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PILOT STUDY: BODY-ORIENTED THERAPY

Characteristics of women seeking body-oriented therapy as an adjunct to psychotherapy during recovery from childhood sexual abuse

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Abstract This paper examines the psychological and somatic profile of women who seek bodywork as an adjunct to psychotherapy in recovery from childhood sexual abuse. The subjects were eight women who participated in a pilot-test comparison of body-oriented therapy. Measures included interview, life history questionnaire, physical symptoms checklist, and standardized psychological questionnaires. Results indicate symptom characteristics similar to those found in studies of this population, with high levels of distress and high numbers of physical symptoms. While clinical experience indicates that avoidance and denial of emotional aspects of somatic experience is common to survivors, the participants in this study articulated a relationship between their physical symptoms and their abuse. Clinically, this study points to the importance placed on somatic healing in recovery, characteristics of those who seek and can presumably benefit from body-oriented therapy, and the need for adequate training among bodyworkers who work with this population.

Introduction

Bodywork therapists frequently have clients with a childhood history of sexual abuse, and psychotherapists may have clients receiving adjunctive therapy from a bodywork therapist. High utilization of alternative therapies has increased interest in the types of therapy services and consumers of such therapies (Kelner and Wellman, 1997; Eisenberg et al., 1998). The characteristics of women who seek bodywork therapy (an umbrella term for hands-on healing modalities) in recovery from childhood abuse have not been previously examined. Learning more about the women who seek bodywork therapy in trauma recovery will help bodywork therapists better identify the needs of the clients they are likely to see in practice. Likewise, such information will help other healthcare professionals to better identify challenges faced by this population in recovery, and understand the motivation for seeking alternative therapies such as bodywork. This paper examines the characteristics of women in therapeutic recovery from childhood sexual abuse who participated in a small pilot study of body-oriented therapy.

Body-oriented therapy refers to bodywork practice that includes a primary focus on somatic and emotional awareness. The focus of body-oriented therapy is on identifying and experiencing bodily

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sensation and any associated emotional component, during bodywork. Bodywork therapists and psychotherapists who work with adult survivors of childhood sexual abuse report a high incidence of separation—or dissociation—from the body (Timms and Connors, 1992; Kepner, 1995; Courtois, 1988). The state of bodily dissociation, a helpful and protective mechanism for coping with childhood abuse, may become a habitual pattern that continues into adulthood. A primary therapeutic focus of body-oriented therapy with this population involves addressing dissociation from the body as an important element in recovery from childhood sexual abuse (Timms and Connors, 1992; Ford, 1993; Ogden, 1997). Reduction of bodily dissociation in clinical practice is thought to occur through the development of body awareness and involves the experience of physical and emotional sensation (Timms and Connors, 1992; Levine, 1997; Ogden, 1997). Body-oriented therapy facilitates the awareness and experience of unresolved emotion held in the body.

A common clinical profile of childhood trauma also includes post-traumatic stress disorder (PTSD) and somatization (van der Kolk et al., 1996; Briere and Runtz, 1993; Herman, 2000). PTSD is characterized by intrusive memories, avoidance symptoms, and persistent arousal. Somatization is characterized by physical complaints in the absence of a medical explanation. It is marked by ''an inability to identify the emotional valence of physiological states'' (van der Kolk et al., 1996), and includes reference to ''somatic equivalents of anxiety'' (Derogatis et al., 1977). The desire to resolve physical problems leads women with sexual abuse histories to seek out allopathic treatment in primary-care settings. The numbers of women who seek medical care for physical distress and who have childhood abuse histories is extremely high; studies in primary-care settings report prevalence of 43% (McCauley et al., 1997) and 32% (Walker et al., 1999). Similarly, distress related to physical complaints, particularly those with no medical ''cure'', often motivates adults to seek bodywork therapy (Palinkas and Kabongo, 2000). Body-oriented therapy may be particularly challenging to women with childhood sexual abuse histories because they are often fearful of physical touch and the emotions associated with bodily sensation; yet many of these women are motivated to seek out body-oriented therapy. This paper is a first step in gathering information on the demographic characteristics, psychological profile, physical symptoms, and self-descriptions of the women who sought participation in a small pilot study of body-oriented therapy.

