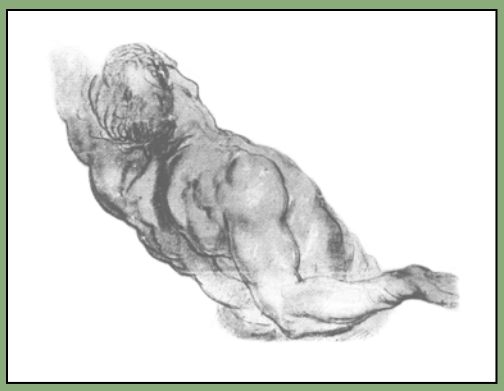
the usa body psychotherapy journal



The Official Publication of

THE UNITED STATES ASSOCIATION FOR
BODY PSYCHOTHERAPY

Volume 4 Number 2 2005

Table of Contents

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 USA Body Psychotherapy Journal
Editorial, Vol. 4, No. 2, 2005

This issue of the USABP Journal is dedicated to research. For whom do we design and publish research? For ourselves? Our colleagues? The larger medical or healing or helping community? The answer to that question affects the design, execution and certainly the outcome of any project. In a newly burgeoning field such as body psychotherapy, we must not only seek knowledge of the intricacies of human beings, fascinating and useful as that is in and of itself. We also want to be able to communicate with our peers in psychology and the other social sciences. Sociopolitical realities and financial considerations oblige even clinicians with no research interests per se to be familiar with body psychotherapy research. Not only can it inform the way we practice, but it can also help us to explicate our work to psychological, medical, and other helping professionals.

As Dr. Margit Koemeda-Lutz points out in her excellent introduction to our lead article, "Health professionals have an ethically imposed duty to have their services guided by most recent scientific findings, to take part in educational training programs and to continuously evaluate the effectiveness of their therapeutic work…"Dr. Koemeda-Lutz and her colleagues were honored with the USABP Research Award at the 2005 USABP Conference for their presentation of the preliminary results from a multi-center study of patients in outpatient clinics in Germany and Switzerland. In our lead article, they compare outpatients in body psychotherapeutic treatment with a matched sample of other psychotherapeutic patients…." Three questions guided design of the study:

1. What kind of patients ask for outpatient body psychotherapy?
2. how much do patients improve during treatment?
3. Can these results be preserved after the termination of treatment?

Looking at data from standardized tests administered before treatment, at 6 months of treatment, and after 2 years of treatment, they found interesting differences between the two groups which are detailed in their article.

The student research award went to Amelia H. Kaplan and Laurie F. Schwartz for their pragmatic case studies of two of Ms. Schwartz's patients. Utilizing videotapes, transcriptions of selected sessions as well as standardized tests and pre- and post-therapy interviews, they present us with what Clifford Geertz in *The Interpretation of Cultures* (New York: Basic Books, 1973), would have called "thick description." Although he is speaking of cultural analysis, he could well be depicting sophisticated clinical psychological research when he suggests that its import lies in "…guessing at meanings, assessing the guesses, and drawing explanatory conclusions from the better guesses, not discovering the Continent of Meaning and mapping out its bodiless landscape." (p. 20). HE goes on to point out that therefore, "the essential task of theory building here is not to codify abstract regularities but to make thick description possible, not to generalize across cases, but to generalize within them…called…[in] depth psychology, clinical inference." (p. 26). By presenting the therapist's theoretical approach and her thoughts about how it applied to each patient as she tracked their different patterns of progress, the cases in this study take on a richness which fleshes out the quantitative measures employed by these two investigators.

A similar approach to data reporting is taken in one of the earliest studies in body psychotherapy, undertaken in the late '70's by Drs. Alice and Harold Ladas, but never published. They include both quantitative results and quotations from survey questionnairs.

Dr. Ladas provided the following narrative of how this study came about:

> In 1977 at a Bioenergetic Conference in Waterville Valley, women Bioenergetic Analysts met separately from the men. The following season, a number of women therapists met for 10 sessions in New York City. Alice Ladas served as secretary. Attendees appeared reluctant to express their beliefs openly in the presence of trainers...even though female. So the Ladases decided to give women a chance to express their beliefs and feelings anonymously. "Women and Bioenergetic Analysis" is the result. Rather than welcoming the study, which supported the efficacy of the therapy, while challenging some of the theories of Al Lowen about womens'sexuality,(Reich and Lowen descended from Freud who believed a woman immature unless she transferred her focus on her clitoris to her vagina.)
>
> Women and Bioenergetic Analysis, one of the earliest valid research projects in body psychotherapy, was not published in the Bioenergetic Journal nor was it listed in the Bioenergetic bibliographies. Although it was printed privately as a pamphlet by The Connecticut Society for Bioenergetic Analysis (under Dr. John Bellis), the study has never been readily available to interested clinicians and lay persons until now.

Following the above three quantitative studies, we have an annotated compendium of published empirical studies of the outcome of body psychotherapy treatment.In “the Outcome of Body Psychotherapy,” John May provides a valuable resource for researchers contemplating projects in this field as well as for clinicians seeking information on the effectiveness and/or efficacy of various theories and methods. This article updates material presented in the last two conference Proceedings.

Our final article represents a quite different sort of research. Colleen Campbell’s annotated list of body psychotherapy modalities began life as a project for one of her academic courses, but soon outgrew those limits. She spent more than a year relentlessly tracking down body psychotherapy modalities and their founders as she defines them in her article, culminating in a summary of the history, theory and process of each modality. In addition, she provides a summary of an article which in her judgment and/or that of the founder, describes it, along with directions referring the reader to additional journal and online sources. This is meant as an introduction to the field of body psychotherapy and will be a valuable resource for body psychotherapists to easily access essential materials outside of their own modalities.

I would like to think that the variety of research articles in this issue is indicative of the multiple directions in which our efforts and interests can expand. We must become aware of the number of “modalities” in our field and the often-subtle differences between them. As I read through Colleen Campbell’s manuscript, I was struck most by the similarities and the minuteness of the differences. I do not know what, if anything, this means. Are we coming close to being able to cite a common body of theories and practices…a unified filed? Would we even want to?

Jacqueline A. Carleton, Ph.D.
Editor

Letters to the Editor: An Exchange

Response to John May's article, "Body Psychotherapy Under the Rashomon Gate" in the 2005 journal (volume 4, #1.)
Ruella Frank

I am distressed to see the author of a critical examination of body psychotherapy literature confused as to the nature of the psychotherapy process itself and muddled in his notions of human nature. Although I will address some of his criticisms in this response, I am equally persuaded of the futility of such a venture when the premises of his criticism itself are so suspect. I will let my book, "Body of Awareness: A Somatic and Developmental Approach to Psychotherapy," – and my work – speak for itself and trust more careful readers will find them valuable.

What I glean from Dr. May's article is that I fail to provide sufficient case material to justify the claims of my theory. My case studies do not convince him and the evidence he uses "appears" to be drawn from my book. Ironically, he seems to be doing precisely what he claims I do. He uses his own misunderstanding of my work to pick and choose details from my chapters that are out of context, sometimes misquoted, and yet which serve to support his own argument. I shall give two brief examples from his article to illustrate his misreading/misunder-standing of my book.

May mentions that Chapter 2 contains a "…generalized des-cription of the biomechanical and structural implications of toddling patterns…" but the description itself is only "…marginally related" to the case vignette. Not so.

