Body-oriented therapy as an adjunct to psychotherapy in childhood abuse recovery: A case study

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Women with childhood abuse histories often experience chronic physical and psychological distress. Increasingly, survivors seek body-oriented therapy during recovery, yet body therapies are not typically incorporated as adjunctive treatment to psychological care. The purpose of this study was to examine quantitative and qualitative effects of body-oriented therapy as an adjunct to psychotherapy for a woman with a childhood history of physical and sexual abuse. The design is a descriptive, single case study utilizing pre- and post-self-report measures; methods are multi-modal including interview, written questionnaire, and standardized psychological questionnaires. Pre-to-post results included significant improvement of PTSD status, improvement on all psychological indicators, and improvement on all endorsed physical symptoms except fatigue. Mood states improved steadily across the intervention; qualitative results revealed the positive impact of body-oriented therapy on feelings of safety, emotional connection, and psychotherapeutic progress.

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Introduction

Women with histories of childhood sexual abuse may seek bodywork therapies to address chronic tension, body memories, physical and psychological distress. Bodywork is the umbrella term for therapeutic modalities involving touch, and includes such practices as massage, polarity, and acupressure. Body-oriented therapy is a term often used by therapists trained to combine bodywork practice with emotional processing, and will be used in this paper to reference the therapy employed in this case study. Clinical literature references the benefits – increased awareness of sensation, emotion, and relief of physical discomfort – of bodywork and body-oriented therapy in the recovery process (Kepner 1995, Benjamin 1996, Ford 1993, Timms & Connors 1992). However, there has been little research on the use of

such therapies during recovery from childhood trauma. This case study was designed to examine the quantitative and qualitative effects of body-oriented therapy as an adjunct to psychotherapy, for a woman with history of childhood physical and sexual abuse.

As evident in clinical and research literature, the 'body problem' associated with childhood trauma is broadly recognized. Survivors of childhood sexual abuse often display significant somatic distress that suggests the need for physical healing (McCauley et al. 1997). Physical symptoms and psychological distress are significantly more prevalent in this population than in women who have never experienced abuse (McCauley et al. 1997, Walker et al. 1999), and abuse survivors have a higher utilization rate of health care services compared to women without abuse histories (Beitchman et al. 1992, Sansone et al. 1997).

There is empirical support for the use of massage in the reduction of anxiety, depression and pain (Field et al. 1997b, Sunshine et al. 1996). Findings from qualitative studies suggest that bodywork (Smith et al. 1999) and body-oriented therapy (Bredin 1999) improves symptoms of physical discomfort, provides psychological support, and improves body awareness. Only one experimental study has been published that examines the benefits of a standardized bodywork protocol for women with a sexual abuse history. Findings included a significant decrease in depressed mood, anxiety, and depression pre- to post- intervention (Field et al. 1997a).

To facilitate therapeutic progress with survivors of sexual abuse, it is essential that bodywork therapy should focus on trust in a relationship that involves touch and emotional awareness in the body (Timms & Connors 1992). Safety in the therapeutic relationship is considered fundamental for the development of trust between the client and the therapist, and is consequently essential for the development of self-trust for the client in therapy (Kurtz 1990). This is particularly true for adult survivors with post-traumatic stress (PTSD) who, without this emphasis will typically not experience sufficient safety or guidance to experience inner bodily states. When unassimilated and unregulated, the symptoms and distress in the physical body tend to be overwhelming, contributing to the cycle of dissociation from emotions and body awareness so common in survivors of childhood abuse (Ogden & Minton 2000). Through attention to sensory awareness, the body-oriented therapist can address bodily dissociation and distress in a client with childhood abuse history (Ogden 1997). Each client has his or her own pattern of holding tension in the body, just as each client has her or his own set of physical and/or psychological symptoms. Thus, it is important that bodywork therapy is individualized. This means that the pace and techniques follow the lead of the client, in order to provide the focus of safety and body self-awareness that is appropriate for each client (Timms & Connors 1992, Kepner 1995, Benjamin 1996).

Method

Design

The design was a descriptive, single case study of an 8-week body-oriented therapy intervention utilizing pre-and post-self-report measures, and one repeated measure. Sessions were offered weekly, lasted for an hour and a quarter, and were held in the private office of the research clinician. This design allowed exploration of pre- vs. post-data, change across time, and comparison of the client's data with normative data. This single-case study, part of a larger pilot project, received IRB approval and consent for publication of case history. The study participant received weekly, 1 hour sessions of psychotherapy at a different location (the office of her psychotherapist). These sessions were typically scheduled a day or two after the bodywork session each week.

