysteria". Little Veronika's body wanted both to run toward her mother and to escape. In rescripting, therapy worked not only with protecting the child but also with a more stable posture, deeper breathing, and contact that was neither overwhelming nor detached. The Healthy Adult thus became more embodied than merely intellectually formulated.

Somatic interventions

The interventions were specific and closely linked to the course of sessions. First, therapy mapped transitions between hyperarousal and hypoarousal. Veronika learned to recognize when her body was entering mobilization – shoulder tension, accelerated

breathing, forward pressure, sharpening of the voice—and when it was shifting into shutdown – loss of energy, detached gaze, and flattened speech. These shifts were named together in session, often before the full reaction unfolded.

The co-regulatory relationship was expressed through the therapist's active use of voice, pacing, and stability of contact. During escalation, the therapist slowed down, spoke calmly, and helped Veronika to "hold" the intensity of experience without moving into outburst or collapse. At the same time, the therapist repeatedly pointed out early bodily markers of the Angry Child, such as clenched hands, tension in the arms, or the body leaning forward, and paused the process while it was still manageable.

Work with voice, breathing, and boundary gestures took the form of specific experiments. Veronika practiced placing her feet on the ground, slowing her breath, raising one hand in front of her, and saying simple phrases such as "stop" or "this is too much for me now". The goal was not perfect wording, but a new bodily experience of a boundary that was neither attacking nor collapsing.

Somatic experiments with a "third option" between attack and collapse focused on finding an alternative response. Instead of automatically pressuring the other person or withdrawing into emptiness, Veronika practiced staying in contact, regulating her body, and expressing her needs. These situations were rehearsed in session and later reflected upon in real interpersonal situations. In the next phase, somatically expanded imagery rescripting was used. Veronika did not only change the course of the memory; she also tracked what happened in her body, such as impulses to move closer, withdraw, or protect herself. These impulses were enacted in a regulated way, for example, through changes in posture or gesture, thereby shifting the bodily component of the experience.

The development of the embodied Healthy Adult involved repeatedly finding a bodily state in which Veronika felt more stable and less threatened. This included firmer support through the legs, more relaxed breathing, a more upright posture, and the capacity to remain in contact without escalation. From this position, she learnt to respond to the Vulnerable Child differently, specifically with more protection and compassion.

Outcome

After one year of therapy, relational triggers remained sensitive, but Veronika acted less frequently from states of full affective escalation. Self-harm decreased markedly. She became able to recognize bodily mobilization earlier and, in some situations, to establish a more regulated boundary instead of attacking, collapsing, or relying solely on verbal expression of need. She began to distinguish: "This is not just my anger anymore. It is the frightened part of me that fears being abandoned." Bodily mapping of modes supported mentalization and the development of the Healthy Adult mode.

Case vignette 3: Perfectionism and control

History

Petr, a 42-year-old manager in the pharmaceutical sector, sought therapy for chronic stress, insomnia, inner pressure, irritability at home, and growing emptiness. He appeared competent and well organized but yet stated that "it cannot go

on like this." His mother was anxious and controlling; his father was emotionally cold and performance-oriented. Praise was conditional on achievement, whereas mistakes led to shame or withdrawal of affection. The dominant schemas involved performance-based self-worth, defectiveness, emotional inhibition, and unrelenting standards. The primary modes were the Demanding Critic, Perfectionistic Controller, while the Happy Child and Vulnerable Child modes were only weakly accessible.

Conceptualisation: schemas and body

Petr's clinical presentation was not dramatic, but it was strongly bodily organized. He sat rigidly upright, breathed shallowly high in the chest, barely exhaled, held his jaw tightly, and moved minimally. He spoke fluently and without affective shifts, while his body signaled chronic control and sympathetic readiness. This was an overcompensatory mode protecting him from shame, helplessness, and defectiveness through constant performance, precision, and control.

