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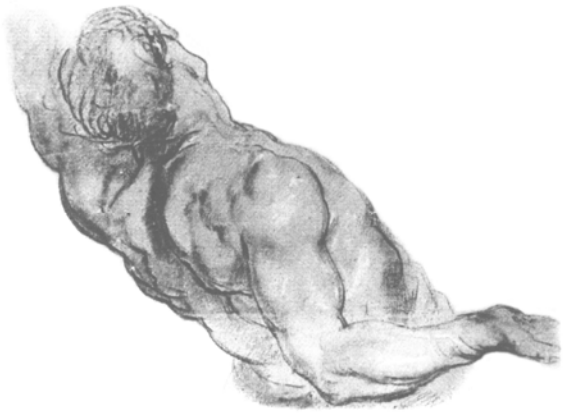
Table of Contents



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The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999)

Moving Clinical Work into Research: Study Preparation, Design, and Implementation

Cynthia Price, M.A.

Abstract

There is growing interest among bodywork therapists and body-psychotherapists, as well as among other health care providers, in bodywork and body-psychotherapy research. Therapists who choose to become researchers will draw from their clinical expertise while entering the world of conceptual framework and linear models. It is important that clinician-researchers have access to conversation and resources about the preparation and implementation process of intervention research in this field. At this time, there is very little literature of this kind available. This article provides a brief account of a doctoral student's learning process as she develops and oversees a body psychotherapy intervention.

Keywords

Body work – Intervention – Moving clinical work into research

Introduction

The following article describes the preparation for, and implementation of, my doctoral research study in body-psychotherapy. I came into the doctoral program having completed a very small pilot study of body-oriented therapy among women in recovery from childhood sexual abuse (Price, 2002a; Price, 2002b). In this initial pilot, there were remarkable reductions in dissociation, PTSD, and somatic symptoms among the experimental group compared to a wait-list control (Price, 2002c). My Faculty Advisor and I were interested in exploring what aspects of the intervention facilitated these changes. To examine the questions related to the underlying mechanisms of the intervention, my doctoral study needed to be designed differently than the initial pilot study. Much that I've learned about research preparation and implementation has been a result of the identified changes made in measurement, protocol development, instrumentation, study design, and the training and supervision of research clinicians. These five areas, and the learning involved, are explained below. The data collection in my doctoral study is close to completion; study results are not yet available.

Study Overview

My doctoral study is a pilot study of 24 women randomly assigned to receive either body-oriented therapy or a standardized massage. Body-oriented therapy is defined as a combination of bodywork and verbal therapy focused on somatic and emotional awareness. Study participants receive eight one-hour sessions of massage or body-oriented therapy for eight consecutive weeks. Utilizing a repeated measures design, a set of six questionnaires is administered prior to the massage and body-oriented therapy interventions - twice during the intervention, one-week post intervention, and at one and three month follow-up. These questionnaires gather data related to psychological well-being, body connection, and somatic symptoms. An initial questionnaire is also administered to gather demographic, health and abuse history. A final written questionnaire is administered to gather qualitative information on the experience and impact of receiving the sessions (both massage and body-oriented therapy). The massage group receives a standardized massage (i.e. it is the same each session). The body-oriented therapy group receives a verbally interactive intervention focused on increasing body awareness through three distinct components: massage, body-awareness exercises, and delving. Delving, developed during my years in clinical practice, is derived from Focusing and involves attending to the felt sense in specific areas of the body. The therapist facilitates the delving process through physical touch, meditation-like attention to the inner experience of the body, and questions about sensory awareness. To maximize the comfort and sense of safety in this population, both interventions are done over clothes and the protocols for both interventions can be individualized to meet the safety and comfort needs of the participant.

The following questions are being explored in this study.

How does the efficacy of a body-psychotherapy process involving massage compare to a standardized massage for women in therapeutic recovery from childhood sexual abuse?

Does increased body awareness play a role in positive outcomes? What is the relationship between body awareness and dissociation?

Does level of engagement in body-psychotherapy process correlate with positive outcomes?

Study development and process

Protocol: The protocol for my doctoral study needed to be more specific than what I had used in the initial pilot and it needed to facilitate examination of the essential elements of the intervention. I went through three steps in protocol development. Each of these steps involved reflection and writing, and each was a challenge because my approach had been developed over many years of clinical practice and much about it had never been articulated. The first step involved identifying the essential elements of my clinical work and the ways in which they tend to fit together. In doing so, I identified three specific approaches - massage, body-awareness exercises, and delving – and these became the three stages of the protocol, the backbone of the intervention.

