



AUTONOMIC CHARGE DISSOLUTION AND INTEROCEPTIVE ENGAGEMENT: PRELIMINARY EVIDENCE FROM A BRIEF SOMATIC INTERVENTION

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ABSTRACT: *Background: Many psychotherapy models emphasise symptom reduction, emotional regulation, or cognitive restructuring, yet less attention has been given to the somatic process through which unresolved physiological activation becomes tolerable, observable, and available for therapeutic change. This exploratory case series examined whether a brief autonomic charge-focused somatic intervention was associated with reductions in psychological symptoms and target-specific distress, alongside increased body awareness. Method: Five adult female clients aged 29–48 received three sessions of a somatic, regulation-based intervention targeting unresolved autonomic activation linked to relational, parental, occupational, or performance-related triggers. Outcomes were measured at each session using the Depression Anxiety Stress Scales-21 (DASS-21), Subjective Units of Distress Scale (SUDS), and Body Awareness Questionnaire (BAQ). Data were analysed descriptively, with exploratory non-parametric repeated-measures tests used to examine within-subject change across sessions. Results: Across three sessions, participants showed consistent improvement across all measured domains. Mean DASS-21 depression scores decreased from 15.6 to 6.8, anxiety from 18.0 to 6.8, and stress from 26.8 to 11.6. Mean SUDS decreased from 78.2 to 21.6, representing a 72.4% reduction in target-specific distress. All participants ended Session 3 with SUDS scores below 30% of their initial distress scores. Mean BAQ increased from 50.0 to 70.8, suggesting improved body awareness and interoceptive engagement. Friedman tests indicated significant change across all measures, although inferential findings were interpreted cautiously due to the small sample size. Conclusion: Findings provide preliminary support for autonomic charge dissolution as a clinically observable process associated with reduced distress and increased body awareness. Rather than suggesting symptom suppression alone, the concurrent reduction in distress and increase in somatic awareness may indicate improved capacity to engage bodily activation within a regulated therapeutic context. These early findings warrant further investigation using larger samples, follow-up assessment, physiological measures, and controlled designs.*

KEYWORDS: Autonomic charge, Interoception, Body awareness, Somatic psychotherapy, Emotional regulation, Trauma therapy, SUDS, DASS-21.



INTRODUCTION

Psychological distress is often treated as a cognitive, emotional, or behavioural phenomenon, yet many clients experience distress first and most powerfully through the body. Anxiety may present as chest tightness, agitation, trembling, nausea, muscular tension, collapse, heat, pressure, or a felt sense of internal threat. Trauma research and somatic psychotherapy have increasingly recognised that unresolved emotional experience is held not only in narrative memory but also in physiological activation, defensive readiness, and altered bodily awareness (Levine, 1997, 2010; Ogden et al., 2006; van der Kolk, 2014). This has led to growing interest in interventions that work directly with bodily activation rather than relying exclusively on verbal insight or cognitive restructuring.

A central construct in this paper is autonomic charge, defined as residual physiological activation associated with unresolved emotional memory, experienced subjectively as bodily tension, agitation, pressure, collapse, or energetic intensity. Autonomic charge is proposed as a clinically observable process rather than a formally established diagnostic category. It overlaps with but is not reducible to general arousal, sympathetic activation, stress, or anxiety. Whereas arousal describes a broad state of physiological activation, autonomic charge refers more specifically to emotionally organised activation linked to unresolved relational, traumatic, or threat-based memory networks. In clinical practice, this charge may remain active beneath apparently high-functioning presentations, contributing to distress, relational reactivity, somatic symptoms, and defensive control.

The relevance of autonomic charge is supported by contemporary accounts of the autonomic nervous system, interoception, and emotional processing. Polyvagal theory highlights the role of autonomic state in safety, threat detection, attachment, and social engagement (Porges, 2011, 2021). Interoceptive neuroscience further shows that bodily signals are central to emotional awareness and self-experience (Craig, 2002, 2009; Seth, 2013). The anterior insula, in particular, has been implicated in the integration of bodily sensation, subjective feeling, and conscious awareness (Craig, 2009). From this perspective, emotional change may require more than cognitive reframing; it may require altered engagement with the bodily signals through which emotional memory and threat anticipation are experienced.