Method

Background on study design and enrollment

A pilot study examining the psychological and physical effects of body-oriented therapy as an adjunct to psychotherapy provided an opportunity to examine the characteristics of women who seek bodywork therapy during recovery. The pilot study, a two-group pilot-test comparison utilizing a wait-list control, offered study participants eight 1-h sessions of body-oriented therapy over 8 consecutive weeks (Price, 2002a). The key elements of the study protocol—safety, massage, body-awareness education, body-mind integration, and session review—are described in further detail in a previous paper (Price, 2002b). Eight women participated in this study. The participants were randomly assigned to two groups. The first group received the body-oriented therapy intervention immediately; the second group waited 8 weeks prior to receiving the intervention. The data for this paper on the background characteristics, psychological profile and somatic symptoms, and self-descriptions of this population were gathered at the initial appointments of the eight study participants prior to their randomization to the two intervention groups.

Study participants were recruited in two large cities in North America through letters to psychotherapists, printed announcement in women's organizational newsletters/web-sites, and to students in a university graduate program. To enhance the clarity of the results with a small sample, interested parties were screened for specific exclusion and inclusion criteria during initial phone contact with the principal investigator. Inclusion criteria required that an individual be in psychotherapy; willing to forgo any (non-study) bodywork treatment 1 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 they be free of current abusive relationships, without recent psychiatric hospitalization (within the year), not addicted to alcohol or drugs, and over 25 years of age (women tend to engage in psychotherapy for recovery after college, and there is reduced risk of date rape after mid-20s).

Data collection

Fifteen women expressed interest and were screened for study participation. Five of these

women were not eligible, four due to lack of current engagement in psychotherapy and one due to inability to finance study participation. The 10 women eligible for participation in the study were mailed an IRB approved consent form for review along with a demographic questionnaire. Two of the 10 chose not to participate—one because of the commitment involved, and one due to the severity of her chronic pain. The eight participants returned the consent form and demographic questionnaire to the principal investigator at their initial appointments, and the self-report questionnaires and participant interview were administered at this time. The items on the questionnaires and questions asked in the interview were sensitive in nature. The consent form addressed the measurement procedures and risks; likewise, the investigator, an experienced clinician with a graduate degree in psychology, was skilled and sensitive in her administration of the measures and interview. This meeting lasted approximately 1 h and took place in clinical office space.

Measurement

Demographic characteristics

Initial Questionnaire consisted of questions aimed at gathering demographic information (i.e. age, education, occupation, income) as well as psychological history (i.e. number of years in psychotherapy, current medication use, and suicide attempts) and abuse history (i.e. age of abuse, identity of abuser, duration of abuse).

Psychological profile

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 0.71–0.85).

Crime-Related PTSD Scale (*CR-PTSD*) is based on selected items from the SCL-90-R that have been identified as indicative of a diagnosis of crime-related PTSD. Crime-related victimization includes sexual assault from anytime in life, including childhood. With excellent internal consistency (α 0.93), the scale effectively discriminates between individuals with and without crime-related PTSD ($F = 98.2$, $P < 0.001$) (Saunders et al., 1990).

Dissociative Experiences Scale (*DES*) measures the frequency of dissociative experiences. It is used to determine the contribution of dissociation to psychiatric disorders and as a screening instrument for dissociative disorders. The DES has proven reliability and validity for measuring these variables (Carlson and Putnam, 1993). The scale has good internal consistency, with a range of α 0.83–0.93 in various studies.

Profile of Mood States (*POMS*) provides a measure of mood states. The scale has proven reliability and validity (McNair et al., 1992). The internal consistency for the six factor scores ranges from α 0.84–0.95. A total mood disturbance (TMD) score provides a global estimate of affective state based on the subscale scores.