Course of therapy

At first, Petr did not want to "talk too much about the past," but wanted to "manage stress better." The bodily perspective showed that the problem was not only external overload, but a chronic bodily regime that blocked regulation and contact with needs.

Therapist: "When you say that you must always be prepared, what does your body do?"

Petr: "I don't know. I'm sitting normally."

Therapist: "Let's explore it. What is your exhalation like right now?"

Petr: "Probably shorter."

Therapist: "Could you try lengthening it just a little?"

(Petr tries, but immediately shifts uneasily.)

Therapist: "What happened?"

Petr: "It feels unpleasant. As if I'm loosening up where I must not loosen up."

Therapist: "It sounds as though there is a part of you that cannot allow relaxation."

Petr: "Yes. If I let go, I'll mess things up."

Focusing on breathing opened direct access to the Demanding Critic and Perfectionistic Controller: control was present in bodily functioning itself.

The next phase mapped bodily states of individual modes: the "I must" regime, contact with failure, the onset of fatigue and the need for support, and a possible bodily form of the Healthy Adult—neither collapsed nor rigidly controlling. In chairwork, a somatic focus was added:

Therapist: "Sit now in the chair of the Demanding Critic mode. Just notice your body."

Petr: "It's hard. Chest forward. Neck tense. Almost no breath."

Therapist: "And now move to the Healthy Adult mode chair. Take your time. What does the body need for this transition to happen at all?"

(Petr is silent.)

Therapist: "Perhaps more support in the legs? A little more exhalation? Softer shoulders?"

(Petr makes a very small adjustment.)

Petr: "This is strange. It's not weak. Just less hard."

Therapist: “How would the Healthy Adult mode speak now to the part that has to keep pushing?”

Petr: “You don’t have to hold me together with so much vigor. I won’t let you fall.”

This sentence was spoken for the first time from a different bodily state, creating an experiential distinction between the Critic and the regulating adult part.

In the middle phase, the Vulnerable Child became accessible through bodily collapse following a loosening control. After a demanding week, Petr became quiet during a longer exhalation and said: “When I stop pushing, all that emerges is terrible tiredness.” Remaining with the fatigue in a regulated way revealed an old experience of a child who was never allowed to be weak. This opened a more compassionate relationship with vulnerability as a legitimate part of the self.

Somatic interventions

The interventions consisted of specific, gradually titrated steps aimed at changing the bodily-organized perfectionistic regime. First, therapy mapped the bodily organization of the Perfectionistic Controller in detail. Petr learned to recognize how this mode appeared in the body: held breath, jaw tension, rigid upright posture, minimal movement, and constant readiness. These signs were repeatedly named in session so that they could be recognized earlier in everyday life.

Breath work focused mainly on gently lengthening the exhalation, not on relaxation as such. In short intervals, Petr practiced extending the exhalation “just a little” while observing what happened in his body and thinking. A crucial moment was noticing the feeling “I am loosening, and I must not,” and linking it with the voice of the Demanding Critic. Breathing thus became not only a regulatory tool but also a diagnostic entry point into inner pressure.

Work with postural rigidity used small experiments: slightly softening the shoulders, leaning back, changing head position, or increasing contact of feet with the floor. These changes were not presented as “correct posture,” but as an exploration of what happens when the body is not in maximum control. Gradually, Petr experienced that less rigidity did not lead to failure, but rather to greater stability.

Chairwork was systematically supplemented by a somatic focus. When moving between chairs, Petr did not only formulate the content of each mode; he also tracked differences in bodily experience. The transition to the Healthy Adult mode was facilitated through particular bodily steps—more support in the legs, freer breathing, a less tense chest—making this mode experientially available rather than merely cognitively described.

The embodied Healthy Adult mode was developed through repeated exploration of a bodily setting in which Petr felt both firmness and less pressure. This state was then used in dialogue with the Critic mode and in contact with the Vulnerable Child mode, especially when fatigue or the need for support emerged. Contact with the Vulnerable Child mode was mediated mainly through work with fatigue and reduced control. Instead of quickly returning to performance, Petr was guided to stay briefly with this state, notice bodily experience, such as heaviness, slowing, and loss of energy, and gradually connect it with earlier experiences in which weakness had not been allowed.

