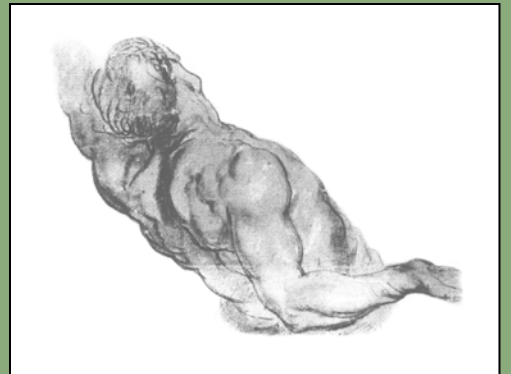


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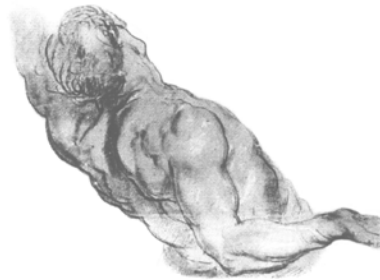


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USABP Mission Statement

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).

The Outcome of Body Psychotherapy

John May, Ph.D.

Abstract

This article attempts to survey all empirical studies on the outcome of body psychotherapy in the English language. Because some of these studies would not meet empirical criteria in peer-reviewed journals, I called this literature "objective." Much of this literature was available only in back issues of journals with limited distribution, personal communications, and theses/dissertations. I located six retrospective surveys, nine efficacy studies, and 18 effectiveness studies. This article describes the studies, providing a resource for investigators planning future studies. It also summarizes, evaluates, and describes the general trends of the literature. More study is needed and many questions remain unresolved. Nevertheless, a body of literature is slowly developing that offers support for body psychotherapy under some conditions.

Introduction

Psychotherapeutic knowing is derived from three sources, which I have described as a three-legged stool. (May, 1998b) One leg represents knowledge that comes from doing one's own inner exploration and work. Direct experiential knowing, sometimes called primordial knowing, plays an important role in this source of knowledge. Another leg of the stool represents knowledge that comes from experience with clients as one sits with them hour-after-hour. Direct knowing also plays a role here, as do case observations that are not systematically and objectively tested. The third leg of the stool represents objective study. This leg of the stool deemphasizes direct knowing and unsystematic case observation in favor of systematic testing with objective measures.

All three legs are needed, or the stool will not be stable enough to support a large body of theory. Almost all general psychotherapeutic theories derive their inspiration and core insights from the first leg of the stool (see Atwood & Stolorow, 1993). These initial insights are developed and refined through experience with clients. How would empiricists know what hypotheses to test without insights and theories derived from these two sources of knowledge? On the other hand, if one stops here, never proceeding to the systematic testing represented by the third leg, then one is left with something more akin to religious dogma than professionally grounded theory.

There has been increased discussion of the importance of empirical study for body psychotherapy, and there have been efforts to import into body psychotherapy scientific knowledge gained in other disciplines, such as neurophysiology. Objective studies of body psychotherapy are rarely cited in our literature, however. Perhaps one should not be surprised, for many of these studies are somewhat difficult to find. Most of the studies I found were published in back issues of journals with limited circulations, in personal communications, or in theses and dissertations. Many of them were not available through public or university libraries. This paper provides information about the conclusions reached by these studies. The hope is that this information will be useful in guiding and refining therapeutic practice. This paper also provides a bibliographic citation and description of each study, so that original sources can be located and used as guides and foundations for future study.

Method

This review includes and updates a review that I presented at the First National Conference of the United States Association for Body Psycho-therapists in Boulder, CO, and which was published in the Proceedings of that conference (May, 1998a). In order to conduct both reviews, the meaning of several terms had to be operationally defined. These definitions set the boundaries of the review, determining what was included and what was excluded. The first term was "psychotherapy." Hans Strupp, a prominent psychotherapy researcher, offered the following definition: "Today the term psychotherapy is the generic term for psychological interventions designed to ameliorate emotional or behavior problems of various kinds." (Strupp, 1978, p.4). The American Heritage Dictionary provides a definition framed in medical terminology, but very similar: psychotherapy is "The psychological treatment of mental, emotional, and nervous disorders." (Berube, 1985). For this review, then, I have used the basic components of these definitions. Psychotherapy is for the purpose of ameliorating, treating, or by any other words, helping. It is for helping with problems or disorders. These problems or disorders are psychological, emotional, or behavioral in nature. And its methods are in some way psychological in nature. These last two qualities differentiate body psychotherapy from bodywork.

The next term is "body psychotherapy." A useful partial definition has been offered by Downing: "There are diverse forms of body-oriented psychotherapy. Shared in common by all is this essential trait: the therapist draws on a repertoire of both verbal and physical techniques..." (Downing, 1996, p. 11.) To this I would add that, in true

body psychotherapy, the use of these techniques is understood via a therapeutic model in which attention to the body is seen as having fundamental psychological significance.