The second step involved thinking about the details of my inner process as a clinician. For example, how do I frame an individual session and a series of sessions over time; what are my decision-making processes and assessment procedures? This step was particularly difficult for the hands-on aspects of my work. For example, how do I assess with my hands? How do I combine physical and verbal assessment? How do I physically respond if someone is dissociating or has a traumatic memory? To answer these questions, I reflected on my clinical experience and focused on identifying consistent and effective patterns of assessment and therapeutic response. These were then incorporated into the protocol.

The third step involved translating this information into a training manual that provided step-by-step instructions for the clinicians who would work on the project. The instructions had to be clear, the language had to accessible, the format had to be linear. The protocol had to be specific enough that the intervention was consistent and expansive enough that the research clinicians could work with the unforeseen possibilities of a session and individual needs of a participant, and stay within the protocol. The assessment procedures became the focal point around which this was achieved. For example, the clinicians needed to assess whether study participants understood and could successfully engage in the body awareness exercises. The training manual gave specific instructions for the tactile and verbal assessment involved. Progression through the protocol depended on the outcome of the assessment. For example, if the exercise came easily to the participant then the clinician would move on to the next level of the protocol. If, however, the exercise was a challenge for the participant then the protocol focused on specific steps to facilitate and support the therapeutic work of the body awareness exercise.

Repeated measures design:

Unlike the initial pilot study, my doctoral study utilized a repeated measures design. This means that the questionnaires used in the study were administered at numerous time points to examine the intervention process. The body-oriented therapy protocol had three distinct stages and measures were administered prior to each stage and after the final stage, to examine change associated with different aspects of the intervention. The same time line for administration of questionnaires was used for both the massage and body-oriented therapy groups.

Instrument Development:

This study examines the role of body awareness and dissociation from the body in the therapeutic process. I needed a measure that would allow me to examine these concepts, and to my knowledge no such measure existed. I needed to design such a measure. I took a course on instrument development and designed a questionnaire with two scales – one scale on body awareness and one scale on dissociation from the body. The items for these scales were developed through a reflection process that drew on the clinical expertise of many colleagues and myself. After completing the scale, I collected 300 responses to this questionnaire for the purposes of confirming that the instrument was reliable and valid.

Two treatment groups:

The design of my initial pilot-test had a wait-list as the control condition. This means that participants were randomly assigned to either a group that received the intervention immediately or to a group that waited two months prior to receiving the intervention. The wait group served as the control - the pre and post measures were administered at the beginning and end of the wait period. In the initial pilot-test, the comparison was between an intervention and no intervention. In contrast, in my doctoral study the comparison group received touch (in this case, massage), allowing a rigorous test of the efficacy of delving as compared to a standardized massage and examination of the hypothesized mechanisms in the body-oriented therapy process.

Training and Supervision:

In the initial pilot-test comparison, I wore two hats: I administered the project and provided the clinical intervention. For my doctoral study I needed to take myself out of the role of clinician to better evaluate the efficacy of the intervention (i.e., can it be taught and successfully administered by clinicians other than myself?). Consequently, I sought four bodyworkers to work as research clinicians on the project: two to provide the standardized massage and two to provide the body-oriented therapy intervention. For the massage group, I hired clinicians without a psychology background who were comfortable providing a fairly standard and technical massage. For the body-oriented therapy group, I hired clinicians with a psychology background who had experience combining touch therapy and verbal therapy. All four clinicians needed to have a minimum of five years in practice, and experience working with women with an abuse history. I contacted many bodyworkers whose names were referred to me by colleagues and I recruited through the local massage schools and a large massage practice that caters to walk-in clients. I was struck by the interest and support for research within the bodywork community – almost every clinician I spoke with was interested in working on the study.

I trained the clinicians using protocols for their particular intervention (massage or body-oriented therapy). Teaching the standardized massage was relatively straightforward since the protocol was the same every session and there was little verbal interaction. Teaching the body-oriented therapy process, however, was much more complicated – the work was subtle, and involved the interplay of tactile and verbal work – and, the protocol changed three times over eight weeks. The body-oriented therapy training involved considerable time – many hours of the training were focused on practicing the protocol and role-playing hypothetical situations that required utilizing the 'what-if' aspects of the protocol. In other words, it was a lot to learn and a lot to teach.

I realized, starting out, that the process of teaching the body-oriented therapy would involve some collaborative refining of the protocol between the clinicians and myself as we went along. The clinicians thought of things I'd not yet considered (for example, how to do closure on the final session); their personal styles influenced certain aspects of the protocol (the choice of words or phrases used in the protocol); and when practicing the intervention we inevitably encountered therapeutic situations that weren't yet addressed in the training manual (for example, how to respond to a participant who isn't interested in doing any of the 'homework'). In each of these situations, their input was invaluable and their perspectives helped to guide my decisions as I refined the protocol.