This particular chapter is entitled, "Developmental Patterns and the Processes of Differentiation," and details how patterns emerge within a ***relational field,*** continually influencing and being influenced by it. These fundamental movements are the root of psychological organizing. The sub-headings of this chapter, "Toddling in Spontaneity" and "Toddling in Disruption," address how the emergence of one particular pattern appears in situations where toddling is without inhibition and situations in which toddling becomes tentative and filled with apprehension. This is a major and oft repeated premise of my theory: early movement patterns always emerge and are embedded within the ongoing context of the infant/caregiver environment and these patterns, the foundation for all movement, are manifest and accessible in adult behaviors. Understanding forming patterns from a developmental frame advises the therapist how our adult clients organize in the present *and* in the presence of the therapist. May seems not to have understood this at all.

The case vignette that ends this chapter is a moment-to-moment phenomenological des-cription of the work as it emerges ***between*** me and my client. In this, as in every chapter of my book, the roots of the client and therapist dyad are understood from their early developmental origins – the infant (or child) and caregiver relationship. By pulling out moments seemingly at random and then tying them together as if they had happened the way May describes, of course, the vignette makes no sense at all.

Let me clarify further. In this particular case vignette, I describe how Karla (32 years old) goes through a slow process of finding support within the session for her habitually collapsed postural pattern. At one point, she experiences the novelty of a well-supported and upright stance. The moment I stand directly in front of her, however, she loses this support and collapses into her routine pattern once more. But this time, she is aware ***that*** and ***how*** she has collapsed herself. As the process continues, history reveals itself and Karla relates the experience of reducing herself in my presence to familiar feelings regarding her critical mother. Later in the session, we each play with shrinking and expanding ourselves while facing each other and notice the difference in our perceptions, beliefs and feelings as they emerge in the doing. These experiments are **somatic, development and relational**.

Moreover, here and through-out my book, I go to great lengths to describe each client's posture, gesture, breathing pattern and gait, state what we did in the session and how we did it, as well as discuss the psychodynamics, all to further illuminate the chapter material. In this particular vignette, I have a brief biomechanical description of walking in general and Karla's pattern in particular. This was meant to reflect the earlier toddling section of the chapter and to once more heighten a basic premise of the work – the contextual nature of all emerging patterns. May exaggerates this so that the biomechanics of toddling seems to be the point of the chapter.

In yet another misinter-pretation of my work, May discus-ses my final chapter which is devoted to a long-term treatment with one client, Annie. "Frank reports that Annie experienced the body interventions 'like another terrible breach of faith,'" he states. But he cannot seem to understand how I would find the body interventions useful "…in the midst of describing how the body interventions were damaging and that the relational interventions facilitative." That is May. But here is what I wrote, and notice how when context is substantially changed, meaning is altered. The exact section he quotes is written in my book as follows: "To Annie, some of my interventions in session seemed like another terrible breach of faith. Once, she was so distraught and enraged with something I said that she shot up from her seat and crouched in the corner of the room behind my chair." Please note, Annie's reaction was from something I *said*…not from any body-based intervention. The rest of that section describes how we repaired that particular moment

and "Annie slowly moved into her chair and we found the words back to each other."

These kinds of misattune-ments and repairs in psychotherapy treatment (similar to infant/care-giver interactions) happen fre-quently within particular client/ therapist dyads and are crucial to the growth of the relationship. It is essential to effective psycho-therapy, and arguably is the heart of its reparative work. This was certainly true for Annie, and at those moments her deepest shames, feelings of self-hate, breaches of faith, etc. moved to the foreground. If explored with sensitivity, these moments can be among the best work we therapists do.

Furthermore, to parse out or separate the "body" interventions from the relational work is another grave misunderstanding. Sitting face to face and speaking with a client in our respective chairs ***is***, of course, body-based. Where else does experience live but in the body? And how else do we perceive ourselves but in the moment of our ongoing body-to-body engagement with another? For May to misunderstand, misquote and then wonder whether "… body interventions hindered the treatment…." is truly puzzling.

May concludes his essay by saying that, "…authors are sometimes expected to provide warrants, arguments that their evidence should be taken as proof of their thesis," and that I have provided no such warrants, there-fore my theory is undermined. May confuses my case studies by thinking that each is presented to scientifically prove my ideas. The case vignettes, examples from ongoing treatment, are described to clarify specific points in the larger chapters themselves. In short, my case material was not written to provide evidence for the truth of my method, but to illuminate the ideas of my work.

No theory is the complete story. My work continues and my theories are developing further. I propose a hypothesis on human development based on study, experience and case material. To assume that psychotherapy is a search for some stable truth, rather than seeing it as indeed the very exploration of subjectivity itself is wrong-minded. May's reference to the film *Rashomon* suggests his commitment to discovering STABLE TRUTH, a determinable truth based on his desire for "…systematic, objective studies, such as experiments." To me, this is his failure to grasp the subjective essence of psychotherapy itself. Any psychotherapy – somatic or semantic, verbal or expressive, speaking or moving – is about the twisting and turnings of significance as they appear within the therapeutic encounter. The jackpot of therapy is not some objective truth, but the discovering of some unique meaning in a personal way. This meaning is a new awareness and this new awareness frees the individual from those constrictions in life's vitality for which psycho-therapy is sought. My work is only one pathway – there are many.

I think it is important and necessary to have critical dialogue regarding our various points of view in this newly emerging field of body psychotherapy. But I do wish that Dr. May's critique had been based in more solid evidence itself such that sufficient ground could have been provided for a more engaging discussion.

Ruella Frank
ruellafrank@nyc.rr.com

Echoes from the Rashomon Gate
John May, Ph.D.

I want to thank the Editor of the USA Body Psychotherapy Journal for giving me the opportunity to offer some thoughts in response to Ruella Frank. I also want to thank Frank for offering her reply (Frank, in press) to my article "Body Psychotherapy Under the Rashomon Gate." (May, 2005). The fact that I used her book as an example in my article meant that I had given it careful attention and thought, and I recognize that she has done likewise with my article. Critical dialog is common in scientific and professional journals. Our profession will benefit if we develop the ability to engage in such critical dialog in a respectful way.

My article was not about any person's work or theory, including Frank's. It was not about psychotherapy, objectivism, per-spectivism, or the nature of life in general. It was about writing. Specifically, I stated my concerns (and frustrations) regarding a set of problems that I saw in the body psychotherapy literature. They were: 1) the tendency for case histories and clinical theory to determine each other and become circular reasoning; 2) the tendency of body psychotherapist authors to make unsupported wild assertions; 3) the tendency of body psycho-therapist authors to cite evidence that seems unconvincing or unrelated to their point; and 4) the tendency of body psychotherapist authors to make contradictory claims that undercut each other. Frank's book became relevant only because I thought it contained examples of the third problem: evidence that was unconvincing or unrelated to the point she was trying to make.