These definitions define the domain of body psychotherapy. They create a domain with indistinct boundaries, however. On one side, body psychotherapy abuts modalities that have many body-oriented characteristics, yet which seem within the boundaries of mainstream psychotherapy: Jacobson's Progressive Relaxation, Barlow's Panic Control Treatment, and recent psychoanalytic work by Beatrice Beebe and Stephen Knoblauch would all be examples. On another side, body psychotherapy abuts bodywork approaches such as Yoga, Feldenkrais, Structural Integration, and Massage. While the boundaries of body psychotherapy must be acknowledged as indistinct, the problem seems no worse than similar problems encountered when one attempts to describe other therapeutic modalities, such as psychoanalysis. (For example, see Pine, 1990)

One final term needs to be defined: "objective." For the purposes of this paper, to be objective a study had to obtain data systematically and had to use objective measures. Data had to be presented using at least an ordinal measurement system. For studies of groups, the data had to be aggregated and analyzed by group. The data presentation had to allow for comparison of the subject's scores at one point of measurement to appropriate comparison scores, and had to allow for the drawing of conclusions regarding the relation of the treatment to the observed pattern of scores. When hypotheses were being tested or comparisons being made, the data had to be presented in a way that allowed either for statistical testing of the hypotheses or for making less formal comparisons among clearly presented summary statistics ("eyeballing"). (Statistical tests are stronger analyses that allow for much greater confidence in the results than does eyeballing; in most areas of research, eyeballing would not be accepted as a valid analysis. At this point in the development of a base of data on body psychotherapy, however, it seems useful to include studies that allowed for clear eyeballing of differences rather than omitting them. They point to potential conclusions that can be confirmed or disconfirmed by additional study.) I did not attempt to systematically evaluate proper usage of statistical procedures. The report also had to describe the population that was studied and to describe what procedures the subjects (and controls, if any) underwent in the study.

I searched the PsychINFO database published by the American Psychological Association and the Dissertation Abstracts International Database for 45 names that I thought might be potential research authors, and for 16 terms that I thought would represent many, if not most, body psychotherapy modalities. The terms and years of publications searched are listed in Appendix 1. I also searched bibliographies on several body psychotherapy modalities and reviewed the archives of as many body psychotherapy journals as I could obtain. I also contacted individuals that I thought would be in a position to refer me to research sources, and the home offices of several body psychotherapy modalities. This extensive search yielded many hundreds of hits, the titles of which were then reviewed to determine if they were research studies of the outcome of body psychotherapy.

Results

My search revealed that there are several modalities that either are body psychotherapy or are very close to body psychotherapy that have developed extensive research literatures devoted to that specific modality, and which have at least one supportive dedicated review of that literature. These modalities were omitted from this review on the grounds of duplication of effort. The modalities are: EMDR (Davidson & Parker, 2001; Mollon, 2005; Van Etten & Taylor, 1998), Dance/Movement (Ritter & Low, 1996), Focusing (Hendricks, 2001), Massage, (Field, 1998), and Yoga (Krishna Rao, 1995).

In all, I found 33 outcome studies, six of which were retrospective surveys, nine of which were efficacy studies, and 18 of which were effectiveness studies.

Retrospective Studies

Retrospective studies are surveys that contact clients and/or therapists during and/or after treatment and ask a variety of questions about the therapy experience. Retrospective studies can yield useful information. Indeed, one of the most important psychotherapy studies of all time (and perhaps the largest), the "Consumer Reports" study (Seligman, 1995) was a retrospective survey. Many methodological limitations need to be kept in mind, however. I will describe the studies, and then discuss some of the methodological issues.

Driver (1985) retrospectively surveyed 73 clients of Radix. Her sample consisted primarily of highly educated young adults. Their income level, however, was far below what would be expected for so highly educated a group. They reported long therapies (mean length of 35 months, only 14% less than one year in length) and almost all had experience in other forms of therapy as well as Radix. Types of change as a result of Radix mentioned by more than 20% of the sample included improved relationships, increased ability to express emotions, change in marital status, increased sense of responsibility, more stable moods, and clearer thinking. Because of the methodology used, however, it is unclear what these changes meant and how large they were.

Thus, Driver's study offered weak support for body psychotherapy, but raised almost as many questions as it answered.

Gerdes (1993) surveyed 25 Radix clients living in Europe. Her subjects reported that they were experiencing and expressing their feelings more strongly, that they were more aware of their bodies, and experienced themselves as more connected, relaxed, and alive. They also reported changes in perception (especially vision) becoming aware of unconscious patterns, and improved relationships. The percentage of clients who reported these changes was extremely high, over 90% in all cases except improved relationships, which was 100%. The section below on methodological issues in retrospective studies contains a discussion of results involving such high percentages.

Gudat (2002) studied 309 subjects who had completed Bioenergetic Analysis. From their therapists he collected data on demographics, diagnosis, character structure, course of treatment, and outcome. A subset of 90 clients also completed a questionnaire designed to retrospectively measure change in psychotherapy. The clients completing the questionnaire reported large and significant levels of change in the desired direction. Regarding therapist ratings of client change, Gudat found that 86% improved significantly, with more than half achieving full remission of their condition. Gudat also conducted a number of interesting case control analyses by stratifying the sample along demographic or clinical variables. (Stratifying means dividing the sample into subgroups according to how they scored on a particular variable.) Some of these results were interesting, and are worthy of further study. For instance, stratifying the sample using the Global Assessment of Functioning Scale (GAF) revealed that the half of the sample with lower GAF scores (greater levels of impairment) improved more than did the half of the sample with the higher GAF scores (lesser levels of impairment). This has not always been the case in studies of verbal psychotherapy (see Garfield, 1994).

Johnson (1974) performed the only retrospective study that compared clients in body psychotherapy to clients in verbal therapy. He surveyed 23 clients of one behavioral/eclectic therapist, 28 clients of two psychoanalytic psychotherapists, and 39 clients of two Bioenergetic therapists. The mean number of sessions was longest for psychoanalytic psychotherapy, somewhat shorter for Bioenergetics, and shortest for behavioral/eclectic, although it must be remembered that not all clients had finished therapy. The clients in each modality said that they benefited from therapy. Therapeutic benefit on most items was not significantly different between modalities. The Bioenergetic clients, however, rated their therapy as more painful and disruptive than did clients of the other two modalities. There were large differences between the samples in several important variables, such as whether or not the treatment was continuing or finished. The findings of the study are most likely confounded by these differences. On some measures, Johnson found that differences between practitioners within modalities were larger than differences between modalities, an interesting finding that has also been noted in the verbal psychotherapy literature (Beutler, Machado, & Neufeldt, 1994).