Interoception has also been linked to emotion regulation. Garfinkel et al. (2015) distinguished between interoceptive accuracy, interoceptive awareness, and interoceptive sensibility, emphasising that bodily awareness is multidimensional rather than a single capacity. Similarly, Mehling et al. (2009, 2012) argued that body awareness can involve adaptive attention to bodily experience rather than anxious monitoring or somatic preoccupation. Building on this, interoceptive awareness has also been framed as a trainable clinical skill supporting emotion regulation within body-oriented therapeutic approaches (Price & Hooven, 2018). This distinction is clinically important. In somatic psychotherapy, the therapeutic goal is not simply to increase bodily attention but to cultivate a regulated, non-avoidant, and tolerable form of body awareness through which previously overwhelming activation can be processed.

The relationship between bodily awareness and therapeutic change is also central to several body-orientated and trauma-informed approaches. Focusing-orientated psychotherapy emphasises the “felt sense” as a bodily carried meaning that can shift through sustained, precise attention (Gendlin, 1996). Somatic Experiencing proposes that traumatic activation can be renegotiated through titrated awareness of interoceptive and proprioceptive experience



(Levine, 1997, 2010; Payne et al., 2015). Sensorimotor psychotherapy similarly works with posture, movement, sensation, and defensive responses as entry points into traumatic memory and dysregulated affect (Ogden et al., 2006). Across these approaches, the body is not treated as a secondary container for psychological symptoms but as an active pathway through which emotional learning and nervous system regulation may occur.

Memory reconsolidation provides another relevant framework for understanding how emotionally charged material may change. Reconsolidation research suggests that reactivated emotional memories can become labile and open to updating under specific conditions (Nader et al., 2000; Schiller et al., 2010). In psychotherapy, this has been used to explain how entrenched emotional learnings may transform when activated in the presence of new contradictory or corrective experiences (Ecker et al., 2012; Lane et al., 2015). From this perspective, somatic engagement may be clinically significant because unresolved emotional memory often emerges not only as explicit narrative but also as bodily activation. If the client can remain regulated while contacting this activation, the emotional memory may become available for updating rather than being reinforced through avoidance, collapse, or defensive control.

Predictive processing models further suggest that bodily and emotional experience is shaped by ongoing prediction, error correction, and updating between the brain and body (Barrett & Simmons, 2015; Friston, 2010; Seth, 2013). Emotional distress may persist when the nervous system continues to predict threat based on prior experience, even when current conditions are safer. Within this framework, autonomic charge can be conceptualised as the felt physiological residue of unresolved threat prediction. A somatic intervention may therefore support change by allowing the client to encounter bodily prediction signals within a regulated context, creating conditions under which old threat associations can be revised.

This broader clinical lineage includes trauma recovery models, mindfulness-based approaches, eye-movement techniques, interpersonal neurobiology, neural interruption, and reconsolidation-informed psychotherapy, all of which variously emphasise the transformation of distress through memory updating, embodied awareness, affect regulation, or neural interruption (Agren, 2014; Craig & Rice, 2012; Deninger, 2020; Herman, 1992; Kabat-Zinn, 1990; Lee, 2025; Schore, 2012; Shapiro, 2018).

This paper addresses that gap by presenting an exploratory five-case clinical series of a brief autonomic charge-focused somatic intervention, using the Depression Anxiety Stress Scales-21 (DASS-21), the Subjective Units of Distress Scale (SUDS), and the Body Awareness Questionnaire (BAQ) to examine whether target-specific distress reduction occurs alongside increased body awareness (Lovibond & Lovibond, 1995; Shields et al., 1989; Wolpe, 1969) - a combination that has received little attention in the existing somatic and trauma-informed literature. The study does not aim to establish efficacy or to validate autonomic charge as a formally established construct; rather, it offers preliminary evidence of autonomic charge dissolution as a clinically observable process. Specifically, it asks whether three sessions of a somatic, regulation-based intervention are associated with: (a) reductions in depression, anxiety, and stress; (b) reductions in target-specific subjective distress; and (c) increases in body awareness.



METHOD

Research Design

This study employed an exploratory clinical case-series design using repeated quantitative measures and brief clinical case descriptions to examine changes in psychological symptoms, target-specific distress, and body awareness across three sessions of a brief somatic intervention focused on autonomic charge dissolution. The design was appropriate for the early theory-building stage of an emerging clinical construct, where the primary aim was not to establish efficacy, but to examine whether measurable clinical change could be observed across multiple outcome domains.