Experiments with smaller amounts of control outside sessions were also important. These included deliberately slowing the pace of work, leaving a minor imperfection uncorrected, or expressing uncertainty to another person. The experiences were later reflected upon at the bodily level, including tension, breathing, and the urge to “push again.” Over time, these steps expanded his tolerance for less rigid functioning.

Outcome

After eight months, Petr recognized the onset of the “I must” pressure and, in some situations, could adjust his breathing, support, and voice before the critical and controlling mode fully developed. His sleep improved, he was less explosive at home, and he could communicate fatigue or uncertainty. He said: “I used to think that if I loosened up, I would fall apart. Now I’m discovering that when I loosen a little, I become visible.” The shift was from rigid control toward a more integrated Healthy Adult mode.

DISCUSSION AND IMPLICATIONS FOR PRACTICE

Based on the present synthesis, the somatic perspective in schema therapy can be understood as a framework linking four interrelated levels: (1) early experiences and needs, (2) schemas and modes, (3) autonomic and bodily organization, and (4) current behavior and relational responses. Somatic interventions primarily operate at the level of bodily organization and, through this pathway, may influence schemas, modes, and behavioural responses. Early relational experiences and unmet needs contribute to maladaptive schemas and modes, which are reflected in autonomic activation, posture, breathing, and muscle tension. The model emphasizes bidirectional interactions between levels, including both top-down and bottom-up processes. Figure 1.

Benefits of the somatic perspective

The somatic perspective may provide access to layers of experience that are not fully narratively organized, but rather implicitly, affectively, and bodily. This is especially relevant in developmental trauma, complex PTSD, dissociative states, and patients whose schemas and modes are activated in the body before they are recognized as conscious thoughts. Dual representation theory proposes that traumatic experience may also be stored as situationally accessible sensory-affective representations (Brewin *et al.* 1996). Since schema therapy conceptualizes schemas as patterns of cognitions, emotions, bodily sensations, and memories, this view is broadly compatible with the model (Young *et al.* 2003). A somatic focus helps identify constriction, collapse, mobilization, impulses to escape, or protective detachment as entry points into implicit memory and mode organization.

A second benefit is the deepening of emotional change. Patients may demonstrate cognitive understanding of their schemas, while their bodies continue

