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A study of somatic experiencing interventions[®] for corona pandemic stress and anxiety in healthcare workers

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ABSTRACT

This study examines whether the SE protocol can reduce stress and anxiety in pandemic-affected healthcare workers over time. This within-group pre-test-posttest study examines frontline healthcare workers' stress and anxiety after a brief SE intervention. The study included 112 healthcare workers who surpassed the 21-item Depression Anxiety Stress Scale (DASS-21) minimum anxiety and stress thresholds. 69 of 112 individuals completed pre- and post-test measures, and 27 completed follow-up scales. Analysis showed that SE sessions reduced stress and anxiety in healthcare workers, and follow-up assessments confirmed this. The findings suggest that two online SE sessions can help frontline healthcare workers cope with the COVID-19 pandemic.

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KEYWORDS COVID-19; somatic experiencing; SE; healthcare workers; stress; anxiety

Introduction

Somatic Experiencing[®] (SE[®]) is a resilience-based mind-body connection approach for people with distress and traumatic life events (Levine, 2010). SE attributes chronic stress and stress-related psychological diseases to stress activation, inadequate defense responses, and ANS dysregulation (Levine, 2010, 2015). SE reduces trauma and chronic stress symptoms using a 'bottom-up' psycho-biological approach (physiology to emotions and

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cognition) (Levine & Frederick, 1997). It targets the neural system to reduce traumatic stress-related physiological, psychological, and emotional symptoms (Levine, 2015; Levine & Frederick, 1997). It boosts resilience by improving bodily awareness and mood control. This awareness helps the person regain self-regulation, handle intense stimulation without feeling overwhelmed, and reach inner homeostasis by balancing autonomic nervous system activity. No individual can 'be more present,' separate themselves from stressful events, and 'contain' their feelings and experiences (Levine, 2010).

According to SE, trauma and chronic stress are a natural part of human life, and the human body and mind are equipped with functions, features, and resources that can handle these negative experiences, such as greater awareness of the options present in their current lives, better coping skills, more resilience in the face of difficulties, and discovery of their authentic choices (Levine, 2010; Parker et al., 2008). SE practices focus on self-regulation since it is so vital for everyone since unprecedented circumstances and events such as pandemics, terror attacks, and natural disasters emerge increasingly so nowadays (Chen et al., 2020). Especially some professionals (healthcare professionals, teachers, etc.) in service of people can benefit more from self-regulatory capacity since they are more prone to be exposed to the stress and anxiety of the pandemic (Smith & Langenecker, 2021).

Emerging findings suggest SE as a psychological intervention that can be used in various settings/populations in working with stress (Brom et al., 2017; Payne et al., 2015), chronic pain (Andersen et al., 2020) such as PTSD (Almeida et al., 2020; Brom et al., 2017; Fritts, 2021), and eating disorders (Scatoloni, 2019); in natural disasters like hurricanes (Parker et al., 2008) and earthquakes (Miller-Karas & Leitch, 2009); and also with at-risk groups such as military members (Stanley et al., 2011) and members of gender-diverse identities (Briggs et al., 2018). Studies indicate that individual or group-based SE work is highly effective in reducing levels of anxiety, depression, traumatic experiences, and pain (Andersen et al., 2017; Brom et al., 2017; Changaris, 2010). Moreover, SE can enhance resilience (Winblad et al., 2018) and psychological well-being (Briggs et al., 2018).

After the 2004 Thai tsunami, survivors received one or two SE sessions for physical discomfort, sleep difficulties, headaches, and anxiety or agitation. More than 90% of participants stated that these symptoms vanished or diminished after the sessions, lasting up to a year (Leitch, 2007). Another study gave hurricane-affected social workers SE stabilization sessions (Leitch et al., 2009). Participants' PTSD symptoms and resilience improved significantly after two SE sessions.