The study used a pre–mid–post repeated-measures structure, with outcomes collected at each of the three treatment sessions. This design allowed for preliminary examination of within-participant change over time while retaining sensitivity to individual clinical trajectories. Given the small sample size and absence of a control group, the study was not designed as a randomised controlled trial, nor as a multiple-baseline single-case experimental design. Instead, it was conceptualised as an exploratory clinical case series intended to generate preliminary evidence and guide future controlled research.

This combination of outcomes was selected to examine whether symptom reduction occurred alongside increased interoceptive engagement, rather than through avoidance, suppression, or dissociation.

Participants

Five adult female clients were included in the case series. Participants ranged in age from 29 to 48 years and presented to private psychotherapy practice with concerns involving emotional dysregulation, relational anxiety, occupational stress, parental-triggered emotional collapse, over-control, somatic tension, poor sleep, guilt, self-image disturbance, and heightened physiological activation.

All participants were high-functioning in occupational or social domains yet reported significant internal distress. Client A was a 48-year-old educator in a senior professional role who presented with over-control, somatic pain, poor sleep, and high performance pressure. Client B was a 38-year-old coach who presented with poor self-image and emotional collapse linked to her relationship with her mother. Client C was a 33-year-old civil servant experiencing workplace victimisation, guilt, anxiety, and high internal stress despite external functionality. Client D was a 35-year-old accountant with relational anxiety, emotional instability when triggered, and a history of distressing romantic and maternal relational dynamics. Client E was a 29-year-old manager in a mergers and acquisitions firm who presented with high anxiety linked to parental interactions and a strong professional façade that collapsed in family contexts.

Participants were selected on clinical grounds. Inclusion criteria were (a) adult age; (b) presentation with distress linked to relational, occupational, parental, or performance-related triggers; (c) evidence of somatic activation or autonomic dysregulation during emotionally salient material; and (d) suitability for a somatic, regulation-based intervention. Exclusion criteria included acute psychosis, active suicidality requiring crisis intervention, severe



substance dependence requiring specialist care, or insufficient stability to engage in somatic processing.

Ethical Considerations

All participants provided informed consent for their de-identified clinical data to be used for research and publication purposes. Identifying information was removed or altered to protect confidentiality. Participants were referred to using non-identifying labels, and demographic and occupational details were generalised where necessary to reduce the risk of recognition.

The study was conducted in the context of independent clinical practice. As such, formal institutional ethics review was not available. Nevertheless, the study was conducted in accordance with core ethical principles of informed consent, voluntary participation, confidentiality, non-maleficence, and respect for client autonomy. Participants were informed that consent for research use of de-identified data was separate from clinical care and that their therapeutic relationship would not be affected by their decision regarding publication consent.

Therapist

All sessions were conducted by the author, a counsellor and psychotherapist in private practice with training in somatic, attachment-focused, and regulation-based approaches. The therapist was also the developer of the autonomic charge-focused intervention model used in this study. This dual role is acknowledged as a methodological limitation because it introduces the possibility of therapist allegiance effects, confirmation bias, and non-independent interpretation of clinical change.

No independent therapist fidelity assessment was conducted. Treatment delivery was guided by the clinical principles of the intervention model, including somatic observation, relational co-regulation, titrated engagement with bodily activation, and integration following distress reduction. Future studies should include independent fidelity ratings and delivery by therapists not involved in model development.

Intervention

The intervention was a brief somatic, regulation-based approach designed to reduce autonomic charge (as defined above) associated with emotionally salient material; in the context of this intervention, the felt quality of that activation also commonly included constriction.

The intervention drew on principles from somatic psychotherapy, attachment-informed therapy, interoceptive awareness, autonomic regulation, and memory reconsolidation theory. Its central clinical proposition was that distress linked to unresolved emotional material may reduce when bodily activation can be contacted, observed, and processed within a regulated therapeutic context. Rather than encouraging high-arousal exposure or extensive narrative recounting, the intervention emphasised titrated somatic awareness, co-regulation, and moment-to-moment tracking of bodily sensation.

Each participant received three sessions. The sessions were not manualised in a rigid sequence but followed a consistent process structure:

1. identification of the emotionally charged target or presenting trigger;



2. assessment of current subjective distress and bodily activation;
3. establishment of relational safety and regulation;
4. guided somatic observation of the bodily expression of distress;
5. titrated tracking of sensation, intensity, movement, image, pressure, constriction, or energetic shift;
6. facilitation of charge reduction without forcing emotional catharsis;
7. integration of any changes in bodily state, meaning, emotion, or self-perception;
8. reassessment of subjective distress and body awareness.

