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BODY-ORIENTED THERAPY

Body-oriented therapy in sexual abuse recovery: A pilot-test comparison

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Summary The purpose of this study was to examine the effects of body-oriented therapy, as an adjunct to psychotherapy, for women in recovery from childhood sexual abuse. A two-group randomized design was employed. Eight women were recruited from a community sample and randomly assigned to an experimental group or wait-list control group. The experimental condition involved eight 1-h weekly sessions of body-oriented therapy, a combination of bodywork and the emotional processing of psychotherapy. The study examined changes in somatic and psychological symptoms, and the subjective experience of the intervention using a mixed method approach. Methods included interview, written questionnaire, and self-report outcome measures of psychological symptoms, dissociation, post-traumatic stress, and physical symptoms. Pre–post comparison of the two groups revealed remarkable decreases on SCL-90 global score, PTSD, number and severity of physical symptoms, and a trend toward decreased dissociation for the experimental compared to the control group. Qualitative results revealed the positive impact of body-oriented therapy on sense of inner security and psychotherapeutic progress.

Introduction

Previous studies have demonstrated that women who have experienced childhood sexual abuse have significantly greater psychological distress and physical symptoms compared to women who have never experienced abuse (McCauley et al., 1997; Walker, et al., 1999). Likewise, studies indicate specific psychological symptoms significantly associated with childhood sexual abuse among women including interpersonal and sexual problems, PTSD, and dissociation (Neumann et al., 1997). For adults who seek psychotherapy in recovery from childhood sexual abuse, these symptoms create common and particular challenges due to the loss of feeling safe, the loss of caring relationships with others, and the loss of an internal sense of wholeness (Janoff-Bulman, 1992). Consequently, therapeutic recovery involves reclaiming and reconnecting with the inner self as a path toward empowerment and connection with others in the world (Herman, 1992).

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This aspect of recovery involves re-association with aspects of the self often fragmented through the dissociative process of living with trauma. Dissociation involves separation from the body (Sadock and Sadock, 2000) and is often apparent in clients who indicate that they feel cut-off from their bodies—including little awareness of physical sensation, difficulty accessing emotion and emotional regulation, and a tendency to mentally ''leave'' in situations that are emotionally difficult. Thus, adults with child abuse histories may have little sense of connection to inner somatic and emotional experience. Clinical experience suggests that reconnecting with the body provides access to emotional and somatic aspects of the inner self, important for the reclaiming and reconnecting process of recovery. Body therapy in sexual abuse recovery serves to facilitate somatic and emotional awareness, reducing dissociation and physical symptoms, and improving psychological well-being (Timms and Connors, 1992; Ogden, 1997; Fitch and Dryden, 2000). Pilot study results indicate that desire for increased body connection is a primary reason that women seek body therapy in sexual abuse recovery (Price, 2004).

The use of body therapy in sexual abuse recovery has become more legitimate in recent years—evidenced by the clinical and educational resources for bodywork and somatic therapists (Benjamin, 1996; Levine, 1997; Ogden and Minton, 2000; Kern, 2001; Aposhyan, 2004) and psychotherapists (Timms and Connors, 1992; Kepner, 1995; Crowder, 1995; van der Kolk, 2002). Likewise, the survivor literature references body therapy for recovery (Bass and Davis, 1994; Wisechild, 1998), as do resources for the general bodywork consumer (Knaster, 1996). However, with the exception of a case study (Price, 2002) and a study of characteristics among women seeking body therapy in sexual abuse recovery (Price, 2004), there has been little research in this area. This is a pilot-test of body-oriented therapy as an adjunct to psychotherapy for women in recovery from childhood sexual abuse. Body-oriented therapy involves the combination of bodywork with the emotional processing of psychotherapy. A primary emphasis of this approach involves body-awareness, the goal of which is to increase connection with the body thereby reducing dissociation and facilitating psyche-soma integration (EABP, 2004). The purpose of this study was to examine the efficacy and subjective experience of the body-oriented therapy process. The hypothesis was that participants in the body-oriented therapy group would demonstrate greater psychological and physical well-being compared to participants in the control group.