The COVID-19 pandemic threatened lives worldwide. Physical distance, lockdowns, and remote work and education were quickly deployed to reduce risk during the COVID-19 pandemic (Fontanarosa & Bauchner, 2020; Ornell et al., 2020). The pandemic's trauma includes everyday routine changes and the nervous system's innate fear of death (Mobbs et al., 2015). These changes touched people worldwide, but some put their health and lives at risk during the COVID-19 pandemic. Particularly affected are medical professionals such as doctors, nurses, and technicians (Galbraith et al., 2021).

Healthcare workers have worked long hours without well-defined treatment protocols, especially at the start of the pandemic, in protective gear and face shields, and often with higher-risk groups in hospitals (TMA, 2020). Since their workplace was the least safe, healthcare workers had to wear layers of protective uniforms, which made it harder to move and work and reminded them that they could be infected and spread the coronavirus to their surroundings (Huang et al., 2020; Wu et al., 2020). During the SARS and Ebola outbreaks, healthcare workers faced similar challenges (Bo et al., 2021; Lehmann et al., 2015; Matua et al., 2015; Xiang et al., 2020), and many suffered from acute stress and anxiety, especially psychosomatic symptoms such as pain (Lam et al., 2009), insomnia (Styra et al., 2008), and chronic extrapulmonary symptoms (Leow et al., 2005; Sim et al., 2010).

Recent studies indicate that healthcare professionals face long hours and poor equipment, in addition to their struggle with social isolation, stigma, and worry about spreading the infection to their family (Craft, 2020; Kisa, 2020; Taylor et al., 2020). During the COVID-19 pandemic, healthcare workers worldwide experienced emotional exhaustion, helplessness, sleep disturbances, fear of discrimination, decreased job performance and satisfaction, procrastination, and reduced patient care (Rana et al., 2020; Roy et al., 2020). Intense emotional experiences may result in psychological issues such as PTSD, anxiety, depression, obsessive-compulsive symptoms, insomnia, somatisation, burnout, and depersonalisation (Giusti et al., 2020; Luceño-Moreno et al., 2020; Zhang et al., 2020; Zhu et al., 2020).

After the SARS pandemic, Maunder et al. (2008) stressed psychological first aid and resilience for healthcare workers. Even two years after the pandemic, SARS healthcare personnel had higher burnout, psychological distress, and PTSD. The Italian clinical psychology unit had a plan to work with healthcare staff and COVID-19 patients and their families during the pandemic. They provided a safe space for healthcare personnel to 'decompress' and small group sessions to boost their resources (Cao di San Marco et al., 2020). This study also suggests creating a brief intervention model that helps healthcare workers with stress symptoms and builds their resiliency

before they develop other symptoms or conditions due to high stress and anxiety to reduce burnout, trauma, stress, and overwhelm.

Recent Turkish COVID-19 research has revealed similar findings. The results indicate that healthcare personnel had high stress and anxiety during the COVID-19 pandemic, which may have reduced patient care and work motivation (Kackin et al., 2021; Kiliñel et al., 2020; Sahin et al., 2020). Healthcare workers reported higher anxiety and despondency than non-healthcare workers (Hacimusalar et al., 2020). During the pandemic, Türkiye prohibited healthcare workers' rights to yearly leave, reassignment to other hospitals, resignation, and retirement. This caused constant stress for these specialists. In 2020, the Turkish Medical Association's (TMA) stated that the suspension of legal rights for healthcare personnel during the pandemic, including the right to resign or take leave, increased stress and anxiety levels among these professionals (TMA, 2020).

These findings suggest that healthcare staff, who risk their health to treat patients, are at high psychological risk. During the COVID-19 pandemic, healthcare personnel face elevated risks and consequences, requiring greater self-regulation (Williams et al., 2021). Healthcare personnel need psychological and social assistance throughout the COVID-19 pandemic (Kackin et al., 2021). Thus, healthcare personnel need physiological, psychological, and emotional support (Blake et al., 2021; Santarone et al., 2020).

This study suggests a systematic SE method to reduce pandemic-related stress and anxiety among healthcare personnel. We expect that following two SE telehealth sessions, healthcare workers' stress levels during the COVID-19 pandemic could decrease significantly and last, as measured by pre-, post-, and follow-up score comparisons; and two SE telehealth sessions could significantly reduce healthcare workers' anxiety during the COVID-19 pandemic, with this decrease expected to last, as measured by pre-, post-, and follow-up score comparisons.