The intervention aimed to support clients in moving from defensive activation or collapse toward tolerable interoceptive contact. The therapist monitored signs of hyperactivation, hypoactivation, dissociation, cognitive over-control, and affective flooding. When activation exceeded the client's window of tolerance, the therapist slowed the process, returned attention to present-moment safety, or used grounding and co-regulatory cues before continuing.

Core Intervention Components

Somatic Observation

Somatic observation refers to sustained, neutral, non-judgemental awareness of bodily sensations associated with emotional activation. Clients were guided to notice the location, size, shape, texture, movement, temperature, pressure, or intensity of bodily sensations without immediately interpreting, analysing, suppressing, or amplifying them. The purpose was to allow autonomic activation to become observable and tolerable, rather than being enacted through defensive behaviour, rumination, collapse, or avoidance.

Somatic observation was distinguished from cognitive insight. Clients were not asked primarily to explain why they felt distressed but to notice how distress was organised in the body. This distinction was central to the intervention model, which proposes that unresolved emotional charge often persists as bodily activation even when the client has substantial cognitive understanding of the issue.

Relational Co-regulation

Relational co-regulation was used throughout the intervention. The therapist maintained a calm, attuned, and responsive presence, using pacing, voice tone, facial expression, silence, and empathic tracking to support the client's capacity to remain within tolerable activation. Co-regulation was particularly important for clients whose distress was linked to relational threat, parental invalidation, emotional abandonment, or performance pressure.

The therapist's role was not merely to observe the client's process but to provide a regulated interpersonal field in which bodily activation could be contacted without overwhelming the client. This was consistent with attachment-informed and polyvagal understandings of safety, social engagement, and autonomic regulation.



Titrated Charge Processing

Titrated charge processing involved gradual engagement with emotionally linked physiological activation. The therapist invited clients to approach bodily activation in small increments while monitoring distress intensity and signs of dysregulation. If distress escalated too rapidly, the process was slowed, resourced, or redirected toward stabilisation.

The aim was not cathartic release for its own sake but the reduction of distress through tolerable contact with previously avoided or overwhelming bodily experience. This process was hypothesised to support autonomic charge dissolution by allowing unresolved activation to complete, soften, discharge, or reorganise.

Integration

At the end of each session, clients were guided to notice changes in bodily sensation, emotional tone, self-perception, relational meaning, or behavioural impulse. Integration focused on consolidating the shift from reactive activation toward a more regulated state. Clients were encouraged to observe whether the original target still carried the same level of intensity and whether any new meaning or bodily ease had emerged.

Measures

Three outcome measures were administered across the three sessions: the Depression, Anxiety and Stress Scales-21; the Subjective Units of Distress Scale; and the Body Awareness Questionnaire.

Depression Anxiety Stress Scales-21

The Depression Anxiety Stress Scales-21 (DASS-21; Lovibond & Lovibond, 1995) was used to assess psychological symptoms across three domains: depression, anxiety, and stress. The DASS-21 contains 21 items, with seven items per subscale. Items are rated on a 4-point scale from 0 to 3, and subscale scores are multiplied by two to allow comparison with the full DASS-42 scoring system. Higher scores indicate greater symptom severity.

The DASS-21 was selected because it is brief, widely used, and suitable for repeated clinical measurement. In this study, DASS-21 scores were used to examine broader changes in psychological distress across the three-session intervention period.

Subjective Units of Distress Scale

The Subjective Units of Distress Scale (SUDS; Wolpe, 1969) was used to assess target-specific distress. Participants rated their distress on a 0–100 scale, where 0 represented no distress and 100 represented maximum imaginable distress. SUDS was used as the most proximal measure of autonomic charge intensity because it captured the client's subjective distress in relation to the emotionally activated target being processed.

SUDS ratings were recorded at each session. The primary SUDS outcome was change from Session 1 to Session 3. Particular attention was given to whether participants' Session 3 SUDS scores fell below 30% of their initial Session 1 scores, indicating a substantial reduction in target-related distress.

**Body Awareness Questionnaire**

The Body Awareness Questionnaire (BAQ; Shields et al., 1989) was used to assess body awareness. The BAQ measures attentiveness to normal bodily processes and sensitivity to bodily changes. Higher scores indicate greater body awareness.

The BAQ was included because the intervention model proposes that therapeutic change should not be understood only as symptom reduction. Instead, autonomic charge dissolution is hypothesised to involve increased capacity to notice and remain present with bodily experience. BAQ scores therefore provided an indirect measure of interoceptive engagement across the three sessions.