Method

Design

A two-group, pre–post design was used to test the efficacy of body-oriented therapy as an adjunct to psychotherapy in comparison to a wait-list control. Participants were randomly assigned to either the experimental group or the control group. The experimental group received eight 1-h weekly sessions of body-oriented therapy; pre-test measures were administered immediately prior to the initial body-oriented therapy session and post-test measures were administered 9 weeks later (1 week following the final session). The control group had a 10-week wait period prior to the delivery of eight body-oriented therapy sessions; pre and post-test measures were administered nine weeks apart—at the beginning and at the end of the wait-period.

Participants

To be included in this study, participants had to be female and report a childhood sexual abuse history. Additional inclusion criteria required that an individual be in psychotherapy, over 25 years of age, willing to forgo any (non-study) bodywork treatment one month prior to study involvement and during the study itself, and able to pay for each body-oriented therapy session (at a 50% reduction of the standard cost of a bodywork therapy session). Exclusion criteria stated that participants were not in a current violent partner relationship, had not been hospitalized for psychiatric care within the past year, and that there was no current alcohol or drug addiction.

Participants were recruited from psychotherapist referral or printed announcements placed in women's organizational newsletter/web-sites, and web-based emails to students in a university graduate program. Fifteen women were screened for study participation. Five did not meet eligibility criteria. The ten women eligible for participation in the study were mailed an IRB approved consent form for review along with the Initial Questionnaire. Eight of these women chose to participate in the study. They ranged in age from 28 to 52, and all were college educated. One participant was African-American and seven participants were European-American. All had severe abuse histories, involving rape or recurrent abuse by the perpetrator(s). A detailed description of demographic and background characteristics can be found in a previous publication (Price, 2004).

Procedure

The participants were randomly assigned to one of two groups: the experimental group or the wait-list group that served as the control. The intervention involved 1-h sessions of body-oriented therapy over 8 consecutive weeks. During all sessions participants wore over loose-fitting clothes. The study used a protocol that included flexibility to attend to the comfort and safety needs of individual participants, important for this vulnerable population (Benjamin, 1996). Sessions began seated with a brief check-in utilizing a semi-structured interview to gain insight into the emotional and physical well-being of the participant. Table work (50 min) began first with massage (approximately 25 min). The later half of the time on the table focused on body awareness education and body/mind integration (approximately 25 min). The sessions concluded with session review, when participant and therapist were again seated in chairs (5 min). Key elements of the protocol were integrated into every session (Table 1). Further details of the protocol key elements can be found in a previous publication (Price, 2002).

Measures

The outcome indicators fall within two key constructs—psychological well-being and physical well-being. Psychological well-being, an assessment of intra-personal and interpersonal health, included measures to assess general psychological health (SCL-90), dissociation (DES), 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 the Final Questionnaire. Each measurement is detailed below.

Symptoms Check List Revised (SCL-90-R) is used to assess symptom levels and psychological distress on the global severity index (indicates overall level of psychological distress) and the nine subscales: somatization, obsessive–compulsive, interpersonal sensitivity, hostility, phobic anxiety, paranoid ideation, and psychoticism. Normative data on non-psychiatric patient females was used as a basis of comparison for this study. The scale has proven reliability and validity (Derogatis, 1977). The subscales have good internal consistency (α .71–.85).

Table 1 Key elements of body-oriented therapy protocol.

Key element	Protocol description
Safety	Frequent check-ins to assess participant comfort (i.e., acceptability of touch, emotional comfort, pacing of therapy). Protocol is flexible to individualize to participant safety/comfort needs.
Massage	Swedish-style strokes to facilitate (a) relaxation and (b) body awareness (massage focus in on areas of muscular tension, physical discomfort, and/or anxiety). All massage done over loose-fitting clothes.
Body awareness education	Involves: (a) *Body literacy*: learn to identify what is noticed in the body and to articulate/describe inner experience and sensation. (b) *Inner awareness exercises*: enhance access to inner body experience and body awareness through various exercises (e.g., attending to sensation of breath exhalation; use of mental intention to "soften" tense areas; use of focused attention to specific area of the body). (c) Mindful attention to inner body experience—based on Focusing (Gendlin, 1981).
Body-mind integration	Therapist facilitates participant exploration of inner experience and body connection through touch and dialogue: (a) in response to non-verbal indication of inner experience (i.e., groans, tears, body movement); (b) in response to verbal indication of body sensation, memory associated with body, or insight related to body/self-awareness.
Session review	Therapist facilitates participant verbal overview of the session highlights, to facilitate integration of therapeutic elements of the session.