Physical symptoms

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 as follows: 1 = slight difficulty, 2 = moderate difficulty, 3 = significant difficulty, and 4 = extreme difficulty. Instrument scoring involved figuring the mean score based on the sum of the rated items divided by the number of items endorsed.

Self-description

Qualitative data: Self-Descriptive Questions were asked in an open-ended manner during a semi-structured interview, and self-descriptive questions were also included at the end of the written demographic questionnaire. These questions were intended to provide information on participant self-concept, motivation for seeking body-oriented therapy, and self-care behavior.

Results

Background characteristics

Demographics

As shown in Table 1, the women participating in this study were between the ages of 28 and 52 years. The majority of the participants were Caucasian, one African-American. Five were in committed relationships and seven of the eight women were sexually active. Although incomes varied greatly,

Table 1 Background characteristics of study participants.

Characteristics	No.
Age, mean (range)	38 (28–52)
Racial/ethnic identity	
Caucasian	7
African–American	1
Relationship status	
Committed relationship	5
Single	3
Sexual identity	
Heterosexual	4
Homosexual	3
Bisexual	2
Income	
<$25,000	2
Between $25 and 50,000	3
>$50,000	2
Education	
Completed B.A.	8
Completed M.A.	3
Completed Ph.D.	1
Current graduate student	2
Psychological information	
Psychotherapy in years, mean (range)	12 (1–20)
Medication (♯ using meds)	5
Anti-depressants	3
Anti-anxiety	1
Anti-insomnia	3
Suicide attempt in adolescence/early adulthood	3
Abuse history	
Initial abuse <10 years of age	4
Multiple childhood perpetrators	5
Physically abused by parent(s)	4
Subsequent date rape in early adulthood	6

these women were all highly educated (all had completed Bachelors degrees and the majority were pursuing or had graduated from graduate programs) and professionally oriented (all were employed).

Psychological history: psychotherapy, medication, and suicide

All participants were in psychotherapy and had been seeing their current psychotherapist for at least 1 year and six out of eight had between 7 and 20 years of psychotherapy. Five of the eight participants were taking medication and three had suicide attempts during adolescence or early adulthood (see Table 1). None expressed current suicidal ideation or intent. Recovery from severe childhood abuse can be a long, arduous process, and it is common to see women who enter psychotherapy engaged in therapy on and off over a long period of time as in this sample. Common, as well, is medication given to help survivors like those in this sample, cope with the depression, anxiety, and insomnia frequently seen in this population.

Bodywork history

Seven of the eight participants had at least minimal experience with massage therapy (see Table 1). None had received body-oriented therapy, nor received massage therapy explicitly intended for adjunctive treatment during recovery from childhood abuse. For the group, body-oriented therapy was a new experience.

Sexual and physical abuse histories

Four women reported initial sexual assault and abuse in early childhood, age 10 years or younger (see Table 1). Four women reported initial sexual assault or abuse during adolescence, between the ages of 13 and 16 years, and two of these women questioned whether earlier sexually abusive encounters may have occurred. There were multiple childhood perpetrators for five of the eight participants. The threat of violence accompanied sexual assault/abuse for five of the participants. Four participants also reported physical abuse by a parent(s) throughout childhood. Six of the eight participants experienced subsequent date rape(s) in early adulthood. Sexual abuse would be classified as "severe," involving rape or recurrent abuse by the perpetrator for all the women participating in this study.

Psychological profile

SCL-90-R: Scores on the SCL-90-R subscales were within normal range, although most were above the normed mean. To give an indication of where the participants fell on the range of possible scores for non-patient females, the scores were divided into approximate thirds (low, medium, and high) as shown in Table 2. All participants were at or above 85% percentile rank on the general severity index for psychological distress compared to the normed mean (at 50%) for non-patient females: all scored 90% or higher on depression, 85% or higher on

Table 2 Psychological profile.