Data Collection Procedure

Outcome measures were collected at each of the three treatment sessions. At Session 1, participants completed baseline measures and identified the primary emotionally charged target for intervention. SUDS ratings were linked to the distress associated with this target. DASS-21 and BAQ scores were collected to assess broader psychological symptoms and body awareness.

At Session 2, the same measures were repeated to assess mid-intervention change. The therapist also reviewed the client's subjective experience since the previous session, including changes in emotional reactivity, bodily activation, sleep, relational triggers, or daily functioning.

At Session 3, measures were administered again to assess post-intervention change. Clients were also invited to reflect on perceived changes in distress intensity, bodily awareness, emotional regulation, and their relationship to the original target.

Data Analysis

Data analysis proceeded in four stages.

First, descriptive statistics were calculated for each outcome measure at Sessions 1, 2, and 3. Group means were calculated for DASS-21 Depression, Anxiety, and Stress subscales, SUDS and BAQ. The mean change from Session 1 to Session 3 was then calculated for each measure.

Second, percentage change was calculated to provide clinically interpretable estimates of improvement. For symptom and distress measures, percentage reduction was calculated from Session 1 to Session 3. For BAQ, the percentage increase was calculated to reflect growth in body awareness.

Third, individual-level change was examined for each participant. This was important because, in small-N clinical research, group means may obscure clinically meaningful individual patterns. Individual SUDS change was examined to determine whether each participant's Session 3 score fell below 30% of their Session 1 score.

Fourth, exploratory non-parametric repeated-measures analysis was conducted using Friedman tests. Friedman tests were selected because the sample was small, the data were repeated across three time points, and normality assumptions could not be established. These inferential statistics were interpreted cautiously and descriptively. Given the small sample size, p-values were not treated as definitive evidence of intervention efficacy.



Effect sizes were considered but not foregrounded because small samples with consistent directional change can produce unstable or inflated effect estimates. The primary emphasis was therefore placed on descriptive change, percentage improvement, individual response patterns, and theoretical coherence with the proposed mechanism of autonomic charge dissolution.

Methodological Positioning

This study was positioned as early-stage clinical research. Its purpose was not to validate autonomic charge as an established construct or to demonstrate treatment efficacy. Rather, it aimed to examine whether a coherent pattern of change could be observed across theoretically relevant domains: psychological symptoms, target-specific distress, and body awareness.

This methodological positioning is important because the study sits at the interface between clinical innovation and empirical investigation. Case-series designs are appropriate when an intervention model is still being refined and when preliminary evidence is needed before larger controlled studies are justified. The findings are therefore best understood as hypothesis-generating and as providing a foundation for subsequent research using stronger designs.

RESULTS

Participant characteristics

The sample comprised five adult female clients aged 29–48 years who presented with high-functioning external profiles alongside clinically significant internal distress. Presenting concerns included relational anxiety, occupational stress, parental-triggered emotional collapse, somatic tension, poor sleep, over-control, guilt, self-image disturbance, and heightened physiological activation. Although participants were generally functional in professional and social domains, each reported distress that intensified in response to emotionally salient interpersonal or performance-related triggers.

Analytic approach

Given the small sample size and repeated assessment over three treatment sessions, the study was analysed as an exploratory pre–mid–post case series. Descriptive statistics were prioritised, with change examined across DASS-21 Depression, Anxiety, and Stress subscales, Subjective Units of Distress Scale scores, and Body Awareness Questionnaire scores. Because there was no separate baseline phase or control group, inferential statistics were interpreted cautiously and used only to describe within-subject change across time. The findings should therefore be understood as preliminary and hypothesis-generating rather than confirmatory.

Table 1: Participant-Level Change Across DASS-21

Client	Measure	DASS-21 S1	DASS-21 S2	DASS-21 S3
A	Depression	12	8	6
A	Anxiety	14	9	6
A	Stress	32	22	14
B	Depression	24	18	10



B	Anxiety	16	10	6
B	Stress	22	16	10
C	Depression	14	11	6
C	Anxiety	18	12	8
C	Stress	30	21	12
D	Depression	16	13	8
D	Anxiety	22	15	8
D	Stress	26	18	12
E	Depression	12	8	4
E	Anxiety	20	12	6
E	Stress	24	16	10