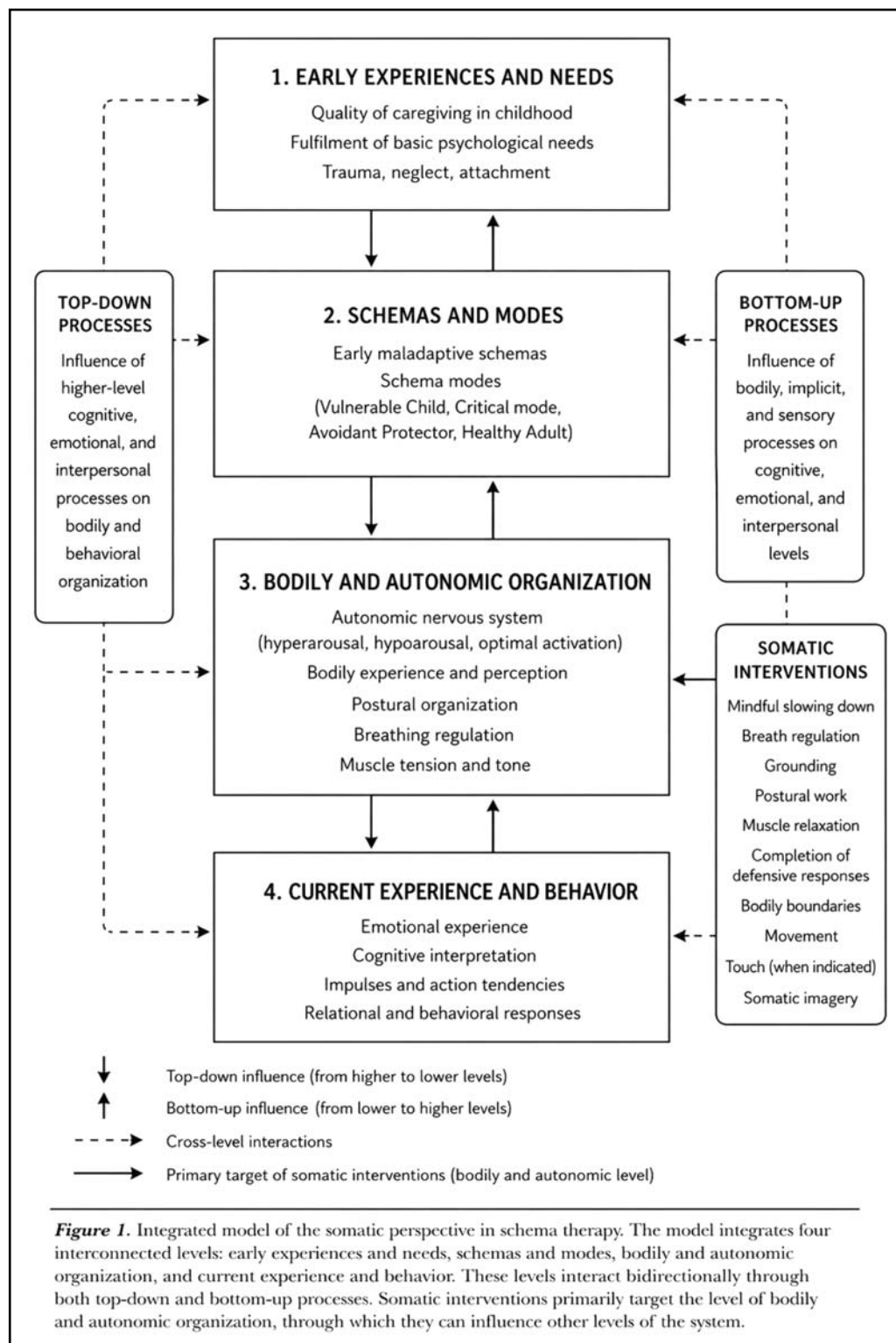


Fig. 1. Integrated Model of the Somatic Perspective in Schema Therapy

to respond according to old patterns. Somatic work, therefore, also attends, during imagery, chairwork, or boundary work, not only to the verbal content but also to breathing, posture, voice, support, motor impulses, and the possibility of completing a blocked response. Imagery rescripting can change the emotional meaning of early experiences; the somatic perspective adds

change at the level of bodily states and action tendencies (Arntz 2012; Ogden & Fisher 2015).

A third contribution is the integration of body and mind within one model of schemas and modes. Patients may begin to experience the body not as a “betrayer” but as a source of information about schema activation, the need for protection, closeness, boundaries, or rest. This process supports the embodied Healthy Adult,

expressed not only in adaptive statements but also in regulated breathing, more flexible posture, clearer boundaries, and greater capacity for contact with oneself and others (Young *et al.* 2003; Leichsenring *et al.* 2024).

Limitations and risks

A primary clinical risk of somatic work is overwhelming activation. Bodily focus may quickly open implicit memory; in individuals with complex trauma, unstable arousal, dissociation, or fragile self-structure, even a small experiment may contribute to hyperarousal, hypoarousal, or fragmentation (Steele *et al.* 2005; Cloitre *et al.* 2011).

A second limitation concerns therapist training. Somatic work typically requires knowledge of trauma, autonomic regulation, schema modes, phase-based treatment, nonverbal markers, and the therapist's own self-regulation. The therapeutic relationship is itself a regulatory instrument; technique without attunement and clinical judgement may be ineffective or destabilizing (Young *et al.* 2003; Ogden & Fisher 2015; Schore & Schore 2008).