Participant

The study participant was a Caucasian female in her mid 40s, with a graduate degree who worked full-time in a demanding job. Divorced and living with her two children, she had been seeing her current psychotherapist, an experienced clinical psychologist, weekly for 3 years. She began a low dose of Prozac during the first week of the current study. She had no history of suicide attempts, and medical history was unremarkable. She had a total of 8 years of psychotherapy as an adult. She reported physical abuse throughout childhood, perpetrated by both her parents. She also witnessed many accounts of violence in her home as a child. She reported sexual assault at ages 6 and 7. As a young adult she reported several accounts of rape.

The major physical symptoms reported upon entering the study were throat constriction, cold hands and feet, and neck pain. Her past experience with bodywork therapy was minimal; she had fewer than 10 massages in her life and no prior experience with body-oriented therapy. However, she was aware that she was typically tense and that she frequently dissociated from her body. She expressed a desire to increase body awareness.

Measures

The outcome indicators fall within two key constructs – psychological well-being and physical well-being. Psychological well-being, an assessment of intra- and interpersonal health, included measures to assess general psychological health (SCL-90), mood (POMS), and post-traumatic stress (CR-PTSD). Measurement of physical symptoms of discomfort (Physical Symptom Checklist) was used to assess physical well-being. The meaning and impact of the body-oriented therapy was addressed through a written questionnaire. Each measurement is detailed below.

Physical symptom checklist

A list of physical symptoms common to women with an abuse history was completed by the participant pre- and post-intervention. The Brief Confidential Medical History Form was used as the basis for the symptom checklist. It was designed for, and is used in, clinical practice with adult survivors of childhood sexual abuse (Timms & Connors 1992). The client circled symptoms that she was having 'difficulty with' and rated each of the circled items on a scale of 1–4, representing extreme to slight difficulty with the symptom.

Symptoms check list revised (SCL-90-R)

The SCL-90-R was administered pre- and post-intervention to assess symptom levels and psychological distress on the global severity index and the nine subscales: somatization, obsessive–compulsive, interpersonal sensitivity, hostility, phobic anxiety, paranoid ideation, and psychoticism. The global severity index indicates the overall level of psychological distress. Normative data on non-psychiatric patient females was used as a basis of comparison for the current study. The coefficient alphas for internal consistency of the scales in the initial normed study ranged from 0.71 to 0.85, and the test–retest reliability was 0.68–0.91 with a 2-week interval (Derogatis 1977).

Crime-related post-traumatic stress disorder scale (CR-PTSD scale)

Selected items from the SCL-90-R (administered pre- and post-intervention) have been identified as indicative of a diagnosis of crime-related PTSD. Crime-related victimization includes sexual assault from anytime in life, including childhood. Internal consistency reliability (coefficient alpha) was 0.93; the scale effectively discriminates between individuals with and without crime-related PTSD ($F = 98.2$, $p < 0.001$) (Saunders et al. 1990).

Profile of mood states (POMS)

The POMS, administered pre- and post-intervention as well as before each of the individual bodywork sessions, provided a measure of change in mood over time. The coefficient alphas for internal consistency for the six factor scores ranged from 0.84 to 0.95, and the test–retest reliability was 0.61–0.69 with a four-week interval (McNair et al. 1992).

Qualitative data

Post-intervention, using an open-ended questionnaire, the participant was asked to: (A) Reflect on the work you have done in psychotherapy during the past 2 months. Are there important shifts/insights that you have made during this time? If so, please comment. (B) Do you feel that receiving bodywork has had an impact on your psychotherapeutic work? If so, please comment. (C) What would you say are the most important things that you learned/experienced while receiving bodywork while in psychotherapy?

Procedure

Pre-intervention

Initial contact with the participant was established after psychotherapist referral to the study. She was screened over the phone for exclusion and inclusion criteria. The exclusion criteria: under 25 years of age, addicted to alcohol or drugs, in an abusive relationship, and hospitalized for psychiatric treatment within a year. To be included she had to be in psychotherapy, willing to forgo any (non-study) bodywork treatment 1 month prior to study involvement and during the study itself, and be able to pay a fee for each bodywork session (a 50% reduction of the typical cost of a bodywork therapy session). An IRB approved consent form was mailed to the participant for review along with a demographic questionnaire, both to be returned at the initial session.