Method

Participants

After recruiting on social media and SE Türkiye's website, at least 140 healthcare workers joined 200 volunteers. This project's main goal was to help healthcare professionals manage COVID-19 stress and anxiety using two SE-based telemedicine sessions, excluding 60 non-healthcare workers from the statistical analysis. We also excluded the data from 28 healthcare participants because their stress and anxiety levels were lower than the minimum score on the Depression Anxiety Stress Scale-21. The study only included healthcare workers with high stress and anxiety scores according to the DASS-21 criteria; nevertheless, support was ultimately provided to

everyone who applied for it. Pre-test data was collected from 112 medical and mental healthcare personnel at COVID-19 pandemic units in Turkish hospitals. 8.9% men and 91.1% women participated, with a mean age of 33.7 years. Professionally, 17.8% were doctors, 19.6% nurses, 10.7% technicians, 25.8% mental health workers, and 25.8% other healthcare workers like delivery nurses, physiotherapists, and pharmacists. Every participant gave informed permission.

Instruments

To gather participant demographic data, researchers created a demographic form with age, gender, and occupation questions. The 1995 Depression Anxiety Stress Scale-21 (DASS-21) by Lovibond and Lovibond assesses depression, anxiety, and stress using three subscales. The DASS-21 was translated into Turkish by Sarıçam (2018), resulting in Cronbach's alpha values of .87, .85, and .81 for depression, anxiety, and stress subscales. This study found Cronbach's alpha values of .82 and .81 for the pre-test, .78 and .80 for the post-test, and .83 and .84 for stress and anxiety. Test-retest reliability coefficients for subscales ranged from .61 to .68 (Sarıçam, 2018). This study employed the anxiety and stress subscales, excluding the depression subscale. Given that the stress associated with the pandemic was deemed acute rather than chronic, no substantial alteration in participants' depressive symptoms was expected. Scores for each subscale are normal, mild, moderate, severe, and extremely severe. The severity classifications indicate the complete range of scores in the population, so 'mild' means the person is above the population mean but presumably still below the normal severity of someone seeking help. DASS manual z-scores define severity (Lovibond & Lovibond, 1995) Additional information is given in the [Appendix A](#).

Design

The study used a one-group pretest-posttest design with pre-, post-, and follow-up single-factor repeated measurements. Experimental models test the effect of the independent variable on the dependent variable to determine cause-and-effect relationships (Creswell, 2011). A quasi-experimental research design differs in two main ways: participants are not randomly assigned, and there is no control group. The present study used a single-group pre-test-posttest design to examine how SE-based intervention affected healthcare workers' stress and anxiety during the COVID-19 pandemic.

Procedure

SE training group providers in Türkiye began their volunteer effort in March 2020, shortly after the onset of the COVID-19 pandemic. The project clinical supervisor and an advanced faculty member from Somatic Experiencing International (SEI) developed a protocol for telehealth sessions with health workers using SE methods to stabilise and regulate skills. The protocol was standardised by the coordinating team. The detailed protocol is given in the [Appendix B](#).

The project was publicised biweekly on social media and the SE Türkiye website for three months, attracting over 200 applicants. Online applications and informed consent forms were submitted. Participants who satisfied eligibility criteria were randomly paired with SE providers based on availability and had two 50-minute online sessions over two weeks. Online forms were used to collect pre-test, post-test, and follow-up data before, after, and two weeks after the first session. Volunteer SE Providers had 32 hours of group supervision with a clinical SE supervisor, averaging 2 hours per week, during the project.