Mental health symptoms	No.
Total SCL-90-R[a] (assesses psych distress)	
Low	0
Med	0
High	8
CR-PTSD (indicates post-traumatic stress)	
Below cutoff for active PTSD	2
At or above cutoff for active PTSD	6
DES (indicates dissociative symptoms)	
Within average range (gen. Population)	2
Above average range	6
Total POMS[a] (indicates affective state)	
Low	0
Med	1
High	7

[a]Total SCL-90-R and POMS scores were divided into approximate thirds.

obsession–compulsion, 78% or higher on interpersonal sensitivity. Four participants were at 95% or higher on paranoia; four were at 95% or higher on psychoticism; six were at 93% or higher on anxiety; four were at 90% or above on hostility; five were at 88% or higher on somatization; and seven were at 77% or higher on phobic anxiety. The participating women experienced significant levels of psychological distress, consistent with the typical profile of women abused in childhood.

CR-PTSD: PTSD is characterized by intrusive memories, avoidance symptoms, and persistent arousal; it is one of the many trauma-related features of childhood abuse. Six study participants had CR-PTSD scores at 0.89 or higher; 0.89 is the cutoff for clinical indication of PTSD (Saunders et al., 1990). The other two participants had scores below 0.89, but high enough to be within one standard deviation of the cutoff score. The majority of study participants had current PTSD, while others had frequent symptoms associated with PTSD.

DES: The DES is a screening tool used to identify those with dissociative psychopathology. Mean DES scores range from 4.4 to 7.8 for the general population, while scores for people with diagnosed psychiatric disorders are significantly higher; scores above 20 indicate need for further clinical exploration of dissociative experiences and scores of 30 and above are indicative of dissociative disorders (Carlson and Putnam, 1993). Study participant DES scores varied considerably: two women had scores of 4, four had scores ranging from 12 to 19, one had a score of 25, and one a score of 33 (see Table 2). Although there was a wide range in DES scores, the majority of study participants endorsed frequent symptoms of dissociation.

POMS: The TMD scores were similar among the participants and seven out of eight scored between 0.5 and 1.0 standard deviation (S.D.) above the norm for a non-patient female population. To give an indication of where the participants fell on the range of possible scores for non-patient females, the scores were divided into approximate thirds (low, medium, and high) as shown in Table 2. Consistent among participants were high depressive mood and fatigue scores; five scored at or above 1 S.D. of the mean for depression and seven participants scored at or above 1 S.D. above mean for fatigue. The particularly high scores on depressive mood and fatigue among the study participants are consistent with the high endorsement of depression on the SCL-90-R, and ''fatigue'' and ''insomnia'' on the Physical Symptom Checklist.

Physical symptoms

Physical Symptom Checklist: Study participants indicated many symptoms as problematic; each endorsed an average of 10.5 symptoms of 31 possible symptoms. Although the endorsed items varied among individuals, common symptoms were neck or back pain, sexual dysfunction and/or discomfort, menstrual discomfort/PMS, fatigue, insomnia, temporal-mandibular joint dysfunction, and digestive problems (see Table 3). The symptom difficulty among the study participants was 3.5, a

Table 3 Physical symptoms.

Total ♯ endorsed, mean (range)	10.5 (0–31)
Symptom difficulty, mean (range)	3.5 (1–4)
Commonly endorsed	♯ of times endorsed/total *n*
Neck or back pain	7/8
Sexual dysfunction/ discomfort	6/8
Menstrual discomfort/PMS	5/8
TMJ (temporal-mandibular joint dysfunction)	4/8
Fatigue	4/8
Insomnia	4/8
Digestive problems	4/8

mean score (on a 1–4 point scale) representing between "significant" and "extreme" difficulty. Thus, these women tended to report a high number of physical symptoms—the majority of which were experienced with "significant" difficulty; the number and level of endorsed items suggests the degree of somatic discomfort that these women endure.

Self-description

What brings participants to the study?