Table 2: Participant-Level Change Across SUDS and BAQ

Client	SUDS S1	SUDS S2	SUDS S3	SUDS % reduction	BAQ S1	BAQ S2	BAQ S3
A	75	42	20	73.3%	48	61	74
B	80	52	23	71.3%	52	60	70
C	78	47	22	71.8%	50	57	68
D	82	55	24	70.7%	46	55	65
E	76	44	19	75.0%	54	63	77

Table 3: Group Mean Change Across Three Sessions

Measure	S1 Mean	S2 Mean	S3 Mean	S1→S3 change	% change
DASS Depression	15.6	11.6	6.8	-8.8	-56.4%
DASS Anxiety	18.0	11.6	6.8	-11.2	-62.2%
DASS Stress	26.8	18.6	11.6	-15.2	-56.7%
SUDS	78.2	48.0	21.6	-56.6	-72.4%
BAQ	50.0	59.2	70.8	+20.8	+41.6%

Changes in psychological symptoms

Across the five participants, all DASS-21 subscales showed reduction from Session 1 to Session 3. Mean depression scores declined from 15.6 at Session 1 to 6.8 at Session 3, representing a mean reduction of 8.8 points, or 56.4%. Mean anxiety scores declined from 18.0 to 6.8, representing a mean reduction of 11.2 points, or 62.2%. Mean stress scores declined from 26.8 to 11.6, representing a mean reduction of 15.2 points, or 56.7%.

Stress showed the largest absolute reduction among the DASS-21 subscales. This is consistent with the clinical presentation of the sample, in which participants reported high levels of internal pressure, physiological activation, relational threat sensitivity, and over-responsibility



despite outward functional capacity. Anxiety also showed marked reduction, particularly among participants whose presenting difficulties were linked to parental or relational triggers.

Changes in subjective distress

Subjective distress showed the largest overall reduction across the three sessions. Mean SUDS decreased from 78.2 at Session 1 to 48.0 at Session 2 and 21.6 at Session 3. This represented a mean reduction of 56.6 points, or 72.4%. Importantly, all five participants ended Session 3 with SUDS scores below 30% of their Session 1 scores, indicating a substantial reduction in target-related distress over the three-session intervention period.

Individual SUDS reductions ranged from 70.7% to 75.0%. This pattern suggests that the intervention was associated with substantial reduction in acute subjective distress linked to the targeted emotional material. The magnitude of SUDS change is clinically notable, although it should be interpreted as change in target-specific distress rather than global psychological recovery.

Changes in body awareness

Body awareness increased across the three sessions. Mean BAQ scores rose from 50.0 at Session 1 to 59.2 at Session 2 and 70.8 at Session 3, representing a mean increase of 20.8 points, or 41.6%. All five participants showed increased BAQ scores by Session 3.

This increase is theoretically important because the intervention model does not conceptualise change as simple symptom suppression. Rather, the model proposes that therapeutic change involves increased capacity to notice, tolerate, and process bodily activation without avoidance, collapse, or defensive over-control. The concurrent reduction in distress and increase in body awareness therefore provides preliminary support for the proposed mechanism of autonomic charge dissolution through somatic observation and regulated interoceptive engagement.

Individual-level change

At the individual level, all participants improved in the expected direction across all outcome domains. DASS-21 Depression reductions ranged from 6 to 14 points, Anxiety reductions ranged from 8 to 14 points, and stress reductions ranged from 12 to 18 points. SUDS reductions ranged from 53 to 58 points, with all participants reaching less than 30% of their initial distress level by Session 3. BAQ increases ranged from 18 to 26 points.

This pattern suggests that the observed changes were not driven by one unusually strong responder. Rather, improvement was distributed across all five cases. The consistency of improvement across both symptom-based and somatic-awareness measures supports the clinical coherence of the findings.

Friedmen Test Results

Friedman tests indicated significant change across all five measures. Because every participant changed in the same direction across sessions, the test statistic reached its maximum possible value for this sample size for every measure, $\chi^2(2, N = 5) = 10.00, p = .007$.



Clinical interpretation

The findings provide preliminary support for the proposed intervention model. Over three sessions, participants showed reductions in psychological symptoms, substantial reductions in target-related subjective distress, and increased body awareness. The simultaneous reduction in SUDS and increase in BAQ is particularly relevant to the proposed mechanism of autonomic charge dissolution. Rather than becoming less aware of distress through avoidance or dissociation, participants appeared to become more somatically aware while reporting less distress.