I would like to correct some inaccuracies about my thinking in Frank's reply. First, Frank says that I am unable to grasp the subjective nature of psychotherapy, and that I believe in a STABLE TRUTH (her capitals) that comes only from empirical study. I actually wrote: "While reality may be fundamentally subjective, it does not follow that all versions must be equally valid." (May, 2005, p. 7) I further wrote that "knowledge about body psychotherapy was like a three-legged stool. One leg represented knowledge gained by thinking about oneself and one's own process, doing one's own introspective work. A second leg represented knowledge gained by observing one's clients carefully and thoughtfully. And the third leg represented knowledge gained through systematic,

objective studies, such as experiments…. The stories of body psychotherapy need to be supported by all three legs of that stool, or they will not stand. One cannot seize the secrets of life by the throat, one must build up knowledge slowly. Each piece of knowledge is like a brick. It must be fitted with hundreds, perhaps thousands of other pieces, before something useful is created." (May, 2005, p.23)

Frank accuses me of taking her words out of context. I freely acknowledge it, and indeed, I could hardly have done otherwise. My article was a fraction of the length of her book, and the part that dealt with her book was only a fraction of my article. A fraction of a fraction – of course things were out of context. Any time we discuss another author's work, we are forced to take things out of context, otherwise we would have to quote entire articles and books. The real issue is the way in which we take the words out of context. I used Frank's words to illustrate a problem I see in some of the body psychotherapy literature, and to represent my experience in reading her book, which was one of confusion and frustration. Although she objects to this use, I feel that it was appropriate.

Frank also says I failed to understand her book adequately. Again, I fully agree. Indeed, that was my whole point. I could not follow the relation between her examples and the theory she was trying to explain. That is why I picked her book to use as an example. In her reply, Frank explains how her phenomenological descriptions of sessions with clients relate to her theory. But I could not follow this connection when I gave her book multiple readings in preparing my article, and as I return to it now upon reading her reply, I still have difficulty with it. In saying this, let me state one final time that I am not talking about the quality of her therapeutic work or the ultimate validity of her theory. This is a writing issue: when one cites evidence it is important to make sure that it supports (or illustrates) the material it is intended to in a way that will be clear to the reader. If the connection won't be clear to the reader, then one must provide warrants, which are explanations of how the evidence supports or illustrates the point being made. Otherwise, the reader can become confused and frustrated.

Finally, I would like to acknow-ledge one error for which I believe Frank does deserve an apology from me, though she did not mention it in her reply. In preparing my manuscript, I did not think to send a copy to her prior to submitting it for publication (nor did I to Pat Ogden or Stanley Keleman, whose writing or public presen-tations I also discussed). I have been informed since then that to do so is considered a customary courtesy, and I should have. I regret that oversight and offer my apology to Frank and the other authors.

References

Frank, Ruella. (in press). Response to John May's article "Body psychotherapy under the Rashomon Gate" in the 2005 Journal (volume 4, #1.). USA Body Psychotherapy Journal.

May, John. (2005). Body psychotherapy under the Rashomon Gate. USA Body Psychotherapy Journal, 4, (1), 5-27.

John May
1mayway1@earthink.com

Body Psychotherapy Research: An Introduction

Alice Ladas, Ed.D.
Research Chair, USABP

I have a dream….that every physician, nurse, psychologist, social worker, and other healthcare practitioners, get some training in how to deal with muscle tension, breathing, touch (when appropriate and agreed upon), and learn to be focused or centered with their patients or clients. What do we need for this to happen? We need research! Shortly before the conference I had dinner with two renowned physicists. Although seniors, they acted like excited kids when talking about the latest research. They said several things relevant to our work. From the study of emergent behavior in physics and biology, no matter how thoroughly you study the properties of individual water molecules, you cannot predict the different qualities which will lead them to becoming a solid, liquid or gas. You can only find out the answers by observation. But Heisenberg told us that when an observer observes a molecule, the mere act of observation changes it. My dinner companions also said that if you know in advance what you are going to find, the research is not worth doing. And they added that when you work with human subjects, research problems intensify exponentially.

Taking all these factors into consideration, it is easy to understand why we received fewer submissions this year than we did in 2002. Research in our field is not only supremely difficult and unfounded; it is time consuming, expensive, tedious, demanding, and when you get all through, you may not have anything worthwhile to show for the effort.

Problems in psychological research are by no means confined to body psychotherapy. From an article in the December 2004 Psychotherapy Networker: "…the debate over what constitutes evidence has vast implications for the future of psychotherapy." Ronald Levant, current president of APA, was quoted in the New York Times, saying: "this entire approach - to develop manuals and require practicing psychologists to use them - is fundamentally insane." His statement came as a rebuke to those who are pushing for tightly controlled trials that rely on highly standardized therapy methods, also known as evidence based research. In deciding which studies merited our prizes this year, we faced similar kinds of problems. Do case studies qualify as valid research? Did the therapists participating in the prize-winning study actually use the methods advocated by their groups? Should we give the prize to a study that is still in process?

The 7 criteria by which we reached our decisions are:
1. Does the study add to the knowledge base about body psychotherapy?
2. Are the objectives of the study clearly stated?
3. Are the protocols and procedures used to test the objectives clearly described?
4. Can the study be replicated using the same or different body psychotherapy modalities?
5. Does the treatment of subjects conform to ethical guidelines?
6. Are the results presented in a clear well organized fashion?
7. Are the conclusions clearly stated and justified by the data?

The winner of the $500 Research Award, a study which met these criteria is: "Preliminary Results Concerning The Effectiveness Of Body-Psychotherapies In Outpatient Settings- A Multi-Center Study In Germany and Switzerland." The chief investigator is Dr. Margit Koemeda-Lutz, one of the editors of Bioenergetic Analysis: The Clinical Journal of The International Association for Bioenergetic Analysis, along with fellow authors: Martin Kaschke, Dirk Revenstorf, Thomas Scherrmann, Halko Weiss and Ulrich Soeder. As one committee member said: "This is an ambitious study with a worthy aim. It examines the practice of body psychotherapy in the real world, involving multiple therapists and multiple treatment modalities". It is a prospective rather than a retrospective study. The introduction and background information outlines the need for such a study in light of the political and economic problems we face in bringing the value of body psychotherapy to the wider community. This is the seventh year the researchers have been collaborating on this study. Hopefully, their work will stimulate some group or groups in the United States to organize a comparable project. We are in dire need of positive research studies. As Bioenergetic trainer Virginia Wink wrote in a recent letter to me: "I think the lack of research in the Institute over the years is a tragedy. Had we had it, we would be in such a different place today to have a significant voice in the field…."

An article about psychological science in the most recent American Psychological Association Journal, states: "most research in the social sciences is produced by one or two people who share the same background and…methods….the rewards of running a large collaboration balance out the time demands….big interdisciplinary science will attract big money." The Koemeda-Lutz study is right in line with the push for collaborative work. As for attracting big money….well…I don't think $500 qualifies. At the Conference, we were fortunate enough to be able to

invite one of the study collaborators, Gustl Marlock from Unitive Psychology in Germany, to receive the award on behalf of himself and his colleagues and to say a few words to our very receptive audience.

Our Student Award of $100 was presented to Amelia Kaplan, Psy.M, and her mentor Laurie Schwartz, LMT, MS, for "Listening To The Body: Pragmatic Case Studies Of Body-Centered Psychotherapy," both of whom were invited up to receive the award and say a few words. Committee member Cynthia Price, winner of an NIH Grant for her study which received an honorable mention from us three years ago, had these words to say about this current study: "The study incorporates theory and process. There is a nice blend of quantitative and qualitative data which makes a good model for future case study format. This is the kind of clinically-based literature that informs theory and practice and helps to stimulate further research questions, important for building science in the field." Cynthia is one careful researcher and critical evaluator of new research. My thanks to all my active committee members: Dr. Erica Goodstone, Dr. John May, Anita Ribiero, and Dr. Michael Bridges.

June, 2005

(reprinted from a speech given at the Awards Ceremony: Fourth National Conference, The Body of Life: Body Psychotherapy in the Real World, Tucson, AZ.)