Participants were asked what the primary reason(s) were for participating in this study and for wanting body-oriented therapy. The responses were: "to relieve physical pain I attribute to abuse"; "to experience release from chronic back pain and from body tension related to my PTSD, TMJ, sleep disorders and panic attacks. I hope to experience feelings that will aid my recovery"; "to decrease feelings of bodily unease"; "to learn more about how my sexual abuse has been retained in my body"; "I am working on remaining present in my body"; "I'm working on blocks to my sexuality; to get out of my head"; "to address problems with depression and shoulder/neck problems"; and "to receive massage which I anticipate will be pleasurable, helpful and will provide me more awareness of my body". Common themes among the participants for study participation were physical discomfort or the desire for increased body awareness. Striking in these responses is the relationship these women articulated between their symptoms and their abuse; implicit is a search for increased levels of recovery that involves attending to the body.

Lifestyle habits

Seven of the eight participants reported engaging in regular, active exercise approximately three times a week for 1 h. Six participants reported going out for evening entertainment or friend get-togethers once or twice a week; the two who reported no evening socializing were parents of school-age children. The participants rated their ability to do self-nurturing activities using a scale of 1–5, where 1 is "very difficult" and 5 is "easy"; three endorsed a rating of "2", three endorsed a "3", one endorsed "4", and one endorsed "5." The responses on exercise and social habit reflect the high level of motivation, commitment to health, and interpersonal involvement of these women. Self-nurturing behavior, however, did not come easily to the majority of the study participants. Poor self-esteem contributes to difficulties with self-nurturing; participant difficulty with self-nurturing was consistent with the high scores on interpersonal sensitivity, which represents poor self-esteem.

Strengths brought to recovery

In response to a question about what strengths they bring to help themselves in recovery, the participants replied: "probing/honesty and scrutiny of self and others"; "sense of humor, perseverance, and spirituality"; "my attitude: I want to heal and be healthy in my life"; "I m not afraid to be honest about scary things, and I have a sense of humor. I am creative and productive and want this to get better; I allow others to help me, despite my wariness"; "intelligence, spirituality, perseverance"; "a commitment to getting better"; " lots of experience identifying and tolerating my emotions"; "the ability to connect my thoughts and feelings"; "the belief that change is possible, and professional knowledge/experience in the field of traumatic violence and healing"; and "stubbornness." The women in this study recognize their personal strengths. The overwhelming picture presented by these study participants is one of commitment to their health and healing.

Discussion

The physical and psychological symptoms of the study participants reflect high levels of distress, consistent with characteristics of this population found in previous studies. Participants endorsed the types and large numbers of physical symptoms (six or more) typical of women with childhood abuse histories (McCauley et al., 1997; Walker et al., 1999). Likewise, the level of psychological distress reflects increased emotional symptoms found in women with histories of childhood abuse (McCauley et al., 1997). Among women survivors of sexual abuse, severe abuse (i.e. involving rape or recurrent abuse by perpetrator) is associated with increased long-term effects from the trauma (Herman et al., 1986)—including an association between severity of abuse and PTSD symptoms (Rodriguez et al., 1997). All participants experienced severe abuse. Dual abuse—combined physical abuse and sexual abuse in childhood—is associated with increased physical symptoms (McCauley et al., 1997), dissociation (Mulder et al., 1998), and PTSD (Rodriguez et al., 1997); half of the study participants experienced a dual child abuse history. Combined childhood and adult abuse is associated with higher levels of physical symptoms and psychological distress than abuse

only in childhood (McCauley et al., 1997); six of the eight participants reported rape in early adulthood subsequent to child sexual abuse. Taken together, the severity of child sexual abuse, and the high occurrence of dual abuse and combined child and adult abuse, likely contributed to the high numbers of physical symptoms endorsed (average of 10.5), and the high level of psychological distress, including dissociation and PTSD. The proportion of study participants with a dual abuse history, or combined child and adult sexual abuse history, are similar to the percentages in McCauley's findings. The proportion of study participants who met the criteria for current PTSD is similar to percentages reported in study by Rodriguez et al. The overall psychological and somatic symptom characteristics among the study participants was similar to those found in the general population and primary-care studies of women with histories of childhood sexual and/or physical abuse.