Initial appointment

The self-report measures were administered at this time. The investigator reviewed the demographic questionnaire for clarity of response and then proceeded with a brief semi-structured interview to gather personal history and clinical information. The first body-oriented therapy session was scheduled immediately following the initial appointment. The subsequent seven weekly body-oriented therapy sessions were scheduled.

Intervention

The study participant wore loose-fitting clothes. The key elements of the protocol, listed below, were integrated into every session. The order of the sessions went as following. Each session began with

administration of the POMS, followed by a brief check-in while both participant and therapist were seated, using a semi-structured interview format. The study participant was asked how she felt physically and emotionally. Her response to this interview served to guide the emphasis of each bodywork session; for example, complaints of back pain would orient the session toward relief of back pain. After the initial administration of the POMS and check-in (15 minutes), the therapist and participant moved to the massage table. Table work (50 minutes) began first with massage (approximately 25 minutes). The latter half of the time on the table focused on body awareness education and body/mind integration (approximately 25 minutes). The sessions concluded with session review, when participant and therapist were again seated in chairs (10 minutes). The body awareness work was an explicit part of the protocol, while the body/mind integration work happened in response to the participant. For example, if the participant expressed pain, emotion, or memory, then this served as a cue to lead into this level of work (please see description in protocol). The initial sessions (first 2–3) included more of a body awareness focus and the later sessions (4–8) were focused more on body/mind integration; this was a natural progression into emotional awareness work as the client became more comfortable and more engaged in the treatment.

Key elements of the bodywork protocol

(a) *Safety*. Safety is attended to throughout the session with use of frequent check-ins (i.e., asking client about the acceptability of touch) to assess comfort level. The check-in provides the bodywork therapist with information that guides pacing and choice of techniques. Appropriate pacing prevents the client from feeling overwhelmed with the speed or level of therapeutic work, thereby reducing the possibility of dissociative response to bodywork.

(b) *Massage*. Massage is used throughout the session to facilitate relaxation and body awareness. All sessions begin with massage to attend to areas of muscular tension and physical discomfort and/or anxiety. For example, most sessions with this study participant began with massage to the upper chest, shoulders and neck because she experienced these areas to be particularly tense.

(c) *Body awareness education*. While not delivered in a linear progression, the educational component of the sessions can be broken down as (1) learning to identify and articulate what is noticed in the body and the best words to describe the inner experiences and sensations (body literacy); (2) use of breath to release tension by focusing on feeling the sensation of exhalation; (3) use of focused attention to specific areas of the body to enhance awareness of sensation, tension, relaxation, emotion; (4) use of focused attention to specific areas of the body to enhance release of emotions held in the body.

Individualized body awareness exercises are incorporated to facilitate each of these levels of body awareness. For example, this study participant identified the sensation of tightness through her mid-back to sternum, in other words around her heart, during the process of paying attention to her inner experience with massage and breath work.

Through exercises focused on conscious relaxation of her inner chest and back, she first experienced the physical release of tension and then the emotions connected to this area of her body. Maintaining focus on both emotional experience and the physical area (around the heart), she experienced long-held somatic images of being trapped and strong emotions of fear, anger and then sadness. She found this experience very meaningful and useful for her psychotherapeutic process.

(d) *Body/mind integration*. The client is encouraged to verbalize her experiences during the session; the therapist questions the client about her experience if there is non-verbal indication of significant experience such as groans, tears, or body movement. If the participant experiences pain or body sensation related to the bodywork, expresses insight related to bodily/self-awareness, or shares a memory associated with her body, the bodywork therapist facilitates further exploration of the experience and the bodily connection involved through the use of both touch and dialogue.

(e) *Session review*. At the end of the hour, the session is reviewed with the participant to facilitate cognitive integration of the session material. The review focuses on experiences within the session that offer new information, particularly if the participant experiences the merging of sensory and emotional experience and cognitive insight. The body-oriented therapist asks the participant to put her experience during the session into words, and to replay the experience chronologically to help

remember it as fully as possible. The client is encouraged to share these experiences with her psychotherapist. For example, the participant in this case study did not cry easily or often. After the first session during which she cried deeply, the session review involved examining how she felt in her body before she started to cry, the accessed memory, how she felt in her body after she completed crying, and insight she had about herself during this process.