Data analysis

The study included 112 healthcare workers, but only 69 completed both the pre-test and post-test scales, so only 69 were analysed. Follow-up data was also analysed; 27 participants completed pre-, post-, and follow-up testing. The data was analysed using SPSS 22. After confirming a normal distribution with the Shapiro-Wilk Test ($p > .05$), a paired groups t-test was conducted to see if pre-test and post-test stress and anxiety scores differed. No normality was guaranteed for the follow-up data, so a Friedman test was done to compare the pre-test, post-test, and follow-up scores. The Wilcoxon Signed Ranks Test compared post-test and follow-up data.

Results

The current study examined the effect of SE-based sessions in reducing healthcare workers' stress and anxiety during the COVID-19 pandemic. Descriptive analyses were conducted to determine the participants' stress and anxiety scores before the sessions, and the scores are presented in [Table 1](#).

When utilising the DASS21, it is essential to multiply the acquired scale scores by 2; thus, the scores are multiplied by 2 and added to the table. According to DASS-21 scoring, scores between 8 and 9 represent mild, and 15–19 represent severe anxiety levels. For stress, scores between 15 and 18 represent mild stress levels, and 19–25 represent moderate stress levels

Table 1. Descriptive statistics for the pre-test of stress and anxiety scores.

Variable	<i>N</i>	\bar{x}	<i>sd</i>	Min	Max
Stress	112	9.67	4.10	8.00	21.00
Anxiety	112	13.27	3.30	4.00	21.00

(Lovibond & Lovibond, 1995). Table 1 shows that participants had mild and severe stress levels, as well as mild and moderate anxiety levels, prior to the sessions.

The current study explored the potential of SE-based sessions to mitigate stress and anxiety among healthcare workers during the COVID-19 pandemic. Paired t-test analysis was used to determine if there were significant differences in stress and anxiety before, after, and two weeks after the last SE session.

As seen in Table 2, the paired-group t-test performed to determine whether the difference in pre- and post-test mean scores was significant revealed a statistically significant difference between mean stress scores ($t=13.04$; $p<.001$); the same was true for mean anxiety scores ($t=10.05$; $p<.001$).

To compare pre-test, post-test, and follow-up scores, a Friedman test was performed, as follow-up data was not normally distributed. The results are presented in Table 3.

As shown in Table 3, the Friedman test demonstrates significant differences between pre-test, post-test, and follow-up stress scores ($X^2=29.33$, $p=.000$). Both post-test and follow-up stress levels were significantly lower than pre-test ($p<.001$). Table 2 also shows a significant difference between pre-test, post-test, and follow-up anxiety scores ($X^2=29.33$, $p=.001$). Both post-test and follow-up anxiety scores were significantly lower than pre-test scores ($p<0.001$).

Table 4 shows the results of the non-parametric Wilcoxon Signed Ranks Test, conducted to examine the difference between the stress and anxiety post-test and follow-up-test scores of the participants. It revealed no statistically significant difference in mean scores for either variable.

Discussion

Since the onset of COVID-19, healthcare workers have faced prolonged and extreme stress and anxiety due to physical, psychological, and social difficulties. Considering stress-related physical and psychological problems such as cardiovascular diseases, anxiety, and depression (Giusti et al., 2020; Luceño-Moreno et al., 2020; Zhang et al., 2020; Zhu et al., 2020), coping with uncertainty, burnout, and traumatic stress can be challenging (Barello et al., 2020; Marzetti et al., 2020) yet pivotal to protect the wellness of healthcare workers. Thus, the present study set out to investigate a

Table 2. Paired groups t-test results to test the significance of the difference between stress and anxiety pre-test and post-test scores.

Score	Groups	N	\bar{x}	sd	t-test	
					df	t
Stress	Pre-test	69	12.75	4.052	68	13.04*
	Post-test	69	5.85	3.130		
Anxiety	Pre-test	69	8.63	4.158	68	10.05*
	Post-test	69	3.65	3.052		

Note. Stress and anxiety levels were assessed based on the stress and anxiety subscale scores of the DASS-21. * $p < .001$

Table 3. Friedman test results to test the significance of the difference in stress and anxiety among pre-test, post-test, and follow-up scores

Variable	N	\bar{x}	Mean rank	χ^2	Sd	p
Stress						
Pre-test	27	13.444	2.81	29.333	4.107	.00
Post-test	27	6.481	1.59		2.778	
Follow-up	27	7.000	1.59		3.922	
Anxiety						
Pre-test	27	9.1852	4.26	28.02	4.394	.00
Post-test	27	3.518	1.85		2.470	
Follow-up	27	4.222	1.98		4.209	

Note. Stress and anxiety levels were assessed based on the stress and anxiety subscales of the DASS-21.