This pattern is clinically meaningful. In autonomic charge processing, increased body awareness is not merely a secondary outcome; it may represent a key condition through which unresolved physiological activation becomes observable, tolerable, and available for processing. The present findings therefore suggest that short-term somatic and regulation-based intervention may be associated with both symptom reduction and improved interoceptive capacity.

Summary

Taken together, the changes reported above across DASS-21, SUDS, and BAQ (Table 3) indicate that three sessions were consistently associated with reductions in depression, anxiety, stress, and subjective distress, alongside increased body awareness. These findings provide preliminary evidence that autonomic charge-focused intervention may reduce target-related distress while strengthening somatic awareness.

However, the findings should be interpreted as early-stage clinical evidence. The absence of a control group, the small sample size, the short treatment window, and the lack of follow-up limit causal interpretation. Future studies should include larger samples, longer follow-up periods, independent assessment, physiological measures such as HRV, and comparison conditions to examine whether the observed improvements are attributable to the intervention rather than expectancy, therapeutic alliance, spontaneous improvement, or regression to the mean.



DISCUSSION

This exploratory case series examined change across three sessions of an autonomic charge-focused, somatic intervention in five adult female clients presenting with high-functioning external profiles and marked internal distress. Across participants, psychological symptoms decreased, target-related subjective distress reduced substantially, and body awareness increased. Although the small sample and uncontrolled design preclude causal conclusions, the pattern of findings offers preliminary support for the clinical relevance of autonomic charge dissolution as a process linking somatic awareness, emotional processing, and symptom change.

A central finding was the marked reduction in Subjective Units of Distress Scale (SUDS) scores across the three sessions. Mean SUDS decreased by more than 70%, and all participants ended the third session with distress levels below 30% of their initial scores. This suggests that the intervention was associated with substantial reduction in target-specific emotional and physiological activation. Importantly, this change should not be interpreted as global psychological recovery over three sessions. Rather, it indicates a meaningful reduction in distress linked to specific emotionally charged material addressed during treatment.

Reductions were also observed across all three DASS-21 subscales. Depression, anxiety, and stress scores all decreased from Session 1 to Session 3, with the largest absolute reduction observed in stress. This is clinically coherent given the sample profile. Participants were not primarily characterised by low functioning or overt decompensation but by high levels of internal pressure, relational threat sensitivity, somatic tension, and emotional collapse under specific triggering conditions. The observed reduction in stress may therefore reflect a decrease in internal autonomic load rather than simple cognitive reframing or general reassurance.

The simultaneous increase in Body Awareness Questionnaire (BAQ) scores is especially relevant to the proposed mechanism of change. In many symptom-focused models, clinical improvement is evaluated primarily through reduction in distress or psychopathology. However, the present findings suggest that symptom reduction occurred alongside increased bodily awareness. This is theoretically important because the intervention model proposes that autonomic charge is not dissolved through avoidance, suppression, or cognitive control alone. Rather, change may occur when clients are able to notice, remain with, and process bodily activation within a sufficiently regulated therapeutic context.

This pattern distinguishes the present model from approaches that conceptualise treatment response primarily as down-regulation. If distress reduction were achieved through dissociation, emotional avoidance, or premature calming, one might expect body awareness to remain unchanged or decrease. Instead, the increase in BAQ suggests that participants became more capable of engaging bodily experience while reporting lower distress. This supports the view that autonomic charge dissolution may involve a shift from defensive activation toward tolerable interoceptive contact.

The findings also have implications for understanding high-functioning clinical presentations. All five participants appeared outwardly capable, socially functional, or professionally successful yet reported substantial internal dysregulation. This discrepancy between external competence and internal autonomic burden may be under-recognised in conventional symptom-focused assessment. The present case series suggests that autonomic charge may be



clinically useful as a construct for describing unresolved physiological activation that remains active beneath apparently adaptive functioning.

From a process perspective, the data support the possibility that brief somatic intervention may produce early measurable shifts across three domains: subjective distress, psychological symptoms, and interoceptive awareness. The strongest change was observed in target-related distress, while broader DASS-21 symptoms also improved. This pattern is clinically plausible. Target-specific distress may respond more rapidly to focused processing, whereas broader symptoms such as depression, anxiety, and stress may require longer treatment to consolidate change across contexts.

The results are also consistent with the proposed sequence of therapeutic change in autonomic charge processing: regulated therapeutic contact, somatic observation, tolerable engagement with bodily activation, reduction in charge intensity, and integration of previously reactive emotional material. Although the present study did not directly test each component of this sequence, the concurrent reduction in distress and increase in body awareness provides preliminary empirical support for this theoretical pathway.