Preliminary Results Concerning the Effectiveness of Body Psychotherapies in Outpatient Settings: A Multi-Center Study in Germany and Switzerland

Margit Koemeda-Lutz, Dr. rer. soc., Dipl. Psych.; Martin Kaschke, Dipl. Psych., Dipl. Biol.;
Dirk Revenstorf, Prof. Dr. rer. soc., Dipl. Psych.; Thomas Scherrmann, Dr. rer. Soc., Dipl. Psych.; Halko Weiss, Dipl. Psych.; and
Ulrich Soeder, Dipl. Psych.[1]

(This article was first published in German in: Psychotherapie Forum (2003) 11: 70-79)

Abstract

Preliminary results of an outcome study on routine applications of body psychotherapy in outpatient settings are reported. Out of 38 member institutions of the European Association for Body psychotherapy (EABP) 8 are participating in this study. At 3 points of measurement (at the beginning, after 6 months and at the end of therapy) established questionnaires (e.g. Beck Anxiety Inventory, Beck Depression Inventory, Symptom Check List-90-R, Inventory of Interpersonal Problems-D) were answered by patients. Patients in body-psychotherapeutic treatment (n= 157) are compared to other outpatient psychotherapeutic patients with regard to socio-demographic data, level of impairment and psychopathology.

After 6 months of therapy patients (N=78) have significantly improved with small to moderate intraclass effect sizes. After two years of treatment, large effect sizes are attained in all scales (N=21), the data base presently available for this latter result still being small.

INTRODUCTION, BACKGROUND, AND TREATMENT

Health professionals have an ethically imposed duty to have their services guided by most recent scientific findings, to take part in educational training programs and to continuously evaluate the effectiveness of their therapeutic work, i.e. to optimize the offered service to their clients' needs. Quality management in the sense of Laireiter and Vogel (1998) means "permanent and self-critical reflection on the structure and process of the offered service, as well as a continuous effort to improve the service in the interest of the patient or client". According to this standard, in Germany, the "Gesundheitsreformgesetz, GRG" (Health Reform Bill, 1988), as well as the "Psychotherapeutengesetz" (Bill for Psychotherapists, 1998) demand an evaluation of the effectiveness of health services. In Switzerland the same is ensured by the "Krankenversicherungsgesetz, KVG" (Health Insurance Bill, 1998).

The standards for assessment and improvement have changed considerably during the last few years. Scarce resources and a critical development in health care also affected psychotherapeutic treatments. The call for more "professionalisation" (as put forward by Grawe et al., 1994) was linked with the assertion of a rather biased understanding of empiricism. Clinical studies that tested hypotheses were preferred over single-case studies, documentation of processes or "discovery-oriented" studies. Task Force, division 12, of the American Psychological Association (APA) further fuelled this development by its demand for "empirically validated treatments - EVT" (Sanderson and Woody 1995; Chambless et al. 1996), despite the fact that professional psychotherapy in Germany developed differently than in the USA (Strauss and Kächele, 1998). Severe imbalances emerged in several countries whose professional services comprised a great variety of treatment approaches: The effectiveness of treatments that could not come up with a sufficient number of hypotheses-testing clinical studies was called in question: These therapeutic schools have already been pushed into the background. However, recent studies (Cierpka et al. 1997, Willutzki et al. 1997, Schweizer and Budowski 2001, Schweizer et al. 2002) show that individual psychotherapists rarely train in only one method, but incorporate several psychotherapeutic techniques into their professional practice.

Political decisions were required before fair research could be done in this professional field. By defining rules of admission for professionals, by implementing certain refunding policies, politicians and health insurance companies influenced the competition among professionals.

[1] The authors would like to thank the Swiss section of the European Association for Body psychotherapy (CH-EABP) and its president Dr.T.Ehrensperger for supporting their work with considerable financial help. The "Deutsche Gesellschaft für Körperpsychotherapie, DGK" (German Association for Body psychotherapy) with its president G.Marlock also promised financial support. Above all, this study is widely based on the honorary engagement of all participating patients, therapists, coordinators and members of the research group. Thanks to all of them.

Cierpka et al. (1997) state that the complexity of the field of application determines the variety of psychotherapeutic methods. The authors of the present article contend that body-psychotherapeutic perspectives - in theory and application - are an integral part of the science of psychotherapy. The origins of body psychotherapy probably go back to the very beginning of medical art. It was self-evident to the philosophers and physicians of occidental antiquity that diseases are comprised of both physical and mental aspects. They also regarded human beings as psychosomatic entities. Only in more recent time, mental and physical medicine developed into separate professional fields. However, there have always been boundary commuters on both sides (von Weizsäcker 1947, von Uexküll 1979, Hahn 1979, Janet 1924, Ferenczi 1984, Groddeck 1988 and many others).

Especially in the 1970's a variety of body-psychotherapeutic schools emerged, most of them remote from academic institutions. Some of them still keep this distance. Body psychotherapists in Switzerland and Germany on the other hand contribute considerably to outpatient and inpatient psychotherapeutic health care (Schweizer and Budowski 2001, Schweizer et al. 2002, Seidler et al. 2002). Although some studies about their effectiveness have been published (i.e. Gudat 1997; Ventling and Gerhard 2000; Müller-Hofer 2002), representatives of this approach are still under pressure to prove the effectiveness of their work. Despite the fact that methods which have not been evaluated do not necessarily have to be ineffective, professional politics seem to be following just this logic. The group of researchers responsible for this study was formed mainly to counteract this development.

By now, many suggestions have been made concerning a systematization and historical classification of body-psychotherapeutic approaches (i.e. Boadella 1990; Müller-Braunschweig 1997; Geuter 1996, 2000; Geissler 1999; Röhricht 2000; Michel and Koemeda-Lutz 2002; Schatz 2002). The European Association for Body-Psychotherapy published definitions of common basic concepts on their homepage in the World Wide Web, that are continuously refined within a communicative process among representatives of the participating institutions.

Some of the basic body psychotherapeutic concepts are the following (note that this is only a selection):

1) The body is an indispensable component of human existence and should therefore be given more attention in (mental) health applications.

2) Mental and physical processes evolve parallel in time, interact and can be observed, examined and influenced from separate system levels.

3) From a developmental point of view an extended phase of non-verbal communication precedes verbal communication - ontogenetically as well as phylogenetically.

4) Also in adult life information processing and communication mediated by cognition or speech only constitute a subset of all processes involved.

5) Memory contents as well as unconscious material can to some extent be triggered and moved to consciousness by affective, motor or sensory engramms.

6) Vitality and health consist not only of a clear mind, but are also based on well-balanced and well-regulated physiological and emotional functions (this is self-evident in eastern healing techniques)

7) Body-psychotherapeutic techniques are characterised by incorporating a) non-verbal interventions, b) behavioural dialogues, c) physical contact, d) diagnostics that also consider non-verbal (i.e. visual) information, e) therapy goals that are defined psychosomatically.

We report here on a study that examines the effectiveness of body-psychotherapeutic treatment in outpatient settings under natural conditions in Germany and Switzerland. According to the rules of research in medical or natural sciences (Linden 1987, 1989), this study can be assigned to phase IV, i.e. an evaluation of "routine applications" in practice. Following Rudolf (1998) it can be associated with the phase of "applied psychotherapy research". We still know little about the effectiveness of psychotherapy other than in inpatient settings or university institutions (Seligman 1995). Essentially the present study evaluates the process and outcome of body psychotherapy. Data about symptoms and well-being of the patients were collected at several points in time throughout the therapeutic process (beginning of therapy, half a year later, end of therapy (at the latest 2 years after the beginning) and a follow-up measurement after one year). Research was initiated in January 1998 by the Hakomi Institute of Europe. First results were presented at the 7th European Congress on Body Psychotherapy at Travemünde, Germany (Soeder et al. 1999). Since then the study has become multi-

centered (Dresden, Heidelberg, Tübingen, Zürich). Only patients who are treated with body-psychotherapy on an outpatient basis are examined.