Ventling (2002) gathered data on demographics, length of therapy, diagnosis, and character structure from every Bioenergetic therapist in Switzerland for all clients that were seen from January, 1991 to December, 1996. She then attempted to retrospectively survey those clients who had experienced a minimum of 20 hours of Bioenergetic therapy. About 23% of the total population seen in Bioenergetics remained in therapy for a minimum of 20 sessions; of that group, the mean number of sessions was 91, indicating that these were long term therapies. One hundred forty-two completed questionnaires were returned. This represented 49% of those sent, and 10.2% of all Bioenergetic clients.

The clients were predominantly between the ages of 30 and 50, and were 64% female and 36% male. Fifty-eight percent had been diagnosed with neurotic, stress, and somatic symptoms (ICD-10 F4 group). The rest of the ICD-10 diagnostic groups were each represented by fewer than 13% of the subjects. Compared to before therapy, subjects rated their functioning at termination as better in all areas surveyed: psychological well-being, relational problems, physical suffering, and quality of life. Since clients were contacted well after the termination of the therapy, change post-termination could also be surveyed. About 66% of all clients reported continued gains post termination, almost as strong a finding as the gains for the therapy experience itself. This interesting finding raises questions regarding the actual cause of the reported improvements. If clients improved almost as much after their therapy as during it, could the cause of improvement be something other than the therapy? Could the entire result reflect an optimistic response set rather than actual change during treatment? One simply cannot know without further study.

West (1992, 1994) sent surveys to every client who terminated Energy Stream therapy (a Reichian therapy in England) during 1990-91. He received responses from 68, representing 45% of the population. This is a very large percentage for such a study. Twenty-five percent terminated within three months, and another 14% did so by six months, though the mean length of treatment was 17 months. These findings compare to findings in the general psychotherapy literature that about 25% of therapy clients quit after the first interview, and that more than half quit before the 10th (Garfield, 1994), and to Ventling's (2002) findings (discussed above) that 77% terminated before 20 sessions, but for those that stayed, the mean number of sessions was 91 (about 22 months). Seventy-seven percent of West's sample was satisfied or highly satisfied with their therapy. Not surprisingly, almost all dissatisfied and neutral clients terminated within the first six months. Clients for whom Energy Stream was the first therapy experience were significantly less satisfied than were clients who had previous therapy experience.

West also studied the frequency with which specific Reichian and non-body oriented techniques were used during the therapy, and whether clients experienced each technique as helpful. He found that specific body-oriented techniques, such as breathing or massage, were frequently used and rated as helpful by about 2/3 of the subjects. But general factors that should also be common to many verbal therapies, such as listening to the client, and helping the client identify feelings, were even more frequently used and even more helpful.

West's findings raise interesting and important questions about the nature of the therapeutic effect of body psychotherapy. More study needs to be done to address these questions more fully.

Trends and Methodological Issues: Retrospective Surveys

One issue faced by all retrospective surveys occurs because retrospective recall of previous psychological state, such as how one felt or how well one was doing, is particularly unreliable. (Henry, Moffitt, Caspi, Langley, & Silve, 1994). Retrospective studies of psychotherapy investigate precisely this domain, however. Some authors have suggested that retrospective surveys may not measure actual change in psychotherapy, but rather current attitudes towards the therapist and the therapy. Those attitudes are significant and important, but they are different from measures of actual change. (Kasdan, 1998)

A second concern that must be kept in mind involves the fact that these retrospective studies were performed with self-report surveys. Henry and his colleagues (Henry et al., 1994) discovered that retrospective self-report was vulnerable to systematic bias. The source turned out to be an optimism common to all self-report, whether concurrent or retrospective. "Eighty percent of American men think they are in the top half of social skills; the majority of workers rate their job performance as above average; and the majority of motorists (even those who have been involved in accidents) rate their driving as safer than average." (Seligman, 2002, p. 37) By definition, however, only half (50%) can be above average. When normed psychological tests are used to collect self-report data, subjects' responses are compared to the answers of those in the normative group. Since both groups are similarly affected by optimism, the bias is controlled. Retrospective surveys, however, typically use surveys that are not normed, and thus, subjects' responses are not compared to normative groups. Thus, control of this bias is lost. One result is that retrospective surveys of psychotherapy usually find very high levels of improvement (satisfaction). In the Consumer Reports Study, for instance, of those who said they were feeling "very poor" when they began therapy, 87% were feeling "so-so," "good," or "very good" by the time of the survey. In a retrospective survey, 80-90% percent satisfaction is an average result, and the results summarized above need to be interpreted in this light.

Third, one must be alert to distortions arising from sampling issues. Some of the studies reviewed above accepted only clients that remained in therapy a set number of sessions. We might rationally suspect, and West's findings confirm, that such a strategy systematically eliminates those clients who did not do well or did not like the therapy. Even when an attempt is made to contact the entire population of clients, this problem arises. West received completed surveys from 45%. This is an unusually high number, but it is still less than half of the population. We might suspect that those who felt warmly about the therapy are overrepresented among those who completed the survey, while those who were somewhat unsatisfied might be underrepresented. This sort of sampling problem affects all studies where subjects are not randomly assigned to treatment and control groups.

Thus, there are significant methodological problems common to all retrospective surveys that limit the confidence one can place in these six. Nevertheless, these studies provide important data about the kinds of clients being seen in body psychotherapy. They were a relatively highly educated adult population suffering primarily from neurotic or stress related symptoms or from affective disorders. They seemed to feel that body psychotherapy had been helpful on a wide variety of general psychological factors, at rates that are roughly equivalent to rates found in large surveys of verbal psychotherapy. There was considerable agreement that body psychotherapy is a long-term process. Each of the following was suggested by one study, but needs further confirmation: 1) body psychotherapy may be better at helping with general psychological factors than at altering specific symptoms or behaviors; 2) it may be better appreciated by clients with a previous psychotherapy than by those new to psychotherapy; 3) it might subject clients to somewhat more discomfort and disruption than does verbal psychotherapy; and 4) the most helpful elements may have nothing to do with specific body interventions, but rather with the way the therapy allows for the provision of non-specific therapeutic factors that would be common to most therapeutic approaches.