The evidence base for body focused schema therapy (BFST) remains relatively limited. Evidence for schema therapy in personality disorders is growing, and systematic reviews and meta analyses support it as an important evidence informed approach for complex psychopathology (Zhang *et al.* 2023; Leichsenring *et al.* 2024). In contrast, direct research on BFST currently consists mainly of conceptual papers, clinical chapters, training materials, and case-based observations. The broader literature on somatic therapies for PTSD also lags behind research on standard trauma focused approaches; available studies primarily support feasibility and acceptability and underline the need for more rigorous research on efficacy and mechanisms of change (Sariahmed *et al.* 2025; van de Kamp *et al.* 2019).

A key limitation of the current model is the lack of clear operationalization of somatic interventions within controlled clinical trials. While clinical observations suggest potential benefits, the causal mechanisms remain insufficiently specified. It therefore remains unclear to what extent observed changes are attributable specifically to somatic components, as opposed to general therapeutic factors such as therapeutic alliance, attention, or exposure.

Implications for practice

Integrating the somatic perspective does not require the abandonment of standard schema therapy. It requires broadening clinical attention to bodily processes that occur alongside narrative and emotion (Young *et al.* 2003; Ogden & Fisher 2015). A practical starting point is somatic mapping of modes: the therapist observes how the Vulnerable Child mode, Critic mode, Detached Protector mode, or Healthy Adult mode appears in

breathing, posture, facial expression, movement, voice, and vitality.

Somatic interventions are best introduced as brief, ongoing micro-level interventions rather than separate treatment blocks. These may include slowing down, focusing on the breath, sensing bodily contact with the chair or floor, noticing tension, orienting to the room, or tracking an impulse to move. The bodily sensation is then linked to a schema, mode, and need—for example, withdrawal with the need for safety, pressure in the body with a boundary, or mobilization with protection. In this way, bottom-up and top-down processing are integrated (Mehling *et al.* 2011; Price & Hooven 2018; Brewin *et al.* 1996; Siegel 1999).

For safe practice, several principles are central: begin with regulation rather than exposure; monitor micro-indicators of change; work with the body as a language of needs; respect the patient's pace and boundaries; use the therapist's own bodily responses in reflection and supervision; and integrate somatic focus into imagery rescripting, chairwork, mode work, and cognitive restructuring (Corrigan *et al.* 2011; Ogden & Fisher 2015).

In group schema therapy, the somatic perspective may help to identify modes in real time, support mentalization of others, and regulate emotions in an interpersonal context. The group makes it possible to observe nonverbal reactions, withdrawal, loss of contact, tension, or changes in voice directly within relational situations. Sensitive reflection on these processes can connect bodily reactions with schemas and needs (Koole & Tschacher 2016).

In practical terms, somatic work can be operationalized in three steps: identifying a bodily marker of activation, linking it with a specific mode and need, and introducing a small somatic intervention, such as a change in support, breathing, gesture, or boundary. This microprocess can be viewed as a basic clinical unit of intervention in somatically expanded schema therapy.

Figure 2 illustrates a micro cycle of somatically informed intervention in schema therapy, derived from the clinical examples above.

Future research should evaluate the effectiveness of BFST, mechanisms of change, indications, contraindications, patient selection, therapist training, and the optimal integration of somatic interventions into routine practice. The current state of knowledge supports cautious clinical use of the somatic perspective as a complementary extension, not as a universally superior model.