Therapists from the following schools participate (in order of joining the project; names of foundation presidents (international and national), literature in brackets): Hakomi Experiential Psychology (Ron Kurtz, Halko Weiss; Kurtz 1994); Unitive Psychology (Jacob Stattmann, Gustl Marlock; Stattmann 1987); Biodynamic Psychology (Gerda Boyesen; Boyesen 2001) - in Germany - and Swiss Association for Bioenergetic Analysis und Therapy SGBAT (Alexander Lowen; Thomas Ehrensperger; Koemeda-Lutz et al. 2002); Client-centered Verbal and Body psychotherapy GFK (Christiane Geiser; Ernst Juchli; Geiser-Juchli 2002); Institute for Integrative Body-Psychotherapy IBP (Jack Lee Rosenberg; Markus Fischer; Fischer 2002); Swiss Institute for Body-oriented Psychotherapy SIKOP (George Downing; Meyer et al. 2002); International Institute for Biosynthesis IIBS (David Boadella; Boadella und Boadella 2002) - in Switzerland.

The following questions guided this study:

1) What kind of patients ask for outpatient body psychotherapy? They are described by demographic, diagnostic and psychopathological measures (not specific to body psychotherapy)

2) How much do patients improve during treatment?

3) Can these results be preserved after the termination of treatment (follow-up measurement one year after the end of therapy?

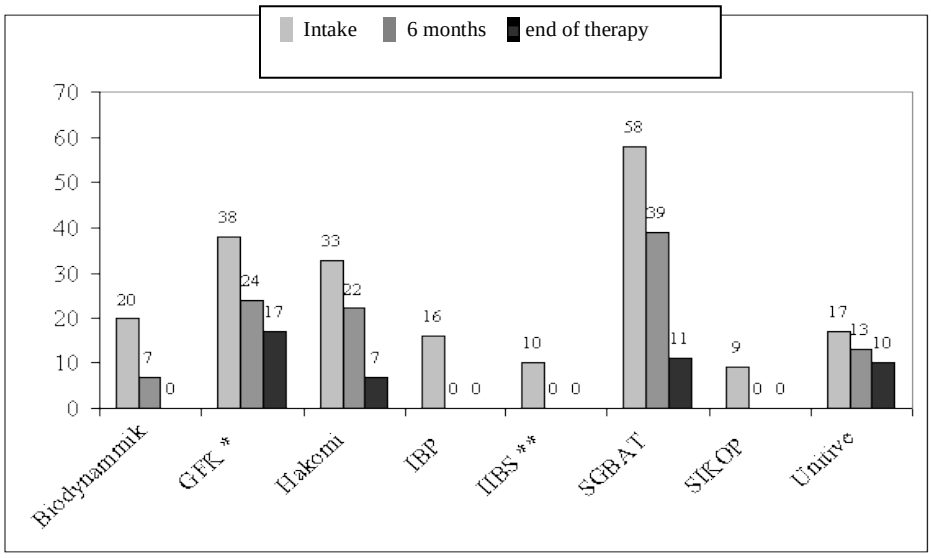


Figure 1: Number of cases at intake, six months later and at termination of therapy - grouped by the participating institutes[2] Up to now 201 completed questionnaires from intake are available. The following preliminary results are based upon 157 cases (beginning of therapy), 81 cases (after six months) and 28 cases (end of therapy). Cut-off date for data input was the 31st of August 2002).
* Results from 34, 24 and 17 cases (after one year) are reported in Müller-Hofer 2002.
** These questionnaires reached us after the cut-off date.

METHODS

Sample and Procedure

Eight member institutes of the European Association for Body psychotherapy (EABP: http://www.eabp.org/) participated. The Swiss institutes among them (N=5) are also members of the "Schweizer Charta für Psychotherapie" (http://www.psychotherapie-charta.ch/) (fig. 1). The selection of institutes was not systematic.

[2] Biodynamic Psychology, Client-centered Verbal and Body psychotherapy (GFK), Hakomi Institute of Europe, Institute for Integrative Body Psychotherapy (IBP), International Institute for Biosynthesis (IIBS), Swiss Association for Bioenergetic Analysis and Therapy (SGBAT), Swiss Institute for Body-Oriented Psychotherapy (SIKOP), Unitive Psychology

The EABP represents 12 professional societies in Switzerland and 16 in Germany ("Deutsche Gesellschaft für Körperpsychotherapie, DGK" (German Society for Body psychotherapy)). Each institute taking part in the study named one research coordinator who was in charge of organizing data collection. All certified members of the participating institutes who had completed a full training and worked in outpatient settings, were invited to take part in the study. The therapists taking part were asked to try to recruit every patient who took up treatment within a previously defined period of time and document demographic data, symptoms and preliminary diagnoses including patients who would not participate. All patients were informed about the study and given the information that participation was voluntary. Participants gave their informed consent to therapists. Data were coded and sent to the coordinators who surveyed the schedule of assessment. Anonymity was ensured by using a self-generated code consisting of 6 letters.

Data collection occurred at the beginning of therapy, after 6 months, and at the end of therapy (at the latest 24 months after intake). There is a follow-up one year after the end of therapy.

The estimation of the sample size necessary for the study followed Bortz (1984). It was guided by the hypothesis that body psychotherapy is as effective as well-established psychotherapy methods with an improvement rate of about 70% (Grawe et al. 1994), supposing a spontaneous remission rate of up to 30% (Bergin, 1971). A test strength of $1-\beta = 80\%$ and a significance level of 5% results in an effect size of $h = 0.82$. This would be considered a strong effect. Consequently a sample size of $n = 18.3$ would be enough to test hypotheses with sufficient statistical security. Taking into account possible dropouts of about 15%, the sample size was set $n = 25$. Since eight institutes participated, an overall sample size of 200 clients was aimed for.

The eight participating institutes joined the study at different points in time. Therefore, in this preliminary report, the numbers of examined cases vary considerably between institutes at the beginning of therapy and at the other points of assessment. Since this is an ongoing study, no information can be given about the proportion of dropouts yet. The composition of the sample on 08/31/02 is shown in Fig. 1.

Questionnaires

For data collection well-established and/or standardised question-naires were used, in order to make comparison with other studies possible (Fydrich et al. 1996, Schulte 1993). From a body-psychotherapeutic point of view these instruments can be regarded as non-specific.

Demographic information was gathered according to the "Deutsche Standarddemographie" (German standard demography, Ehling et al. 1992).

Psychopathological symptoms were measured using "Beck Angst Inventar, BAI" (Beck Anxiety Inventory, Beck et al. 1988), "Beck Depressions Inventar, BDI" (Beck Depression Inventory, Hautzinger et al. 1994) and the Symptom Check List, SCL-90-R (Franke 1995, 2002). Physical discomfort was measured using the "Beschwerdenliste, BL" (Discomfort List, v. Zerssen, CIPS 1996); social problems were measured using the "Inventar zur Erfassung Interpersonaler Probleme, IIP-D" (Inventory of Interpersonal Problems) (Horowitz et al. 2000). Finally, the general "Selbstwirksamkeitserwartung, SWE" (expected self-effectiveness) (Schwarzer 1994, Schwarzer and Jerusalem 1999) was measured. Patients were also asked to judge changes in important areas of their lives since the beginning of therapy. The overall time to fill in all questionnaires was approximately one hour per examination.