Dissociative Experiences Scale (DES) contains 28 items and measures the frequency of dissociative experiences, from 0% = never to 100% = always, on an 11-point scale. It is used to determine the contribution of dissociation to psychiatric disorders and as a screening instrument for dissociative disorders. The coefficient alphas for internal consistency ranged from .83 to .93, and the test–retest reliability was .79 with a 6–8 week test–retest interval; reliability and validity of the scale are well-documented (Carlson and Putnam, 1993).

Crime-Related Post Traumatic Stress Disorder Scale (CR-PTSD) is based on 28 selected items from the SCL-90 (Derogatis, 1977) that indicate post-traumatic stress disorder. Crime-related victimization includes sexual assault from anytime in life, including childhood. With excellent internal consistency ($\alpha = .93$), the scale effectively discriminates between individuals with and without crime-related PTSD ($F = 98.2, P < .001$) (Saunders et al., 1990).

Physical Symptom Checklist is a list of physical symptoms common to women with an abuse history. 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 and 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; 1 = slight difficulty, 2 = moderate difficulty, 3 = significant difficulty, 4 = extreme difficulty. To score physical symptom discomfort, scoring involved figuring the mean score based on the sum of the rated items divided by the number of items endorsed.

Initial Questionnaire gathered demographic information (i.e., age, education, occupation, income) as well as psychological history (i.e., number of years in psycho-therapy, mental health concerns and symptoms and general abuse history information (i.e., age of abuse, identity of abuser, duration of abuse).

Final Questionnaire gathered responses to questions from intervention group on their experience of body-oriented therapy, and their perception of body-oriented therapy influence on abuse recovery.

Analysis

Statistical and qualitative analysis were employed to provide both empirical and experiential perspectives on the study process, particularly appropriate in such a new field of study. Preliminary analysis included sample descriptive statistics and evaluation of baseline equivalence of the study groups. Paired samples *t*-tests and their non-parametric equivalents, the Wilcoxon Signed Ranks Test and the Mann–Whitney Test, were used to test for intervention outcomes. To avoid Type II error with a small sample, the *P*-value was set at $<.10$. Content analysis was used to describe the qualitative responses of the body-oriented therapy participants to the Final Questionnaire. The Final Questionnaire focused on participant experience of the intervention, and the perceived influence on abuse recovery.

Results

Statistical

There was baseline equivalence between groups on demographic and sample characteristics. Sample characteristics were published in a previous study (Price, 2004). All participants had high psychological and physical distress at baseline. For example, all participants were at or above 85% percentile rank on the general severity index (GSI) for psychological distress on the SCL-90-R; six of the eight participants were at, or above, the cut-off for PTSD (2 participants were just below cut-off); and each participant endorsed an average of 10.5 out of 31 possible physical symptoms.

Pre–post comparisons of the outcomes measures indicated significant improvements in psychological and physical well-being for the body-oriented therapy group. The body-oriented therapy group demonstrated significant improvements on psychological symptoms, PTSD, total number of physical symptoms, and physical discomfort (Table 2). There were no significant improvements on any outcomes for the control group. As might be expected with such a small sample, the results indicated no significant between group (body-oriented therapy vs. control) differences.

The difference between the body-oriented and control groups is evident in the consistent improvements in score across all participants on all outcomes compared to the control group. For example, there was a decrease in physical symptoms for all body-oriented therapy group participants whereas there was no decrease in physical symptoms for any of the control group participants (Fig. 1). Similarly, all experimental group participants experienced a pre–post decrease in PTSD, whereas only two control group participants experienced a pre–post decrease in PTSD (Fig. 2).

Table 2 Nonparametric pre–post comparisons of primary outcomes.