Efficacy studies

Efficacy studies focus on specific interventions, often specified in a treatment manual, and therapist adherence to the manual is often audited as part of the study. They focus on well-defined groups of subjects, made homogeneous through the use of extensive pre-screening procedures. They seek to control or eliminate as many potentially obscuring extraneous factors as possible. In so doing, they maximize internal validity (increase

the ability to draw conclusions from the results of the study). However, they also tend to create conditions that are laboratory-like, poor approximations of the real world or the conditions under which a treatment is used (Nathan, Stuart, & Dolan, 2000). The blind clinical trial is the prototypical example of an efficacy study. I found nine efficacy studies of body psychotherapy.

Clance, Thompson, Simerly, & Weiss (1994) exposed 15 university undergraduates to eight weekly group sessions involving body-oriented Gestalt exercises. Pre- and post measures included measures of attitudes towards oneself and one's body, and of differentiation. Findings were that the Gestalt exercise group improved participant's attitudes towards body and self more than did the control group condition. Changes were larger for males than for females.

Cote, Jobin, Larouche, Desharmias, Dumont, & Trembley (1991) exposed patients recovering from a heart attack to four rehabilitation programs. Each program included walking at home and one of the following: a three-hour weekly Radix group for 10 weeks, three 90-minute exercise groups per week for 10 weeks, a combination of those two programs, and no additional treatment. They measured whether these groups had improved self-actualization using a single measure with 12 subscales. They found that subjects quit the Radix program at rates that were higher than the other groups. On only one of the 12 subscales did gains in self-actualization differ between groups, and even that was because of an inappropriate statistical analysis. Thus, this study seems to have found that Radix was not successful in increasing self-actualization in this population.

Ljiljana Klisic (date unknown) performed one of the most interesting studies of body psychotherapy. Unfortunately, the only report available in English is a personal communication sent to Charles Kelley, who kindly provided a copy to me. Klisic asked six psychodynamically oriented therapists to refer clients who had reached a "standstill" in their therapy. Klisic then provided a brief Radix "intervening technique" consisting of intensive (3 hour) sessions organized several times during a 6-7 day period. The clients then returned to their regular psychotherapy. Effects of the intervention were measured with a scale given to the clients at the end of the intervention, and by a scale completed by the therapist 5-6 sessions after the return of the client. A control group received the same procedure, but the intervention consisted of warm, interested verbal contact from the intervening therapist. From client self-report, Klisic found that the Radix intervening technique had significant and meaningful positive effects compared to control. The psychotherapists reported that the control group did not help resolve any standstills, while the Radix intervening technique helped resolve some standstills. In no cases did it intensify the standstill or derail the psychotherapy.

Thus, Klisic's research seems to point to a potential role for body psychotherapy that has not been much discussed in the literature: as a brief adjunct to verbal psychotherapy at times when the verbal psychotherapy seems to have become stuck. The main caveat here is that Klisic's "n" is small. The study needs replication with a larger sample.

May, Wexler, Salkin, & Shoop (1963) studied the use of a movement intervention they called Body Ego Technique with long-term hospitalized psychotics. Some subjects received the technique in individual sessions, others in group sessions, and still others constituted a no-contact control group. Change was measured with ratings made by a psychiatrist who was blind to treatment group. The authors of this study note that in this population, cooperation with treatment is a major difficulty, and that the group experience elicited more non-cooperation than the other two conditions. The authors also caution that one should not expect large gains in this population. They found that more subjects who participated in the individual technique made gains than did those in the control group, but the gains were small. In the group technique also, those who participated showed more small gains than controls. Those who refused to participate did not. Thus, these authors seemed to find that their body ego technique was not a magical cure for these serious psychotic illnesses, but that it was able to produce small gains in some subjects.

O'Grady (1986) studied the use of somatic exercises and a Gestalt two-chair exercise to help subjects resolve a conflict related to their careers. Twenty subjects constituted a verbal discussion control group. Twenty received a single experience using the two-chair technique, and 20 received an intervention consisting of the two-chair technique preceded by a brief sequence of Bioenergetic grounding exercises. Compared to the control and two-chair-only group, the somatic-plus-two-chair group experienced significantly larger decreases in discomfort and vocational indecision and a significant increase in conflict resolution and feelings of integration and optimism. There were no differences in state anxiety or feelings of personal power.

It is surprising that such a limited intervention as was used in this study could have such measurable effects. On the other hand, perhaps it corresponds with the findings from the Klisic study that body oriented interventions can potentiate other interventions.

Peterson & Cameron (1978) studied the use of an intervention that combined movement therapy with progressive relaxation to reduce anxiety in a small day treatment and outpatient sample whose daily functioning was impeded by their high level of anxiety. They found that the treatment group did not improve significantly more than did the no-contact control group on a self-report measure of anxiety or on a physiological measure.

Petinatti (2002) compared the effectiveness of several body psychotherapy modalities in elderly female subjects suffering chronic pain from osteoarthritis and/or osteoporosis. Measures consisted of several self-report surveys directed towards pain and/or somatic problems. Treatment groups, to which subjects were randomly

assigned, consisted of an attention control group, Reiki, Focusing, Zero Balancing, and Rubenfeld Synergy. The modalities were selected to parse out the energetic, verbal, and touch elements that the author felt are combined in Rubenfeld. Each group received five sessions. Differences in change scores between groups were not statistically tested for significance. However, eyeballing the results revealed that 60% of the control subjects became worse and none improved, 30% of the Reiki group improved and 70% remained the same, 40% of the Focusing group improved and 60% remained the same, 60% of the Zero Balancing group improved and 40% remained the same, and 90% of the Rubenfeld group improved while 10% remained the same. If one accepts Petinatti's hypothesis that Reiki, Focusing, and Zero Balancing parse the contributions of energetic, verbal, and touch elements, then these frequencies represent a rough comparison of their contribution as a curative factor.