Table 4. Results of the Wilcoxon Signed-ranks test conducted to test the significance of the difference between anxiety and stress post-test and follow-up scores.

Score	Ranks	N	S.O	z	p	
Stress follow-up test score	Negative ranks	13	0.35	134.50	.107	.915
	Positive ranks	10	14.15			
Stress post-test score	Equal	4				
	Total	27				
Anxiety follow-up test score	Negative ranks	11	10.14	111.50	-.140	.889
	Positive ranks	10	11.95			
Anxiety post-test score	Equal	6				
	Total	27				

Note. Stress and anxiety levels were assessed based on the stress and anxiety subscale of the DASS-21.

voluntary project that aimed to reduce the levels of stress and anxiety experienced by healthcare workers through stabilisation-focused SE telehealth sessions and examine the effect of such an SE intervention.

This study demonstrated a reduction in stress levels among healthcare workers following SE sessions that utilised stabilisation techniques. The analysis indicated that healthcare workers experienced reduced stress levels following participation in two SE sessions, despite their ongoing employment in inherently stressful hospital environments. A study conducted by Briggs et al. (2018) demonstrates that ten sessions of SE-based therapeutic group work significantly decreased stress, anxiety, and various

biopsychosocial effects in transgender and gender non-conforming individuals. SE is effective not only for individuals undergoing SE-based treatment but also for those trained as SE providers. A longitudinal study was performed on participants who completed the 3-year SE provider training. The findings demonstrated a significant enhancement in participants' capacity to manage stressful situations, with a corresponding decrease in stress levels leading to increased resilience in challenging circumstances (Winblad et al., 2018). The findings of the aforementioned studies align with this study.

This study demonstrated that SE sessions significantly reduced anxiety levels among healthcare workers. Despite the ongoing presence of experiences and circumstances that may have triggered anxiety symptoms, enhanced adaptation and an expanded window of tolerance allow individuals to maintain inner balance (Porges, 2011) and resilience (Winblad et al., 2018). Recent numerous studies demonstrate that exercise lessens the symptoms of anxiety and stress in post-traumatic disorder, abuse, and adverse life experiences (Klapisch et al., 2025; Răman et al., 2025; Van de Kamp et al., 2025). This study's findings align with those of Grabbe et al. (2021), who investigated a body-based program for 20 women in addiction treatment. Their 5-hour program effectively reduced anxiety, depression, and aggression-related symptoms, thereby improving participants' quality of life and enhancing their overall well-being.

Subsequent evaluations indicated that participants' anxiety and stress levels remained lower than pre-test scores after a two-week period. Considering that the voluntary project occurred during the peak stress period of the pandemic, it is noteworthy that the increase was minimal, and scores remained significantly lower than pre-test scores, particularly among healthcare workers who endured prolonged, stressful hours. Research demonstrates that SE effectively reduces stress and anxiety following exposure to traumatic events (Leitch et al., 2009; Levine & Kline, 2014). This study observed a reduction in participants' stress levels following two SE sessions, despite the ongoing stressful event (the pandemic), with lower levels sustained for two weeks. Participants' post-test and follow-up data showed a significant drop in scale completion. 13 of 27 participants' stress ratings decreased, while 4 remained the same. 10 participants' anxiety scores decreased, while 6 remained the same. The fact that most participants' stress and anxiety levels decreased despite the situation that causes them is significant. Increased resilience may explain the lower follow-up scores compared to pre-test scores. Masten (2001) asserts that resilience plays a role in mitigating stress and its associated symptoms, particularly following exposure to trauma. SE practices enhance the self-regulation capacity of the nervous system when confronted with negative experiences,