Therapists gave information about the formal state of the therapy and also judged changes in important areas of the patients´ lives.

RESULTS

The following section contains the key preliminary results of this study. The characteristics of patients using outpatient body psychotherapeutic services are followed by initial results about the course of therapy.

Clients of outpatient body psychotherapists

At intake, 157 clients with an age range between 22 and 64 years (median 41 years) gave their consent to participate in the study. 62 body psychotherapists were in charge of their treatment. 68% of the patients were female. 41% of all patients were married, 47% were single and 13% were divorced. 56% lived with a partner, 46% had children. 64% of the patients had "Abitur" (graduation from the highest type of school in Germany and Switzerland, required for admission to universities), 28% had completed a University degree. 56% of all clients were already experienced with psychotherapy. Treatment costs were fully refunded by health insurance in 32.5% of all cases; they were partly refunded in 29.3%. 26.8% of the patients had no refund at all. 11.8% did not answer this question.

Demographic data for this group of patients vary within the ranges known from other studies of outpatient psychotherapy (Gudat 1997, Ventling and Gerhard 2000, Scheidt et al. 1998; Schweizer et al. 2002, Müller-Hofer 2002).

Main diagnoses at the beginning of therapy followed the ICD-10 criteria (Dilling et al. 1993), and are summarized in Fig. 2. In 72% of all cases, only one main diagnosis was assigned, in 22% a secondary diagnosis was also made. In 6% of all cases therapists assigned 2 secondary diagnoses. Apart from the high proportion of Z-codes, this study shows the same profile (F4 > F3 > F6) as two other studies on outpatient psychotherapy that involved different psychotherapeutic approaches (Scheidt et al. 1998, Schweizer et al. 2002).

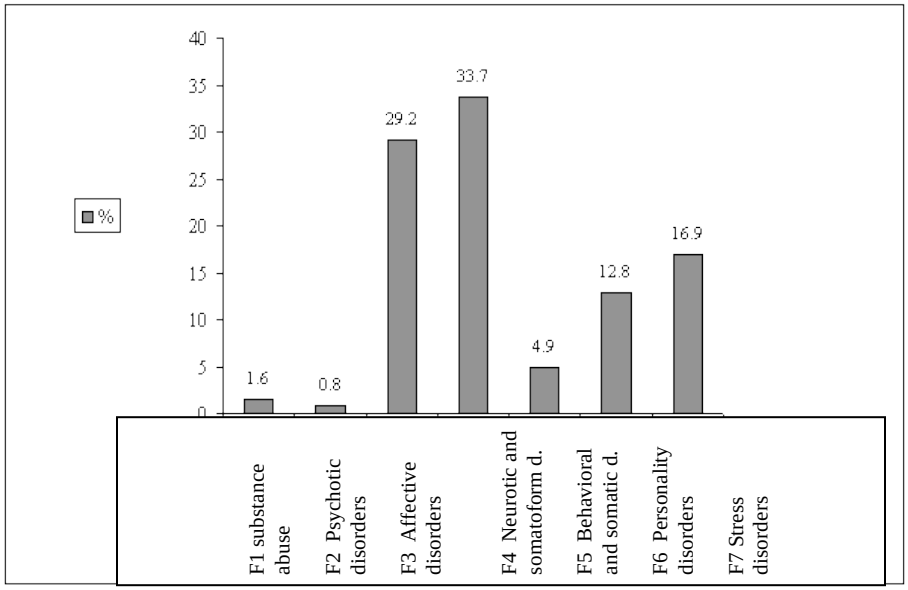


Figure 2: Distribution of main diagnoses in % according to ICD-10.F1 Mental and behavioural disorders due to psychoactive substance abuse, F2 Schizophrenia, schizotypal and delusional disorders, F3 Affective disorders, F4 Neurotic, stress-related and somatoform disorders, F5 Behavioural syndromes associated with somatic disorders, F6 Personality disorders, Z-Code: Factors influencing health status and leading to demands on health services.

According to the questionnaires used patients can be described as follows: In 70.1% anxiety scores were above normal (BAI > 11, complete sample: mean = 17.5, SD = 11.7). Depression scores were normal for 31.2% of the patients (BDI < 10). 35.7% presented raised depression scores (11 < BDI < 17), and 33.1% were clinically affected (BDI > 18, complete sample: mean = 15.1, SD = 9.1). According to data from the SCL-90-R, 62.4% of all patients could be considered to be clinically affected (men: SCL-GSI>0.57; women: SCL-GSI>0.77; according to cut-off points c following Jacobson for psychotherapy patients (Franke 2002, p. 32). Complete sample: mean = 0.94, SD = 0.59). Figure 3 displays SCL-90 profiles from different samples. Patients treated by outpatient body psychotherapy are clearly more affected at intake than non-patients, but are less affected than clients in in-patient treatment. A similar profile was obtained by Scheidt et al. (1998).

Physical discomfort with a mean BL score of 28.6 (SD = 12.6) in this sample was comparable to psychiatric patients (mean = 30.0, SD = 15.4) or

anxiety patients (mean = 29.6, SD = 12.2). It clearly exceeded that of a standard control group (mean = 14.3, SD = 10.8, CIPS 1996, p. 38).

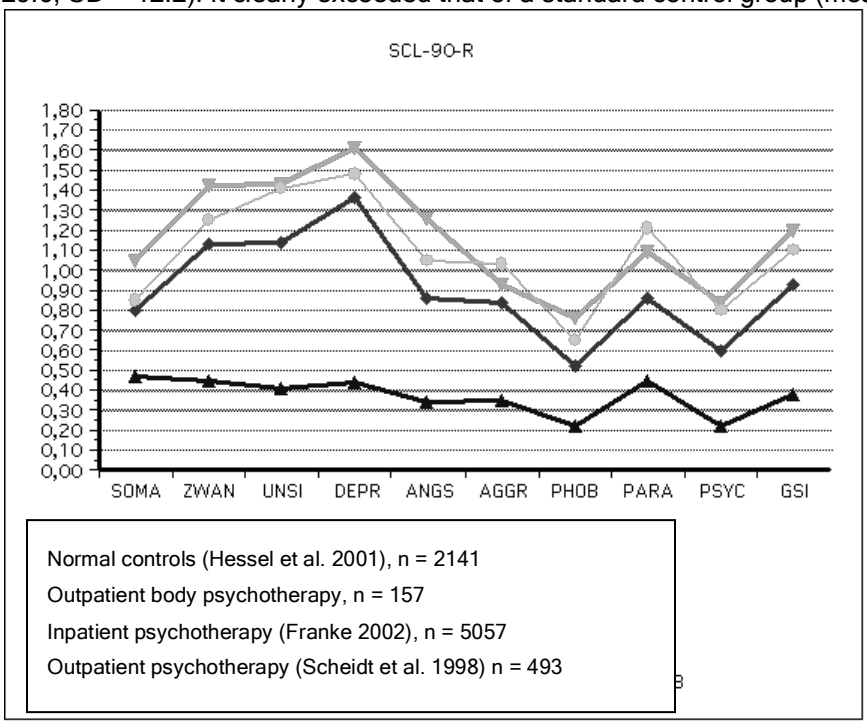


Figure 3: SCL-90-R scores of body psychotherapy patients in comparison to normal controls, an out- and an in-patient psychotherapy group at intake (SOMA: somatisation, ZWAN: compulsiveness, UNSI: insecurity in social interactions, DEPR: depression, ANGS: anxiety, AGGR: aggression/hostility, PHOB: phobia, PARA: paranoia, PSYC: psychoticism, GSI: Global Severity Index (total score)).