As Petinatti herself pointed out, this was a pilot study, and these conclusions need to be viewed critically. She did not use a statistical analysis of her data, and it is not clear why - the data would seem to lend themselves to it. These are promising results, however, and should be followed up. Her approach of attempting to parse the effects of energetic, verbal, and touch elements seems particularly useful.

Price (in press) compared the effects of body-oriented psychotherapy to massage therapy in helping adult victims of child sexual abuse. This study is noteworthy for the care with which subjects were recruited, the precision with which the treatments were manualized, and the steps that were taken to ensure the safety of the participants. Each treatment condition consisted of eight sessions during a 10-week period. A number of measures of psychological characteristics, somatic symptoms, and connection to body were used, and repeated measures were taken before, during, and after the treatment. Participants in both body treatment conditions experienced significant linear improvements over time in psychological well-being, bodily symptoms, and bodily connection. There were no differences between groups in the quantitative analysis. Several between groups differences that may be worthy of further study emerged in a qualitative portion of the study, but that part of the study is beyond the boundary of this review and is not considered here.

Sullins (2002) studied the effects of Rubenfeld Synergy on subjects suffering from fibromyalgia. Treatment consisted of five individual Rubenfeld Synergy sessions vs. a waiting list control group. Measures included a variety of self-report scales focusing on psychological variables and physical symptoms. Sullins found that subjects in the Rubenfeld Synergy condition experienced a greater reduction in pain and a greater reduction in the level of life interference from pain than did the control group. There were no differences on 13 other comparisons conducted. See below for a discussion of the interpretation of inconsistent results such as these.

Trends and Methodological Issues: Efficacy Studies

These studies are tightly focused. The fact that a therapy was found effective in creating one type of change with one type of client population does not mean the same would be true for other types of change or other client populations. Similarly, when the treatment was not found to be effective, consider whether it was reasonable to expect a positive result. For instance, Cote et al. (1991) studied the effect of Radix on self-actualization in patients recovering from a heart attack. It is not immediately clear why such patients would feel interested in self-actualization, or why Radix would be expected to be useful in heart attack recovery. Thus, Cote et al. may have obtained negative results because they were conducting a test for which there was not a reasonable rationale. If they had tested the effects of Radix in helping patients cope with post-infarct depression, or if they had studied the effects of Radix on self-actualization of clients at Esalen, perhaps they would have found positive results.

Second, in both efficacy and effectiveness studies, researchers are encouraged to use multiple measures, and if possible, to make measurements from more than one perspective. This strategy helps to control for error associated with one measure or with one perspective (the optimistic bias discussed above in the section on retrospective studies would be an example of an error associated with the self-report perspective). Thus, studies that measure from multiple perspectives, such as self-report and therapist ratings, or self-report and physiological measures, are often given more weight than those that measure from only one perspective.

A drawback to the multiple measurement strategy, however, is that results between measures can be inconsistent: some show a therapeutic effect, others show none. In such instances, readers have to determine the best way to interpret the results. Should each measure be considered independently, in which case it may be determined that a therapeutic effect was demonstrated on one characteristic (e.g. body awareness), but not on another (e.g. depression). The O'Grady (1986) study is one that I believe should be interpreted this way. In other cases, measures should be considered to have substantial overlap, measuring different aspects of one construct. The subscales of a psychological test often correlate with each other significantly, and show significant correlation with other measures and subscales. In this latter case, inconsistent results may be considered as something more like a vote: three measures found a therapeutic effect, but seven did not, therefore the conclusion is no therapeutic effect by a vote of seven to three. The Sullins (2002) study is one that I believe should be interpreted this way.

The trend of these nine efficacy studies is not overwhelming, but is supportive of body psychotherapy. Five showed clear positive results, and another found that the body psychotherapy and control group both significantly

improved. All three of the studies with negative results tested body psychotherapy in situations where it may not have been reasonable to expect positive outcomes. Thus, they may not be fair tests of body psychotherapy. Although the results are supportive, one must keep in mind that these tightly focused studies are too few in number to begin to fill in a picture of body psychotherapy. Much of the puzzle is yet obscured, and a great deal more study is needed before it is revealed.

Effectiveness studies

Effectiveness studies attempt to determine if treatment approaches are feasible and describe their effects in real life situations. They often involve broad, mixed populations of subjects that are sometimes selected based on the need for treatment rather than pre-screening criteria. Clinical considerations, rather than the experimental protocol, frequently determine the duration of treatment and the conditions under which treatment is administered. The treatments themselves usually do not reflect manualized treatment protocols, but rather the usual repertoire of therapeutic techniques provided by the therapists in the study. Effectiveness studies have the advantage of most closely representing real world experience with the treatment. However, they frequently leave extraneous factors uncontrolled. This weakens the ability to draw conclusions from the results of the study: frequently, alternative explanations for the observed results cannot be ruled out. Many current authors acknowledge the need for both efficacy and effectiveness studies in a program of psychotherapy research. (Nathan, Stuart, & Dolan, 2000). I found 18 effectiveness studies of body psychotherapy.

Djalali (1978) studied the effects on self-concept and attitudes towards one's body of a 24-hour Bioenergetic marathon compared to the effects of a verbal marathon and to a no-contact control group for poly-drug addicts in an inpatient drug treatment facility. Djalali found a few statistically significant differences between pretest and posttest scores on some variables for both marathon groups. However, given that his analysis included over 400 separate t-tests, one would expect there to be 20 spuriously significant t-tests. Thus, one cannot know for sure, but it is likely that his few positive findings were spurious.