Post-intervention

At the end of the final body-oriented therapy session, the participant was given the self-report measures and the final questionnaire to take home and complete within the week. She returned them by mail.

Results

Analysis examined (1) the differences between pre-to-post scores on the self-report measures, and comparison of these scores to the normative data on non-patient females; (2) the pattern of change across time on the POMS; and (3) the qualitative data offered by the participant regarding the impact of body-oriented therapy on her recovery process.

At baseline

Upon entering the study, the participant described herself as often 'numb' to her emotions. She reported constant vigilance, the feeling of complete inner stillness as though frozen, and frequent holding of her breath. She reported discomfort in her body that she attributed to tension and lack of circulation (Fig. 1, Physical Symptom Checklist). She expressed hope that the bodywork therapy would provide her with a pleasurable physical experience and that it would increase her body awareness.

Her scores on the SCL-90-R subscales were within normal range, although all were above the normed mean (Fig. 2). CR-PTSD score of 0.89 was at the cut-off for clinical indication of PTSD (Saunders et al. 1990). POMS scores varied across the subscales in relation to data from adult normative sample: her depression score was 32, significantly higher than the norm of 10.2; her anger–hostility score was low at 5.0 with a norm of 9.7; vigor was extremely low at 1.0 with a norm of 14.9; fatigue score was low at 8.0 with a norm of 13.0. Her initial scores of 10.0 on tension–anxiety and 7.3 on confusion–bewilderment are close to the mean compared to the normative data (McNair et al. 1992). Overall, these results indicate normal to high levels of psychological distress including trauma-related distress apparent in the CR-PTSD score.

Across time

The POMS was administered nine times: at the initial visit prior to the first body-oriented therapy session, before each of the seven subsequent sessions, and post-intervention. Administration of the POMS before the sessions eliminated any immediate effects of the body-oriented therapy on the results, and provided an indication of change across time. Except for the subscale 'vigor,' on which she maintained a low and relatively stable score, all subscores changed over time (Fig. 3). Her anger–hostility score rose on the second administration of the measure, stabilizing around 10.0 (about the mean on normative data). The remaining subscores: depression–dejection, tension–anxiety, confusion–bewilderment, and fatigue–inertia, tapered rather steadily over time (see Fig. 3). The confusion–bewilderment score was close to the norm for a non-patient female at pre-test and dropped incrementally throughout the intervention to 0 at post-test.

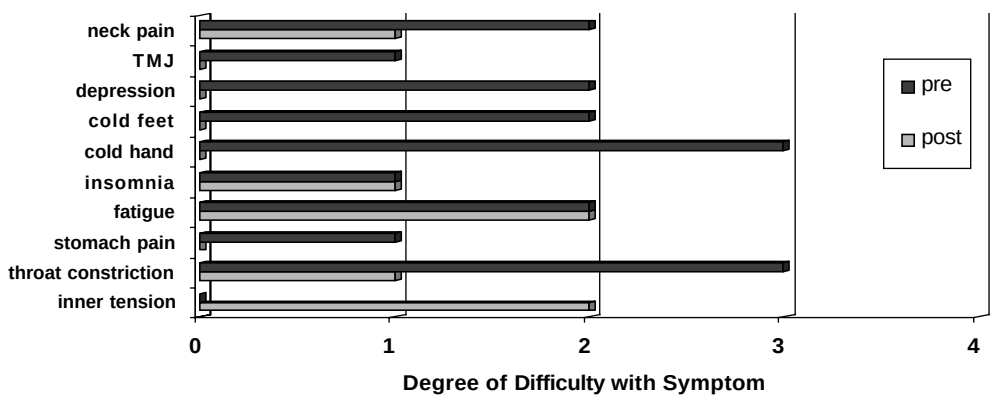

Fig. 1 Physical symptom checklist pre- and post-intervention.