CONCLUSION

The somatic perspective can be understood as a theoretically grounded extension of schema therapy through the systematic inclusion of body-focused processes. Schemas and modes are not merely mental

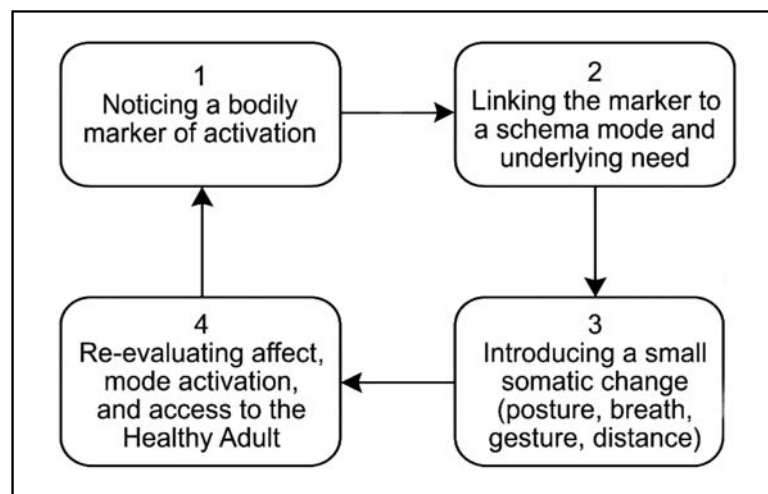


Fig. 2. Micro-unit of somatic intervention in schema therapy

Legend: The diagram illustrates a flexible clinical micro cycle used in somatically informed schema therapy. The therapist and patient (1) notice a specific bodily marker of activation, (2) link it to the currently active schema mode and underlying need, (3) introduce a small, reversible somatic change (for example in posture, breathing, gesture, or interpersonal distance), and (4) re evaluate affect, mode activation, and access to the Healthy Adult mode. The cycle can be repeated and titrated within the patient's window of tolerance and is intended as a basic unit of intervention rather than a rigid protocol.

representations but may also be reflected in breathing patterns, muscle tone, posture, movement, and autonomic reactivity (van der Kolk *et al.* 2014; Ogden *et al.* 2006).

From a theoretical standpoint, this perspective represents a natural deepening of a model that has, from its inception, incorporated early experiences, emotional needs, and implicit processes (Young *et al.* 2003; Arntz *et al.* 2012). If such experiences are encoded not only cognitively but also in sensorimotor and neurophysiological forms, their transformation may require interventions that engage the bodily dimension.

Clinically, the somatic perspective appears particularly relevant in conditions characterized by emotion dysregulation, dissociation, complex trauma, and borderline personality disorder, where contact with experience is often fragmented or mediated through bodily states (Lanius *et al.* 2011; van der Kolk *et al.* 2014). It may enhance interoceptive awareness, support arousal regulation, facilitate earlier recognition of schema modes, and promote integration between implicit and explicit experience (Price & Hooven 2018; Payne *et al.* 2015).

The somatic perspective contributes to bridging the traditional mind–body divide in psychotherapy by conceptualizing schemas as an integration of affective, cognitive, relational, and bodily processes (Koole & Tschacher 2016). It may further enhance the effectiveness of experiential techniques such as imagery rescripting and chairwork by addressing not only meaning but also the bodily organization of experience.

Overall, the somatic perspective may meaningfully enrich schema therapy by addressing the implicit, body organized dimension of psychopathology. In the clinical material reviewed, somatic attention appears to support earlier detection of mode activation and more targeted regulation, while at the same time placing higher demands on clinical expertise. Its specific contribution, however, requires further empirical validation. The current evidence base for

somatic interventions within schema therapy remains relatively limited and methodologically heterogeneous, underscoring the need for randomized controlled trials (RCTs) and mechanism focused studies to clarify efficacy, mechanisms of change, and differential clinical indications.

AUTHOR CONTRIBUTION AND USE OF ARTIFICIAL INTELLIGENCE

This manuscript was edited with the assistance of an AI based language model (ChatGPT, OpenAI) under the supervision of the first author. Generative artificial intelligence tools were used only to assist with language refinement, stylistic editing, and structural suggestions. All conceptual ideas, clinical interpretations, case material, and scientific responsibility remain entirely with the authors.

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