Fernandez, Turon, Siegfried, Meermann, & Vallego (1995) compared the effects of two treatment programs, one of which included a body psychotherapy component, in the treatment of anorexia nervosa. Although they found that the treatment program that included body psychotherapy achieved results more quickly than the other program, methodological problems make it impossible to draw any conclusions. There were many differences between treatment groups: the two groups differed at pretest on the severity of comorbid psychological conditions, the treatment programs were located in different hospitals in different European countries, and one treatment approach was primarily cognitive behavioral, while the other was behavioral-family with an added body psychotherapy component. These differences could easily be more important than the inclusion of body psychotherapy in one program, and thus, no conclusions can be drawn.

Foulds & Hannegan reported two separate studies of the effects of Psychomotor Psychotherapy. In both studies, subjects were college undergraduates randomly assigned to a Psychomotor group that met once weekly for eight weeks or to a waiting list control group. In one study (Foulds & Hannegan, 1974), subjects were tested pre-, post-, and follow-up with a measure of attitudes towards self and other. In the other study (Foulds & Hannegan, 1976), subjects were tested with measures of locus of control and tendency to portray oneself in socially desirable ways. Both Psychomotor groups changed in the desired direction on all measures used, while neither control group changed on any measure.

Giddens (1984) compared the effects on attitudes towards self and body of a 12-week body psychotherapy group, a 10-week verbal psychotherapy group, and a no-contact control group. There were no differences in change scores between the body psychotherapy and verbal psychotherapy groups on any of the variables. The body psychotherapy group changed more on two measures than did controls. Because of the large number of repeated independent tests (33), 1-2 spuriously positive findings would be expected in this study. In addition, there was considerable overlap in the variables Giddens studied. Thus, Giddens's study may be a case where the findings should be taken as a 31-2 vote that there was no difference between these groups on these variables (see discussion of interpreting inconsistent results above).

Hanratty (2002) reported a complex study to test the effects of Holotropic Breathwork and to test a model designed to predict who will benefit from psychotherapy. Only the material related to the first goal is considered here. Subjects were participants at a seven-day national Holotropic Breathwork workshop. There was no control group. Subjects were found to be higher on hypnotizability than the general population, and to be more likely to describe themselves in socially desirable ways. At posttest participants showed reduced negative affect, reduced psychological distress, and no change in death anxiety. It was further found that experienced and novice breathworkers did not change at different rates on any of the measures.

Holmes (1993) studied subjects in ongoing verbal psychotherapy groups. One-half received a six-month experience of Holotropic Breathwork in addition to their verbal work, the other half did not. The breathwork group showed a greater reduction in death anxiety and greater improvement in self-esteem than did the verbal-therapy-

only group. The groups did not differ on change in sense of affiliation. This study is yet another that seems to show that body psychotherapy can be effective when used as an adjunct to an existing verbal therapy.

Karle, Corriere, & Hart (1973) have published two reports of the same study (see also Corriere & Karle, 1971). They compared physiological markers for three groups: a group experiencing a Primal intensive, a group participating in active exercises, and a group that read and talked. They measured blood pressure, pulse, and rectal temperature daily at the beginning and at the end of the respective groups. Because the measures they took are so variable, they aggregated for each group the total number of increases, decreases, and no changes across subjects and across the three weeks of the study. They found that the Primal group had more decreases in pulse rate than the other groups and a large decrease in rectal temperature where the other groups had none. They found no significant changes in blood pressure in any of the groups. The authors also measured EEG patterns in the Primal group only, finding a slowed frequency of brain waves after the three week intensive. These findings are intriguing and beg for replication with other modalities of body psychotherapy. Many years of experience with physiological measures, however, have taught us that their meaning is not always clear and direct, and that they must be translated into psychological meaning with care. (Fox & Card, 1999)

Koemeda-Lutz, Kaschke, Revenstorf, Scherrmann, Weiss, & Soeder, (2003) reported preliminary results on a subset of subjects from a large, multimodal study. They attempted to collect data on 25 clients in each of eight modalities of body psychotherapy, for an overall N of 200. They collected data at intake, six months, and termination. The preliminary report summarizes results for 157 cases (intake), 78 cases (six months), and 21 cases (termination). Demographics of the sample are not detailed, but described as similar to those found in other studies (see Ventling, 2002, above). Thirty-four percent of the sample was given an ICD-10 F4 group diagnosis (neurotic, stress-related, and somatoform disorders), and 29% were given an F3 diagnosis (affective disorders). At six months, average scores for anxiety, depression, general symptoms, physical discomfort, and interpersonal problems all decreased significantly, and self-efficacy increased. At termination, gains on all measures were greater than at six months, and effect sizes were large. Several of the measures used have published cut-off scores, above which the finding is thought to indicate a clinical disorder. The percentage of scores at or above cut-off scores on these measures decreased significantly from intake to termination. (See also their article in this issue)

So far, the data reported by this group of authors is only preliminary, and (at termination) represents only about 10% of their desired N. Thus, it is premature to draw conclusions. However, this study holds great promise, as it is a well-constructed outcome study that explores results for several modalities of body psychotherapy and which has a large overall N.

May (1997) conducted a small pilot study on three participants in a Radix group. The study explored the use of the standard set of training sessions distributed by the Radix training program as a manual of treatment for use in research, and the use of measures of life satisfaction, personality, and clinical symptoms as measures of aliveness (vitality), character pathology, and current symptoms. He found that the standard set of training sessions became too repetitive towards the end of the study, and did not allow sufficient flexibility to represent Radix as it typically may be practiced. The three measures all worked well. He found that his group of three participants made significant gains in aliveness. They also made gains in an overall measure of character pathology, but the gains were not statistically significant (most likely due to the low power of the study due to the small N). And no change was observed on current symptoms.