One of the goals of taking myself out of the role of clinician was to learn to teach my work – and to teach it within a research framework. It was difficult at times to balance the role of clinician with that of researcher – particularly when I needed to come up with specific guidelines for situations that could be responded to in a variety of ways. I could empathize with the clinicians who were similarly struggling as they practiced following a protocol rather than following their own therapeutic approach. Not infrequently one of the clinicians would ask me what to do in a situation that I hadn't previously considered. The hypothetical situations that I hadn't considered and were not clinically straightforward were challenging to answer with an immediate, concrete response. For example the time someone asked, "If the participant requests a hug at the end of the final session, is it okay to give one?" I had to resist the temptation to throw up my hands and exclaim, "Whatever you feel is the most appropriate response in the moment!"

The data collection process also provided important opportunities for refining the training manual and protocols. Each session was audio-recorded to monitor compliance with the protocols and as a tool for clinical supervision. Clinical supervision occurred through individual feedback to each clinician after I had reviewed the week's audiotaped sessions, and through scheduled group supervision meetings with either the massage or body-oriented therapists. When listening to the audio taped sessions, I would occasionally hear segments of the protocol delivered somewhat differently than expected. I would immediately realize that I hadn't adequately clarified or demonstrated a particular point during the training. From this process - of listening to the tapes and providing supervision - I learned how to better teach the protocol and gained important information to further clarify the protocol within the training manual.

The process of listening to the audio-taped sessions, in the role of witness/observer/supervisor of the therapeutic process, provided me with an important perspective on both the training and delivery of a therapeutic intervention. I learned that it is possible to teach things I'd assumed were too subtle or hard to explain, for example the ability to distinguish when a client has partial versus complete presence focused in an area of her body. Likewise, I gained a greater appreciation of the skills of an effective clinical researcher – for example, the importance of creative intelligence. There were a few times when quick thinking was required to apply the essence of the protocol in an unexpected therapeutic situation not previously encountered. The clinicians were very skilled and experienced, therefore able to successfully negotiate these moments without compromising the protocol. The clinicians working on this project were extremely conscientious and committed to the study – and enhanced my learning immeasurably.

Conclusion

Translating my clinical work for research purposes, developing a questionnaire, and supervising an intervention study have been very rewarding experiences. Through the process of writing and teaching a research protocol I learned how to frame and communicate conceptual and practical aspects of the intervention

process. I also learned that protocol development is an evolving process that is greatly enhanced by careful attention to the delivery of the intervention and involvement of research clinicians. Through the process of developing a questionnaire I learned the steps involved in creating a reliable and valid measure; this experience was also instrumental in helping me to identify the assumptions underlying my work. Through the process of listening to the work of the clinicians on audiotape, and providing supervision, I learned how essential the clinicians are to the success of an intervention study; they must be responsible, have adequate experience, and the appropriate educational background. I did not anticipate the level of intrigue that accompanied each stage of the research preparation and delivery process. There is a sense of discovery that unfolded with each step that feeds my curiosity and deepens my appreciation for this work.

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Biography:

Cynthia Price, M.A. was given an honorable mention at the last USABP Conference for the excellence of her research proposal. She was subsequently awarded a pre-doctoral fellowship from the National Center for Complementary and Alternative Medicine at NIH to pursue her doctoral research described below. Cynthia, a body-oriented therapist for 17 years in the Boston area, is a doctoral student at the University of Washington School of Nursing in Seattle, WA.

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CRITERIA FOR ACCEPTANCE
How does material in this manuscript inform the field and add to the body of knowledge? If it is a description of what we already know, is there some unique nugget or gem the reader can store away or hold onto? If it is a case study, is there a balance among the elements, i.e, back ground information, description of prescribed interventions and how they work, outcomes that add to our body of knowledge? If this is a reflective piece, does it tie together elements in the field to create a new perspective? Given that the field does not easily lend itself to controlled studies and statistics, if the manuscript submitted presents such, is the analysis forced or is it something other than it purports to be?

PURPOSE
This peer-reviewed journal seeks to support, promote and stimulate the exchange of ideas, scholarship and research within the field of body psychotherapy as well as an inter-disciplinary exchange with related fields of clinical practice and inquiry.

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Manuscript should be double-spaced in 10pt. type, with at least a one inch margin on all four sides-please include page numbers, otherwise manuscript should be free of other formatting.

Title, full authorship, **abstract of about 100 words and 3-5 key words precde the text.** Please include an endnote with author's degrees, training, mailing address, e-mail fax, acknowledgement of research support, etc.

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