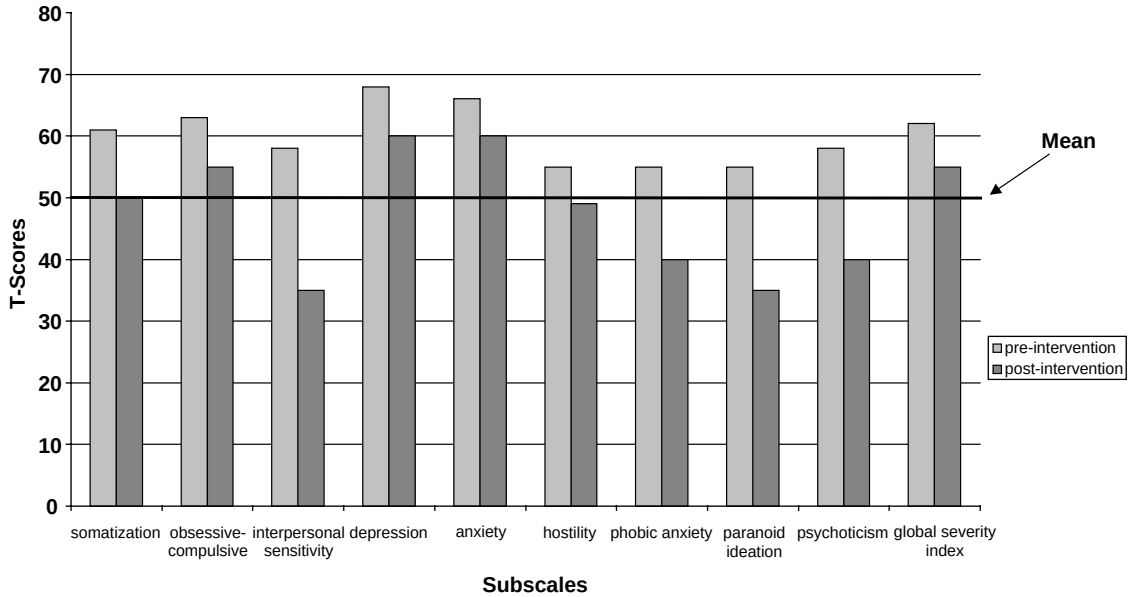

Fig. 2 SCl-90-R scores pre- and post-intervention.

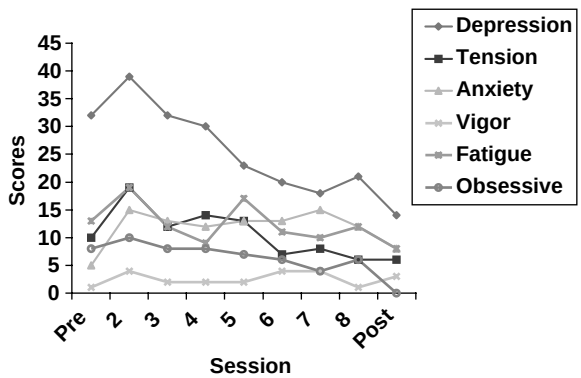

Fig. 3. POMS subscale scores across time.

Notably, the depression–dejection score dropped, falling from two standard deviations above the norm for non-patient females at pre-test to within one standard deviation of the norm at post-test. With the exception of Weeks 2 and 7, the scores on the depression–dejection subscale fell steadily and incrementally over the 9 weeks. Weeks 2 and 7 were particularly stressful and difficult weeks for the study participant, involving family conflict. The rise in distress on Week 2 was evident on all of the POMS subscales, and evident on many subscales for week 7.

Pre–post comparisons

SCl-90-R scores improved on every subscale (Fig. 2), only four of the nine subscales remained above the normed mean. The degree of improvement on the subscales varied. There was moderate improvement on somatization, obsessive–compulsion, depression, hostility, and anxiety; and considerable improvement on interpersonal sensitivity, phobic anxiety, paranoid ideation, and psychoticism. The percentile rank drop, based on normative data for non-patient females, for the final four subscales was: interpersonal sensitivity from 78% to 2%, phobic anxiety from 62% to 16%, paranoid ideation from 68% to 2%, and psychoticism from 75% to 16%.

CR-PTSD score improved pre-to-post, falling from 0.89 to 0.39. This change in score indicates a shift from PTSD to non-PTSD status: the pre-intervention score was within one standard deviation of the positive indicator for PTSD and the post-intervention score was within one standard deviation of the non-PTSD score (Saunders et al. 1990).