May & Swafford (2000) used a combined one-group-pretest-posttest and repeated measures design to explore the effects of a Radix workshop on anxiety and on the expression of anger. The workshop did not affect participants' experience of either state or trait anxiety. The State Expression of Anger Scale on the State-Trait Anger Expression Inventory proved to be an unsatisfactory measure due to floor effects - too many subjects scored at the lowest possible score too much of the time. Subjects did not change on five scales measuring trait expression of anger, but did on one: they had more outward expression of anger after the workshop. Because of substantial overlap in the domains measured by these trait anger expression scales, the results are probably best viewed as a vote 5-1 that the workshop did not significantly change anger expression in these subjects.

McInerney (1974) studied pre- and posttest changes in pulse and body temperature in subjects undergoing Primal Therapy. Using a different statistical approach, his results confirmed those of Karle, Corriere & Hart (1973, see above): subjects experienced statistically significant and physiologically meaningful reductions in pulse and body temperature. While this effect now appears to be a confirmed finding, as noted above, experience with physiological measures has taught us that caution is needed in interpreting their meaning into the psychological realm. (Fox & Card, 1999)

Miller (1979) studied the effects of Bioenergetic therapy on 33 clients seeing 12 Bioenergetic therapists. Measures were taken at the beginning of treatment, after four months, and after nine months. Miller found that at four months, subjects' scores had improved on every scale of a measure of personality (MMPI), every scale of a measure of mood state (POMS) and both scales of a measure of self-actualization (POI). These differences increased at nine months. Like the findings of Koemeda-Lutz et al. (2003), Miller's results were obtained with a sample of subjects drawn from a wide variety of therapists. This increases the likelihood that they are representative of Bioenergetic therapy in general. However, unlike the Koemeda-Lutz et al. study, Miller's design

is a one-group pretest-posttest design, which does not rule out a number of important alternative explanations for the observed gains. Thus, while it is clear that these clients improved, confirmation with a study using a control group is needed before one can be sure that the Bioenergetic therapy was responsible for the gains. For a further discussion of these issues, see any good text on research design, such as Kazdin (1998), or Campbell & Stanley (1963).

Moran, Watson, Brown, White, & Jacobs (1978) studied the effects of an intervention they called Systems Releasing Action Therapy in a population of inpatient VA alcoholics. All were already involved in intensive therapeutic interventions through the regular hospital program. The control group received no additional SRAT, the experimental group received 10 one-hour-long sessions of SRAT over three weeks. Forty-seven psychological, physiological, and behavioral measures were taken. The treatment group showed significantly more improvement on seven of them at posttest, where only two such findings would be expected by chance alone. However, at 6-month follow-up, the differences had disappeared.

Pressman (1993) compared the effects of six sessions of Holotropic Breathwork over 12 weeks to a control group that listened to music on a similar schedule. They were tested with measures of mood state, psychiatric symptoms, and humanistic spiritual orientation. Both groups showed statistically significant improvement on most variables, and the improvements made by the breathwork group were much larger and more clinically meaningful.

Ross (1982) compared the effects of upper body exercises (calisthenics), lower body/pelvic exercises (Bioenergetic grounding exercises), and a no exercise control condition on the sexual functioning/satisfaction of a normal population. All groups met once weekly for five weeks. Ross found preexisting differences between groups on some of the variables he studied. At posttest, he found no differences between any of the groups, except in instances where the differences were attributed to the preexisting differences.

Wagner (1981) studied the effects of Bioenergetics and progressive relaxation on recent young adult admissions to a state mental hospital. All participants participated in the regular daily therapeutic regime of the hospital. In addition, for 20 days one group received a daily 30-minute Bioenergetics experience, one group received a daily 30-minute progressive relaxation group, and the control group received a daily 30-minute casual discussion. As this was a hospitalized group, it is worth noting that "neurosis" and "personality disorder" were the most common diagnostic categories, and "psychosis" only accounted for 17% of the sample. Wagner found that the Bioenergetics group improved significantly more than did the other groups on some self-concept subscales. There were no differences between groups on measures of behavioral adjustment or locus of control. This study is probably an example where the findings should not be taken as a vote against change, but rather as evidence that the Bioenergetics group improved some aspects of self-concept, but not behavioral adjustment or locus of control.

Weigle (1992) studied the effects of a breathing intervention he synthesized from a number of other breathing-oriented techniques, such as Holotropic Breathwork and Pranayama. He had problems with attrition, and there were no significant changes in the group that completed the study.

Trends and Methodological Issues: Effectiveness Studies

The methodological issues discussed regarding the efficacy studies also apply to these studies. Nine of the 18 studies found positive effects, two found equivocal effects, six had negative results, and one was felt to be methodologically compromised. One of the studies with negative results actually showed positive results at termination of therapy, but these gains disappeared at follow-up. As above, the overall trend is supportive of body psychotherapy. I can find no evident explanation for the varied results of these studies - there do not seem to be systematic differences in the validity of the rationale for the study, the methodological soundness of the study, or the professionalism with which the treatment interventions were delivered. Apparently, more study will be required before this mystery is solved.

Summary and Discussion

The results of my search for outcome literature on body psychotherapy revealed that it was not easy to find and required significant effort on the part of the researcher. Hopefully, this review will guide future researchers and help focus their efforts. PsychINFO, the APA database, can be accessed by university students through their university library. Those who are not APA members and who don't have access to a university library, can access it for a fee at <http://www.psycinfo.com/psycinfo>. To search Dissertation Abstracts International, one must go to a university library reference room. Using their computers, one can search the database and make printouts. Once one has printouts, one can use one's own computer to obtain copies through University Microfilms International. They are in the process of moving their web site, but the web address I used was <http://wwwlib.umi.com/dxweb>. If this doesn't work, try googling "ProQuest." You can order a copy of any dissertation they carry for a fee. If you seek a thesis, or if the dissertation is not carried by UMI, then you can order a copy through the library of the university where the thesis was written.