Outcome measure	Experimental group	Control group
Psych symptoms (SCL-90-R)	1.82*	1.10
PTSD	1.82*	.73
Total number of physical symptoms	1.84*	.27
Physical symptom discomfort	1.82*	1.1

*$P < .01$.

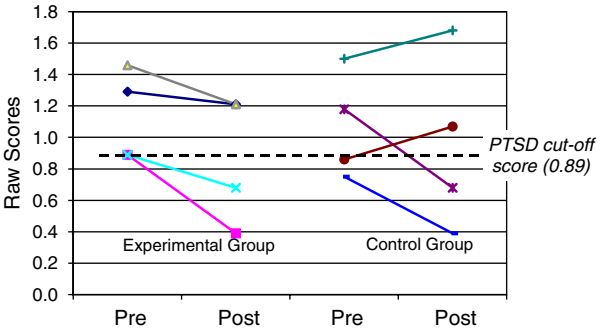

Figure 1 Individual PTSD scores.

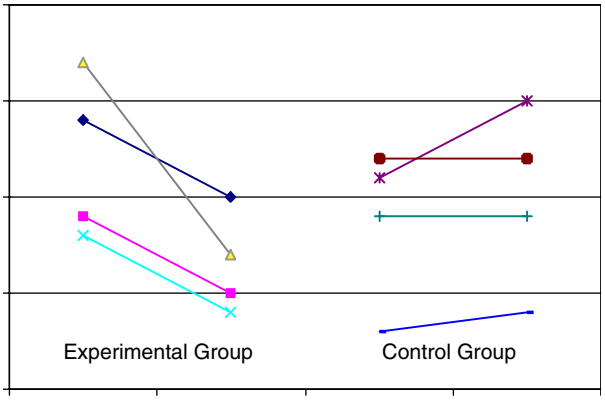

Figure 2 Individual physical symptoms (♯ endorsed).

Notably, two intervention participant scores dropped from above to below the cut-off for active PTSD. In contrast, one control group participant score dropped from above to below the cut-off for active PTSD and one control participant score increased from below to above the cut-off for active PTSD.

The pre–post comparisons of dissociation indicated a trend toward decrease in dissociation for the body-oriented therapy group ($z = 1.46, P < .14$), whereas there was a significant increase in dissociation among the women in the control group ($z = 2.00, P < .05$). Three of the four participants in the experimental group reported decreased dissociation experiences, whereas all of the participants in the control group reported increased

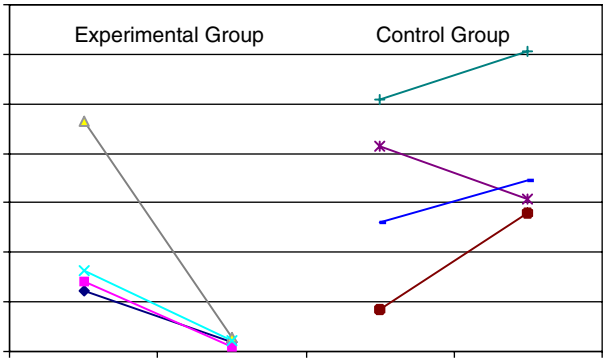

Figure 3 Individual dissociation scores.

dissociation experiences (Fig. 3). Thus, while the body-oriented therapy scores did not demonstrate significant dissociation decrease, their scores indicate remarkable positive change compared to the control group.

The results also indicated decreasing trends on many of the SCL-90-R subscales for the body-oriented therapy group compared to the control group. The subscales indicating close to significant decreasing trends were: depression, intervention group ($z = 1.6, P < .11$) compared to control group ($z = .73, P < .47$); psychoticism, intervention group ($z = 1.6, P < .11$) compared to control group ($z = .37, P < .72$); and phobic anxiety, intervention group ($z = 1.6, P < .11$) compared to control group ($z = .45, P < .66$).