thereby improving individuals' resilience (Briggs et al., 2018; Levine, 2010, 2015; Winblad et al., 2018). Stabilisation exercises, including grounding, orienting, and self-touch, as outlined in the SE protocol, may improve healthcare workers' self-regulation abilities, thereby aiding their coping mechanisms in current situations. Practitioners working with the war effect have used these exercises as well and documented their effectiveness (Sinclair, 2022; Teslyuk, 2025). Although the current study did not directly assess this benefit, it may have also enhanced their resilience capacity over the two-week period. Participants were pleased to use the exercises from the sessions afterward, and that may be why the two-week research had a lasting impact. The two-week work provided participants with psychoeducation on bodily regulation, culminating in simple exercises that promote self-regulation as needed. Future research should measure the resilience levels of healthcare workers to more effectively assess the impact of the SE protocol, given that resilience capacity develops over time (Vella & Pai, 2019). Further investigation should focus on the sustainability of these changes over durations exceeding two weeks. No control group was allocated in the emergency intervention trial; therefore, other stress- and anxiety-reducing elements could not be controlled. It stands out since it was an emergency-related short-term action. Initial psychological support in crises, notably during the COVID-19 pandemic, stresses reaching everyone; hence, interventions may have been conducted without control groups (Duan & Zhu, 2020; Gálvez-Herrer et al., 2022).

The aforementioned outcomes indicate that even two standardised SE sessions can significantly reduce stress and anxiety levels among healthcare workers during the COVID-19 pandemic. Levine (2010) noted that SE positively impacts traumatic experiences and chronic stress, with benefits achievable in a brief period. Additionally, certain standardised SE practices consisted of exercises that healthcare workers could readily implement independently, even in high-stress situations. The standardised protocol is applicable for use by professionals in hospitals, schools, training centres, guidance centres, and research facilities.

Limitations

Despite its benefits, the study had limitations. First, there was no control group; adding one in future studies will boost generalisability. We did not split applicants into two groups and construct a control group because the volunteer project's goal was to support healthcare workers who applied as soon as possible. Data collection occurred when COVID-19 cases in Türkiye were at their highest, as announced by the Ministry of Health, and non-project healthcare workers were too busy adapting to the rising demand

and changes in COVID procedures at hospitals. Second, as follow-up data was obtained two weeks after the last SE session, some participants may not have had time to complete the post-test and follow-up forms due to their busy schedules. Since post-test data was collected immediately after the second SE session, there are fewer missing points than follow-up data. These factors caused a pre-, post-, and follow-up participation gap. Third, SE sessions were examined for their impact on stress and anxiety, but future research might include resilience and post-traumatic growth. Finally, since we did not have a random sample, the study had more women than men.

Based on the promising results of this study, future research may explore numerous avenues. Recent calls to define COVID-19 as an occupational disease (George & George, 2020) could lead to SE-based stabilising training for healthcare personnel. This study raises awareness of healthcare workers' stress and anxiety and the importance of self-regulation in self-care. Due to occupational stress, healthcare workers may be more open to stress management and coping-focused therapies than other professions. SE's generalisability could be tested with participants from different occupations. This study can be reproduced in other professions to evaluate SE's applicability. To address gender inequality, future studies should match individuals by gender. A future study with enough time and resources might include resilience and baseline stress measurements, like cortisol levels, for a more comprehensive design. Results may include post-traumatic growth, and long-term research may investigate SE-based psychological support's impacts. SE-based therapies may assist society in handling post-traumatic symptoms, secondary traumatisation, and communal trauma from this prolonged trauma.

Conclusion

This is the first study to examine a brief SE intervention to reduce pandemic stress and anxiety in healthcare professionals. This study highlights the importance of reducing stress and anxiety in healthcare professionals exposed to trauma during high-stress global events like the COVID-19 pandemic and provides the SE model-focused tool for clinician resilience.

Ethical approval

The study protocol was approved by the ethics committee of Marmara University in Türkiye with the approval number 2020/40 (19/06/2020).