The score for interpersonal problems (IIP-D) was 11.6 (SD = 4.7). With values converted to age-standardized stanine-scores (Horowitz et al. 2000), 23.7% of the sample presented deviant values between 7 and 9. Compared to other groups of psychotherapy in-patients with different diagnoses, body psychotherapy patients suffer less from interpersonal problems and are comparable to psychosomatic patients (mean = 11.2, SD = 4.1) or patients with addictions (mean = 11.5, SD = 3.8, Wuchner et al. 1993).

The mean for “general expected self-effectiveness” was 24.5 (SD = 5.7) at the beginning of therapy. In comparison with a large sample of adults (mean = 29.3, SD = 5.1, Schwarzer and Jerusalem 1999), the expected self-effectiveness is clearly lower in our sample. 40.4% of all body psychotherapy patients achieved scores more than one standard deviation (T<40) below the mean of a control population.

Treatment Process

Since data collection has not yet been completed, no concluding judgement about the progress of therapy can be made. For 6 months after intake, data from 78 cases could be analysed, while for the end of therapy data for 21 cases were available. Follow-up results cannot be presented yet.

A comparison of intake data from all patients with a subset of intake data from those who had also completed their 6 months assessment and with another subset of those who had completed data sets for the end of therapy yielded no statistically significant differences at intake in any of the variables assessed. Statistical testing was carried out with an α-adjusted two-tailed t-test for all questionnaires.

Group changes

Changes over the course of therapy were tested for significance by means of one-tailed t-tests. Further intra-class effect sizes were computed following Mc Gaw and Glass (1980). Effect sizes were classified small (02.-0.5), medium (0.5-0.8) and large (>0.8).

Within the first 6 months, on average 23 sessions were held. Data of 78 cases entered the analysis.

Anxiety (BAI), depression (BDI), general symptoms (SCL-90-R), physical discomfort (BL) and interpersonal problems (IIP-D) decreased significantly (see figure 4). In addition, the expected self-effectiveness increased significantly.

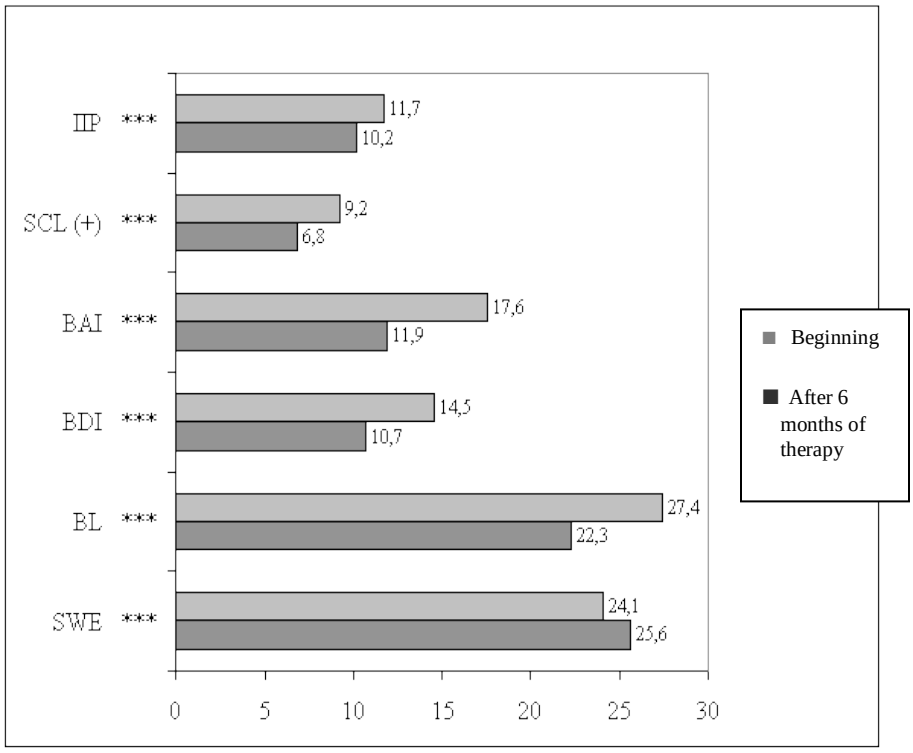


Figure 4: Comparison of means at the beginning of therapy and after six months (n = 78); * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$; IIP: Inventory of interpersonal problems, SCL: Symptom Check List, BAI: Beck Anxiety Inventory, BDI: Beck Depression Inventory, BL: Discomfort List and SWE: expected self-effectiveness.

(+) For illustrative reasons SCL-90-R scores were multiplied by 10.

Data from 21 cases could be used for the comparison between intake and termination. An average of 69 sessions was held.

Improvement on all scales was stronger at the end compared to the assessment at intake. Again, anxiety, depression, general symptoms, physical discomfort and interpersonal problems decreased significantly, whereas expected self-effectiveness increased significantly (see fig. 5).

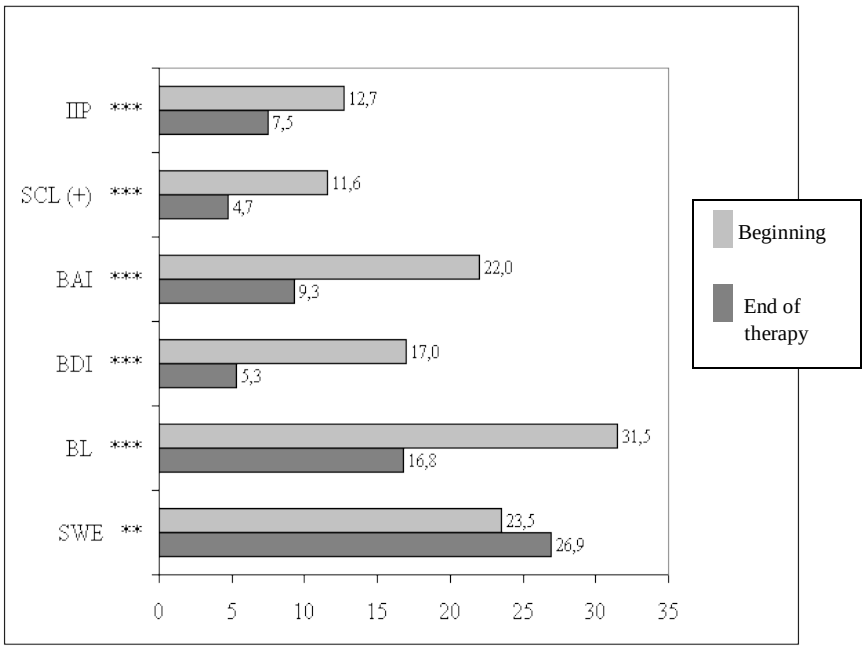


Figure 5: Pre-post Comparison of means (intake vs. termination, n = 21); * p < 0.05, ** p < 0.01, *** p < 0.001; IIP: Inventory of interpersonal problems, SCL: Symptom Check List, BAI: Beck Anxiety Inventory, BDI: Beck Depression Inventory, BL: Discomfort List and SWE: expected self-effectiveness.
(+) For illustrative reasons SCL-90-R scores were multiplied by 10.