Qualitative

Questionnaire responses were collected from the intervention group regarding their experience of body-oriented therapy and its perceived influence on psychotherapeutic recovery. All intervention group participants thought that body-oriented therapy was important to the recovery process and that it positively influenced psychotherapy. Two primary themes emerged. First, the most important thing learned/experienced was the *experience of a more secure sense of self*. For

example, one participant wrote that ''the ability to sense my own bodily integrity and what that feels like as explored and claimed from the inside out rather than through the definitions of others'' was the most important experience because through this process she could ''identify the components of my fear of intimacy.'' Another wrote about the importance of gaining an internal sense of safety, ''to find this inner safe place is a great gift. This is very significant in connection with my sense of overall safety in the world.''

The second theme that emerged was the positive influence of body-oriented therapy on psychotherapeutic work through *deepening and accelerating psychotherapeutic progress*. Participants brought their body-oriented therapy experiences into psychotherapy. This process facilitated (a) accessing emotional issues in psychotherapy, (b) attending to issues associated with strong emotions, and (c) taking a more pro-active approach to recovery. For example, one participant wrote, ''Bodywork has helped me to deal with strong emotions, so I can face the issues underneath.'' Another wrote, ''the opportunity to explore the self-consciousness I felt during massage has helped me gain more understanding about my difficulty in feeling sexual and my fear of sexual activity, most of which results from my father's abuse.''

The responses from the body-oriented therapy group participants suggest that they experienced profound personal insight. This is most apparent in the descriptions of increased emotional awareness among the participants; a key component in the two emergent themes related to the experience of the intervention and its influence on abuse recovery.

Discussion

The study results provide preliminary evidence that body-oriented therapy is efficacious as an adjunct to psychotherapy in sexual abuse recovery. The findings supported the study hypothesis, demonstrating significant positive change in psychological and physical well-being in the body-oriented therapy in contrast to the lack of significant positive change in the control group. The positive change in psychological symptoms is consistent with previous findings that demonstrated similar improvements in pre-post depression and anxiety in a randomized control trial of massage therapy for women sexual abuse survivors (Field et al., 1997). The qualitative findings indicated that the intervention powerfully affected sense of self and psychotherapeutic progress, providing support for the psychological improvements demonstrated in the quantitative results. In particular, these findings suggest that body-oriented therapy facilitated increased emotional awareness and personal empowerment—and points to the important role of body connection in the therapeutic process of reclaiming and reconnecting with the inner self in sexual abuse recovery.

There are important clinical and research implications of these findings. The equally significant decreases in psychological symptoms, PTSD, number of physical symptoms and physical symptom distress—and the strong trend toward decrease in dissociation—suggests a link between psychological and physical well-being. It is important to consider this link within the context of body therapy where touch likely plays an integrative role linking psychological and somatic realms. This may be particularly true of body-oriented therapy—in which the therapeutic emphasis is on the integration of cognitive, emotional and somatic awareness. The relationship between psychological and physical symptom distress in response to body therapy is an important emphasis for future research. Likewise, further study is needed on the body-oriented therapy process to provide insight into the specific role of awareness and integration in body-oriented therapy during sexual abuse recovery.

The qualitative findings also raise important clinical and research questions. The findings suggest that body-oriented therapy shifted participant experience away from the vigilance, fear and dissociation typically associated with PTSD. The reduction in PTSD, dissociation and overall psychological distress supports this interpretation; as do the significant reductions on the psychoticism and phobic anxiety subscales, both of which are made up of items specific to feelings of isolation and fear. It is possible that sense of inner safety is an important component for positive change among linked psychological and physical symptoms so common among women with PTSD (Price, 2002).

There are study limitations to be considered. The small sample size limits interpretation of comparative findings and generalization of the study results. Also, the principal investigator collected and analyzed the data and, thus, was not masked to study condition during the data collection and analyses phases, a limitation of this study design. Future research is needed to address such limitations through the use of a randomized clinical trial, involving third party measurement/questionnaire administration. Likewise, future research ought to

include multiple interventionists to allow for examination of therapist effect. The continued use of a multiple indicator measurement model is recommended, as is the development of instruments designed specifically for this approach to more clearly address the effects of the intervention.

In conclusion, the positive change in the body-oriented therapy group compared to the control group was remarkable given the sample size, suggesting that a larger study is warranted to further test the effectiveness of body-oriented therapy in sexual abuse recovery.

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