Physical Symptom Checklist ratings decreased pre-to-post on every symptom endorsed by the participant at pre-test, except for fatigue (Fig. 1). A decrease in symptom rating is an indication of improvement of the symptom. One finding was somewhat puzzling: the report of inner tension at post-test that was not reported at pre-test. The change in report may represent

an increased awareness of inner tension due to the focus on body-awareness during the intervention process.

Qualitative response to the bodywork intervention

Response to open-ended questions on the post-intervention questionnaire describes pre-to-post impact of bodywork.

Personal learning and growth

The participant identified three lessons she attributed to her body-oriented therapy:

(a) She realized and experienced that she could reach a 'safe inner place' that significantly shifted her experience of safety in the world. 'Relaxation does not merely move me to a pleasant, neutral place; it is deeply satisfying and pleasurable. This is very significant in connection with my sense of overall safety in the world. To find this inner safe place is a great gift.'
(b) Listening to her body allowed her to take better care of her self. In listening to her body, she recognized that she needed more rest and she realized that she often interpreted feeling tired as a sign of 'resistance or depression,' which she no longer automatically assumed. 'I need to give myself a lot more rest.' Allowing herself to listen more to her body provided her with important healing experiences, for example tuning into core inner aspects of her self when she had free time at home 'moved me forward in hearing the ''child'' [within].'
(c) Accessing and experiencing deep emotions and core aspects of her self came more easily through relaxation and feelings of inner safety. She learned that she could gain emotional access and insight through the inward and gentle process of relaxation and inner awareness: 'Huge effort and hard work is not always the way to go from here to there.'

Psychotherapy impact

Reflecting on the impact body-oriented therapy had on her psychotherapy, the participant noted that increased internal body awareness, and increased levels of rest, relaxation, and safety shifted her approach to psychotherapy. 'I felt as if I were coming at the same therapeutic issues from a different angle, a more comfortable approach.' For example, during three psychotherapy sessions that immediately followed bodywork sessions '...my level of relaxation and sense of safety was so high that I easily slid into contact with deep fears and grief. Places which would ordinarily take most of a session to reach were immediately and effortlessly available.' Increased body listening, both at home and during psychotherapy sessions, facilitated psychotherapeutic progress. For example, she found it easier to tune into inner aspects of her self, such as the child placed within, and to engage in related dialogue and exploration during psychotherapy sessions.

Discussion

This case illustrates the potential benefits of body-oriented therapy as an adjunct to psychotherapy for survivors of childhood sexual and physical abuse, and the results of this study are consistent with findings from other massage studies. The measure of mood states improved steadily over the course of the intervention, particularly depression. Field et al. (1997a) found similar reductions in depressed mood over time, as well as reduced pre-to-post depression and anxiety scores with women who had sexual abuse histories.

Psychological indicators improved across all subscales, significantly lowering percentile rank on internal sensitivity, phobic anxiety, paranoid ideation and psychoticism scores. The reduction in psychological symptoms on these four subscales appears to be linked to the experience of profound safety as seen in the change, pre-to-post, on the endorsed items. For example, the endorsed items at pre-test on the four subscales all relate to the experience of lack of safety and can be classified into two general themes: (1) feeling unsafe, for example 'feeling that most people cannot be trusted,' and (2) feeling alone and separate, for example, 'feeling that others do not understand or are unsympathetic.' These categories often reflect each other, that is feeling a 'lack of safety' and 'feeling alone and separate' typically go hand in hand. This was certainly true for this study participant for who increased sense of inner safety provided her with an increased sense of safety in the world. The drop in scores may reflect not only increased safety but the underlying processes of inner connection to the self so often missing in adult survivors of severe childhood abuse (Herman 1992).

Likewise, the significant change from a score that indicated positive PTSD at pre-test to non-PTSD status may indicate the participant's shift toward increased internal and external safety. Like many adults with a childhood abuse history, the participant reported constant vigilance at the initial interview. Vigilance is a strong characteristic of PTSD and reflects a lack of safety and a sense of vulnerability. Dissociation from body and lack of connection to an inner experience of self are also common protective responses, characteristic of PTSD and reflective of a lack of safety

(Timms & Connors 1992, Levine 1997). Many such responses are continued habitually long after abuse, or threat of abuse, is past (Levine 1997). Close to one-half of the items on the measurement scale for PTSD relate to feelings of safety.