It has been suggested that trauma survivors with PTSD may misinterpret somatic sensations and seek medical attention for symptoms that are more accurately psychological in origin (van der Kolk et al., 1996). In contrast, the women in this study sought participation in a study of body-oriented therapy for relief from psychological and physical distress with the hope that the therapy would facilitate further recovery from childhood abuse. This scenario contradicts the presumed psychological/somatic profile of such women. Dissociative symptoms tend to be associated with increased separation from sense of self, including sense of self in the body; PTSD symptoms tend to be associated with decreased sense of safety, increased fear of and separation from others. Together these symptoms would suggest the tendency, common in this population, toward avoidance and denial of emotional aspects of somatic experience. Striking among the women in this study, particularly given the lack of previous experience with body-oriented therapy, was the recognition that attending to somatic distress may be integral to their recovery from childhood abuse.

Four key characteristics of this study group explain their ability to overcome barriers to somato-emotional healing. First, with one exception, all participants had many years of psychotherapy that presumably would contribute to their self-awareness and knowledge, providing a well-honed sense of their needs for recovery. Second, all were highly motivated regarding their health and healing, and created these as priorities in their lives; this included their willingness to enter into bodywork therapy even when many found self-nurturing activities, an element of the therapy, difficult. Third, the participants' physical difficulties were typically chronic rather than acute; they were aware that their physical problems were not easily remedied, and associated physical symptoms to the psychological distress of the abuse. And, fourth, with one exception, these women were in sexual relationships and found sexual intimacy problematic, making it virtually impossible for them to ignore the connection between emotion and body and the impact of childhood abuse on somato-emotional health (Maltz and Holman, 1987).

There are study limitations to be considered: the small sample size and restricted recruitment limits generalization of the study findings. The principal investigator collected and analyzed the data, thus the investigator was not masked to study condition during the data collection and analyses phases, a limitation of this study design. The prominent demographic features, high levels of education and Caucasian race, may be typical of women seeking alternative therapies such as bodywork; they may also reflect recruitment strategies which targeted women seeking psychotherapy in private practice settings, a University population, and/or women who access the web for information services. Nevertheless, the results point to the importance of somatic healing among women in therapeutic recovery from childhood trauma.

The findings suggest important clinical implications. First, participants in this study sought body-oriented therapy to address physical symptoms (including difficulty with sexual intimacy) and the desire to attend to their bodies in recovery. The perceived association between their physical symptoms, abuse history and psychological well-being, suggests that body-oriented therapy may be particularly appropriate for women with physical symptoms engaged in therapeutic recovery. Broadening treatment approaches to include body-oriented therapy offers the opportunity for healing on multiple levels, including physical discomfort, self-nurturing, awareness and attention to bodily self, and interpersonal barriers to trust and safety. Also, the extent that bodywork therapists are likely to find dissociation, PTSD, and somato-emotional difficulties with sexual relations as prominent features among female clients with childhood abuse histories, symptom recognition and therapeutic strategies appropriate for bodywork therapy and referral need to be integrated into the education of therapists engaged in bodywork with this clientele. Advanced training is suggested for bodywork therapists endeavoring to practice with individuals seeking to further trauma recovery through bodywork therapy—and can be found in graduate programs in body psychotherapy as well as

in advanced-practice training in trauma recovery. Last, body-oriented therapy is often an adjunct to psychotherapy and educational programs need to address framing the therapeutic approach of adjunctive practice so that it compliments psychotherapy, and establishing effective communication with psychotherapists. Likewise, it is important that psychotherapists understand bodywork approaches so that they can participate in establishing successful adjunctive relationships and support their clients' participation in bodywork and body-oriented therapy.

In conclusion, the clinical picture of these highly motivated, professional women is one of keen attention and commitment to their therapeutic process, to their general health and well-being, and to their personal and professional lives; they live with chronic somatic discomfort and elevated psychological distress, PTSD symptoms primary among them. These women seek to improve on their recovery from childhood abuse; they turn to bodywork therapy to attend to the physical body, where they sense the potential for healing. They are willing to enter into bodywork therapy that focuses on the integration of emotional and bodily sensation despite, or maybe because of, the pain of being dissociated/disconnected from their bodies, from themselves.

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