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Ilknur Inci is a member of the European Association of Somatic Experiencing® (EASE) Research Committee, serving as a senior-level assistant and one of the organizers of SE trainings in Türkiye. She is the organizer and trainer of Integral Somatic Psychology (ISP) trainings in Türkiye, and she has successfully completed advanced SE trainings, such as Shame and Pride, under the guidance of Dr. Peter A. Levine.

Aliye Didem Caylak is accredited as a senior assistant with Somatic Experiencing International (USA) and EASE (Europe), authorized to provide group supervision and SE introductory seminars in Türkiye. Completed advanced SE trainings in Integral Somatic Psychology, SOMA Embodiment—Emotional Regulation by Movement and Touch, Attachment and Relational Dynamics, Character Structures and Analysis, Personality Disorders, Shame and Guilt, Physical and Sexual Abuse, and Trauma and Spirituality.

Data availability statement

The data that support the findings of this study are available from the corresponding author, [D.E], upon reasonable request.

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Appendix A. DASS-21 Scoring and Cut-Offs

The DASS-21 consists of three subscales: depression, anxiety, and stress. Each subscale contains seven items that are rated on a scale from 0 ('Did not apply to me at all') to 3 ('Applied to me very much, or most of the time'). The total score for each subscale is calculated by summing the item scores and multiplying the result by two, producing a possible range from 0 to 42 (Lovibond & Lovibond, 1995). Higher scores indicate greater symptom severity. The following cut-off values classify severity levels:

- **Depression:** Normal (0–9), Mild (10–13), Moderate (14–20), Severe (21–27), Extremely Severe (28+)
- **Anxiety:** Normal (0–7), Mild (8–9), Moderate (10–14), Severe (15–19), Extremely Severe (20+)
- **Stress:** Normal (0–14), Mild (15–18), Moderate (19–25), Severe (26–33), Extremely Severe (34+)

These severity categories represent gradations above the population mean and do not necessarily indicate clinical diagnosis.

Appendix B. Protocol

A protocol was developed to standardise all the steps to be followed before, during, and after individual sessions; it was shared with SE providers during the supervision meetings and practiced and examined at length. The effort was made to ensure any questions SE providers might have were answered. The following is a summary of the steps of the protocol:

1. Preparation and initial contact: Providers received a notification email from the coordination team that provided contact information on the applicants they were paired with, after which they called the applicants to set up the first appointment. The sentences to be used and the points to be mentioned during the call were standardised in the procedural guidelines. Healthcare workers were informed about the research project and SE sessions during the first phone call and were emailed a link to the online pre-test form. The email reiterated points discussed during the call, such as the online platform where sessions would be carried out and the preparation of the environment (a comfortable sitting area, camera distance adjustment, and a secure area where they would not be disturbed). Applicants were informed that they could skip the forms and study but still get two SE sessions and join the project. There were no verbal or written responses from the applicants regarding not being part of the research study.

2. Building a relationship within a framework of trust: To facilitate rapport building, participants were called by their first name and spoken to with a calmer tone of voice and smiling and emphatic facial expressions. SE providers were encouraged to show a genuine interest in the participants' well-being and communicate their intention to offer support.
3. Psychoeducation about Somatic Experiencing: Participants were provided basic information on SE, how the nervous system works, and how the stabilisation exercises could help them regulate their nervous system and reduce their stress.
4. Stabilisation and regulation exercises: Stabilisation exercises based on grounding, resourcing, orienting, movement, breathing, and self-touch, as well as SE techniques such as validation, containment, visualisation, and imagining missing resources, were used as applicable in each session to reduce the stress and anxiety levels of the participants. SE providers used tools and exercises most suited to each participant depending on their levels of stress. Activation levels of the participants were closely observed in the sessions, and participants with high activation were stabilised by exercises such as self-touch, grounding, and making a sound while breathing in and out. Before concluding the session, SE providers ensured the participants achieved sufficient grounding and stabilisation. Participants were encouraged to repeat the exercises between sessions and asked to review their progress in the second session.