All symptoms initially identified on the Physical Symptom Checklist, except for fatigue, improved pre-to-post intervention. The large improvement of physical symptoms in the current case study are also similar to what might be expected given the significant and positive effect of massage on pain (Field et al. 1997b, Sunshine et al. 1996), and the improvement of physical symptoms post-massage-intervention in qualitative studies (Bredin 1999, Smith et al. 1999). The psychological and physical symptom reduction reported by this client post-intervention may indicate the degree of safety and relaxation reached. For example, many of the physical symptoms experienced by the study participant, such as throat constriction, stomach pain, cold hands and feet, neck pain and TMJ discomfort, are typical tension-related symptoms. Many of these physical symptoms were associated with emotion and were, thus, a focus of the sessions. For example, sessions focused on her throat and jaw brought up held-in emotions of anger and fear. She released emotion primarily through crying, while taking-in the nurturance of trusted touch; exemplifying an important therapeutic balance between release and reception and the power of touch to communicate safety. At the end of her seventh session, she said, 'This is one of the first times I'm really feeling safe touch – and safe in self.'

The participant in this case study illuminated, through her written responses, the impact of body-oriented therapy on her feelings of safety, her ability to tune-in to internal process, and her ability to access emotion. She identified inner safety, the experience of an 'inner safe place,' as the foundation for her movement toward deep levels of relaxation, body-listening, and emotional connection. The experience of inner safety was a profound change that contrasted with her usual experience of braced inner vigilance. The participant experienced these important changes as having a positive and significant impact on psychotherapy. The importance of connecting to feeling states and the importance of safety are strong themes evident in this case study as in prior qualitative studies (Bredin 1999, Smith et al. 1999). The experience of inner safety and safety in the world was a powerful outcome of the bodywork therapy, and may have been the catalyst for many of the positive changes visible in both qualitative and quantitative results.

Despite these interesting findings, there are several study limitations. The body-oriented therapist was the principal investigator, which could have biased the responses of the participant on questionnaires or self-report instruments. The participant's engagement in concurrent psychotherapy may account for many of the changes seen pre-to-post. Likewise, change could be due to maturation over time. The lack of formal assessment of the study participant's psychotherapeutic progress was a study design oversight. Future research is needed to address such limitations through the use of a randomized clinical trial, and third party measurement/questionnaire administration. The continued use of a multiple indicator measurement model is recommended, as is the use of measurement instruments designed specifically for this population to more clearly address the effects of the intervention. A confounding factor in the current study involved the transition to low-dose anti-depressant use that would likely contribute to the drop in depressed mood. However, full relief on Prozac is expected within 4 weeks (Schatzberg & Nemeroff, 1998), and the primary drop in the participant's depressed mood occurred after Week 4 (see Fig. 3). It is unlikely that the use of a low-dose anti-depressant would account for the dramatic psychotherapeutic progress attributed to body-oriented therapy by the client, nor the degree of positive change across multiple factors on the post-test measures.

The clinical implications of this case study suggest that safety and body self-awareness are important components of the intervention providing profound impact on the healing process. The changes visible in the quantitative data on PTSD and psychological status match the participant's expression of her experience in the qualitative data. These findings suggest a link between PTSD status, psychological and physical well-being, and the body-oriented therapy experience of inner safety and connection to self. While there are other ways to promote safety and body self-awareness, body-oriented therapy offers the unique element of touch. Through touch, safety can be communicated directly and immediately providing the client an opportunity to re-establish connection with her inner self. Although certain experiences in body-oriented therapy may be overwhelming and may trigger a fear response, a therapist trained in bodywork and psychotherapeutic approaches for trauma recovery can facilitate the client's negotiation of these feelings. To do so, the therapy must include the emphases on learning to receive soothing touch and learning to bring focused attention to sensory awareness in order to diminish anxiety and to stay present rather than to dissociate. The use of touch and

internal bodily focus to promote body awareness solidifies the learning process, and promotes integration among the bodily systems. While not generalizable to other individuals with a childhood abuse history or to other populations, this case study provides a foundation for exploring the use of body-oriented therapy as a treatment modality in recovery from childhood abuse. Future studies are needed to address the efficacy of body-oriented therapy, detailed examination of processes involved, and exploration of underlying mechanisms. Questions related to when, for whom, and how body-oriented therapy is most useful and not useful, also need to be explored.

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