Thirty-four studies are more than I expected to find. However, it is a small number compared to the many thousands that exist for verbal psychotherapy. With eight outcome studies Bioenergetics is the most studied body psychotherapy modality - the Gudat (2002), Ventling (2002), and Miller (1979) studies are particularly supportive and strong. Radix, Holotropic Breathwork, Psychomotor Psychotherapy, Gestalt Therapy, Primal Therapy, and Rubinfeld Synergy all have more than one outcome study. There are prominent forms of body psychotherapy that have none, however. With each passing year, this omission becomes more serious.

These 33 outcome studies test body psychotherapy in a wide range of circumstances with a wide range of client populations. There is confirmed evidence that some types of body psychotherapy produce alterations in physiological markers, though the meaning of that change needs to be explored. There is confirmed evidence that body psychotherapy can be an effective adjunct to verbal therapy under certain circumstances. There is confirmed evidence that body psychotherapy improves attitudes towards self and towards one's body in several different subject populations. There is confirmed evidence that clients value their body psychotherapy experiences and feel that they benefited from them at rates roughly equivalent to those found for verbal therapy. There have been a couple of large studies of body psychotherapy as it is typically provided in private practice that found it to be helpful on a wide variety of general psychological factors. On the other hand, there has been a substantial group of negative findings, as well. The reasons some studies have positive findings and some negative are not yet well understood. The notions that body psychotherapy is vastly superior to verbal therapy, and that it represents a paradigm-shattering transition into a new age, are not supported by the results of these studies.

Retrospective studies are the most limited in terms of what one can conclude about outcome. However, they are the easiest to do, and the repeated finding that large percentages of clients are satisfied is very persuasive. In addition, they provide important data about the characteristics of body psychotherapy clients. These kinds of studies can be performed by anybody with access to a large sample of clients who are in or have recently terminated body psychotherapy. Training institutes, growth centers, and clinics are all potential sources.

Effectiveness studies are the next easiest to do, and can lead to powerful conclusions and results. This sort of research can best be carried out by any organization that has access to a source of clients. For training institutes, subjects could include the trainees who are receiving their own personal work, as well as the supervised clients they see as part of their training. For clinics, subjects could include those seeking treatment services. All of these classes of potential subjects could be assessed at intake and at termination with standardized assessment procedures. This could be part of the standard procedure of the training institute or clinic, and could be used for treatment planning, discharge planning, and ongoing program evaluation. Networking with students at a university or body psychotherapy graduate program who have to produce a paper as part of their graduate program, could provide the manpower to conduct the study, as well as access to the consultation of the research faculty to guide the study.

Efficacy studies are the most difficult to carry out, and require the most careful control. They require access to a large source of subjects, so that homogeneous groups can be recruited and randomly assigned to the various treatment groups in the study. Thus, they are most easily done with the careful cooperation of a treatment clinic and an experienced researcher to design the study, manualize the treatment, and select the subjects. They are the most widely accepted test of whether or not a treatment works, however (they are sometimes the only type of study accepted by front-line scientific journals). Thus, they may be worth the cost and effort required.

I would like to close by noting that USABP has a standing Research Committee. To date, the Committee's primary function has been to produce conference presentations on body psychotherapy research and to award monetary prizes for outstanding studies on body psychotherapy. Two of the studies reviewed above (Ventling, 2002, and Koemeda-Lutz et al., 2003) are previous recipients of this prize. In addition, the Committee has an interest in encouraging, facilitating, and when necessary, consulting on additional research on body psychotherapy. Interested parties should contact the Research Committee through the USABP main office.

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Appendix I.

Terms searched on the PsychINFO database for the years 1967-2004 and on Dissertation Abstracts International. (** is a truncation search term. J* finds John, Joe, Janet, Jilian, etc. "W/x" means "within x number of words of." For instance, "w/4" means "within four words of." "Adj" means "adjacent to.")

Baker, E*; Boadella, D*; Boysen, G*; Boysen, P*; Brown, M*; Caldwell, C*; Cassius, J*; Conger, J*; DiCenso, G*; Erskine; Grof, S*; Growell, E*; Heller, M*; Keleman, S*; Kelley, C*; Kurtz, R*; Ligabue, S*; Liss, J*; Lowen, A*; Marcher, L*; McNeely, A*; Meyer, R*; Moser, T*; Pesso, A*; Pierrakos, J*; Proskauer, M*; Rispoli, L*; Roth, N*; Sharaf, M*; Stepski-Doliwa; Stolze, H*.

Bioenergetic; Body w/4 therapy; Breathwork; Core Energetic; EMDR; Gestalt (and) therapy (not) Bender (and) language=English; Hakomi; Holotropic; Orgone; Orgonomy; Primal; Radix; Sensorimotor (and) psychotherapy; Somatic w/3 psychotherapy; Therapeutic Touch; Yoga.

Names and terms searched for the years 1998-2004 on PsychINFO and on the whole Dissertation Abstracts International database.

Cornell; Downing, George; Grand, Ian; Klopstech; Ludwig, Mark; Marlock; Ogden, Pat*; Resneck-Sannes; Schmidt-Zimmermann; Totton; Ventling; Weis adj Halko.

Biography

John May, Ph.D. is a clinical psychologist in private practice in St. Louis, MO. His body psychotherapy training was with the Radix Institute. He has served on the Ethics and Research Committees of USABP, was Editor of the Journal of the Radix Institute for a few years, and served on the Committee on Therapist Sexual Misconduct of the Missouri Psychological Association.

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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., background 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?

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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 precede 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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