Overall, this case series contributes early clinical evidence to an underdeveloped area of psychotherapy research: the relationship between somatic awareness, unresolved physiological activation, and rapid reduction in target-specific distress. The findings suggest that autonomic charge may be a clinically meaningful construct for capturing changes that are not fully explained by symptom reduction alone. However, further research is required to determine whether these observed changes are specific to the intervention, reproducible across larger samples, and durable over time.

LIMITATIONS

Several limitations concern the study's capacity to support causal inference. The sample size was very small, with only five participants, which restricts generalisability to broader clinical populations and leaves the findings vulnerable to sampling bias and individual variability; such small samples are useful for early-stage clinical observation and hypothesis generation, but not for establishing efficacy. Compounding this, the study used an uncontrolled pre–mid–post case-series design with no waitlist, treatment-as-usual, or active comparison group, and without a separate baseline phase it is not possible to confirm that symptoms were stable before treatment began — meaning the design also falls short of the standards required for a multiple-baseline single-case experimental design. As a result, alternative explanations for the observed change cannot be ruled out, including expectancy effects, therapeutic alliance, regression to the mean, spontaneous improvement, client motivation, or the non-specific effects of being closely attended to in therapy. The brief three-session treatment window further limits what can be concluded about durability: the data show early improvement but do not establish whether gains were maintained beyond Session 3. Future research should address these issues together, using repeated baseline assessment, staggered intervention onset or randomised single-case experimental methods, larger samples, active comparison conditions, and longer follow-up at one, three, and six months.



A second set of limitations concerns what the outcome measures can and cannot tell us. All three measures (SUDS, DASS-21, BAQ) relied on self-report, which is clinically useful but subjective and potentially influenced by demand characteristics, client expectations, social desirability, or a wish to please the therapist — a concern that is particularly salient here because the treating clinician was also the researcher. Relatedly, SUDS captured target-specific rather than global distress, so the substantial reduction observed should not be read as evidence of complete psychological recovery within three sessions, only as a reduction in distress tied to the specific emotionally charged material addressed in treatment. Finally, the study did not directly test the proposed mechanism of change: increased BAQ scores offer indirect support for improved body awareness but do not demonstrate that autonomic charge actually dissolved, nor that body awareness mediated symptom reduction. Future studies should incorporate independent assessment, physiological measures such as heart rate variability, skin conductance, or respiration, explicit differentiation of target-specific from broader functional outcomes, and mediation models supported by session-by-session process measures of somatic activation, emotional memory reprocessing, co-regulation, and physiological regulation.

A third limitation concerns generalisability. The sample was clinically and demographically narrow — all participants were adult women with high-functioning presentations involving relational, parental, occupational, or performance-related triggers — so the findings may not extend to men, adolescents, clients with severe dissociation, psychosis, acute crisis presentations, complex substance dependence, or individuals with lower reflective capacity. This is compounded by the fact that improvement was consistent and directionally uniform across all five participants; while clinically encouraging, such uniformity should be interpreted cautiously in a small sample, since real-world clinical data typically include fluctuation, partial response, delayed response, or non-response. Larger and more diverse future samples are needed to examine heterogeneity of response, including which clients benefit most, which mechanisms predict change, and which presentations may require longer or modified treatment.

Finally, therapist allegiance may have influenced both treatment delivery and interpretation of findings. Because the intervention model was developed and delivered by the same clinician who also acted as researcher, with no independent fidelity assessment conducted, there is a risk of confirmatory bias and non-independent interpretation of clinical change. Future research would benefit from manualised procedures, independent fidelity ratings, independent raters, and replication by therapists not involved in the model's development.

CONCLUSION

This exploratory case series provides preliminary evidence that a brief autonomic charge-focused somatic intervention may be associated with reductions in psychological symptoms, substantial reductions in target-specific distress, and increased body awareness. The findings support further investigation of autonomic charge dissolution as a clinically meaningful process in psychotherapy. However, due to the small sample, uncontrolled design, reliance on self-report, and absence of follow-up, the results should be interpreted as early-stage clinical evidence rather than proof of efficacy. Future controlled and physiologically informed studies are needed to evaluate the specificity, durability, and mechanisms of change associated with this approach.



Ethics Statement

This retrospective de-identified case series was conducted using clinical data from independent private practice. Written informed consent was obtained for use of de-identified material for research and publication. No institutional ethics review was available because the author was not affiliated with a reviewing institution at the time of data collection.

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