Effect sizes for the changes between the beginning of therapy and 6 months later, as well as between the beginning and the end of therapy are presented in fig. 6. Within the first 6 months small to medium improvements occurred for all tested criteria. At the end of therapy, large improvements with effects between 0.82 (expected self-effectiveness) and 1.40 (depression) were achieved.

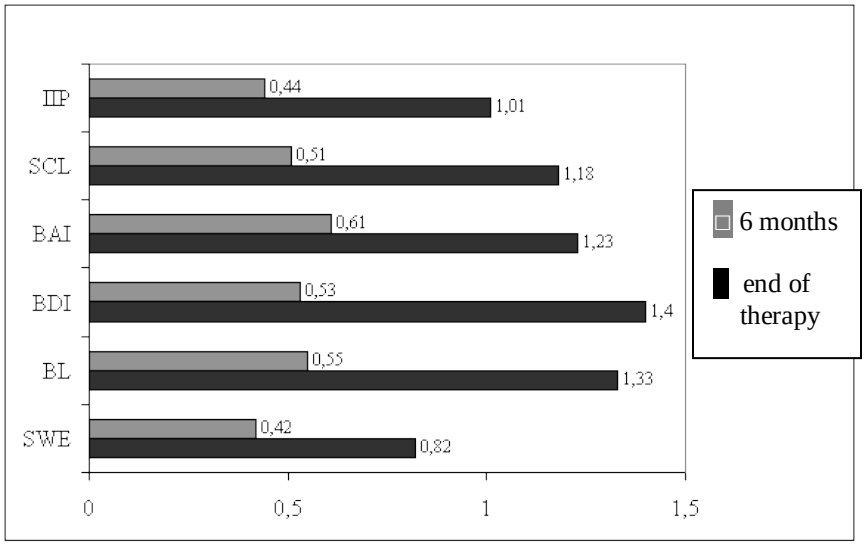


Figure 6: Effect sizes 6 months after intake (n = 78) and at termination (n=21): small (0.2 - 0.5), medium (0.5 - 0.8) and large (> 0.8).
IIP: Inventory for the inquiry of interpersonal problems, SCL: Symptom Check List, BAI: Beck Anxiety Inventory, BDI: Beck Depression Inventory, BL: Discomfort List and SWE: expected self-effectiveness.

Individual changes

In addition to group changes, individual changes for the scales BAI, BDI, IIP-D and SCL-90-R are reported. This analysis contains 21 data sets. The occurrence of clinically relevant anxiety symptoms (BAI>11) decreased from 86% in the beginning to 48% after 6 months and dropped to 33% at the end of therapy.

The occurrence of clinically relevant depression scores (BDI>18) dropped from 43% at the beginning to 10% after 6 months and to 0% at the end of therapy. At termination, the depression score of 10% of the patients was still elevated (11<BDI<17), while 90% of the patients were within the normal range (BDI<10). 33% of the patients ranged within raised scores for interpersonal problems (Stanine >7) at the beginning of therapy. This was true for 19% after 6 months; at the end of therapy it was only true for 5% of the patients.

Cut-off scores as well as critical differences have been published for the SCL-90-R scale. Therefore, statistically and clinically relevant changes can be differentiated for single cases (Jacobson and Truax 1991, Jacobson et al. 1984). Following Franke (2002), a GSI-raw score of 0.3 for psychotherapy patients was assessed as a critical difference. Gender specific cut-off scores are 0.57 for men and 0.77 for women. Clinically and statistically relevant changes are shown in fig. 7. At the end of therapy, more than half of the patients had improved at a clinically significant rate. About one third did not perceive any improvement in their symptoms.

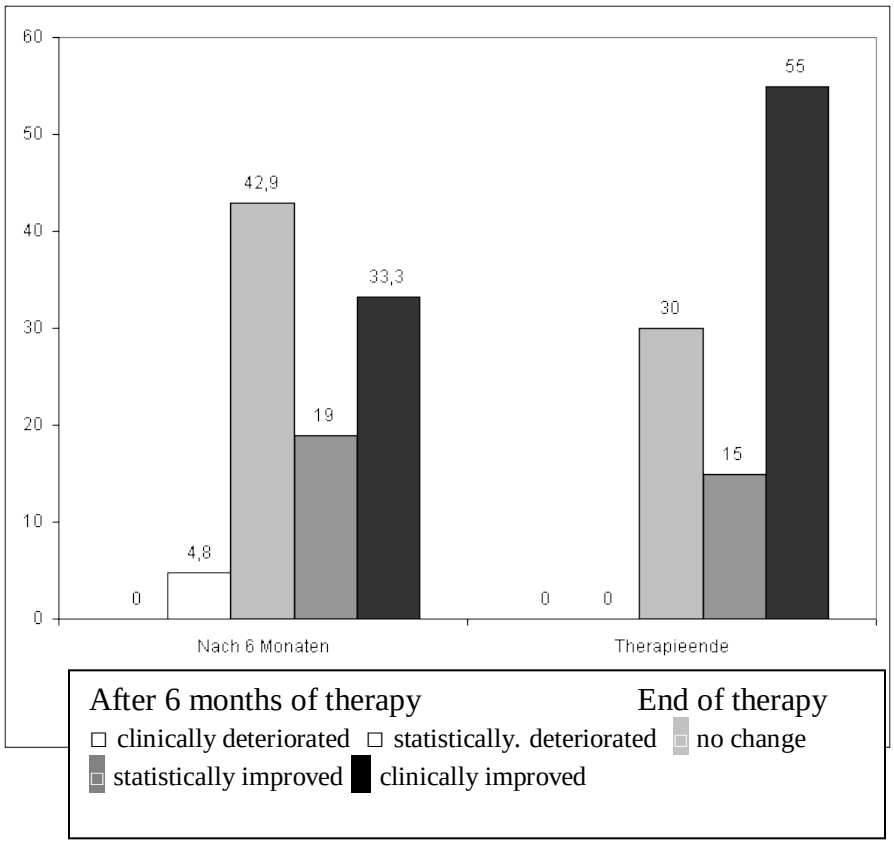


Figure 7: Clinically and statistically relevant changes for the total score of the SCL-90-R (n = 21); Critical difference GSI > 0.30 (psychotherapy patients), cut-off values: 0,57 (Men), 0,77 (Women) according to Franke 2002.

Discussion

The present study documents representative aspects of the factual contribution of body psychotherapists to outpatient psychiatric-psychotherapeutic care in Germany and Switzerland. It also contributes to quality assessment and management in this field. It examines body psychotherapies in the natural environment of outpatient settings.

Many studies of the effectiveness of outpatient psychotherapy have been conducted in university settings. The advantages of high internal validity achieved by manualised versions of therapeutic methods, selected samples and highly elaborated evaluation procedures are opposed by low ecological validity (Seligman 1995). Therefore, comparatively little is known about the effectiveness of psychotherapy outside inpatient or university settings. This study attempts to help fill this gap.

In contrast to other studies evaluating body psychotherapy that only made use of retrospectively collected data (Gudat 1997, Ventling and Gerhard 2000), prospective data are reported here for the first time.

As found for outpatient clients of other therapeutic orientations, the educational level of body psychotherapy patients is higher than that of the average population (Vessey and Howard 1993). Diagnoses and symptom profiles of outpatient body psychotherapy patients at intake are typical of and comparable to outpatient psychotherapy clients in general. The relative frequency of Z-code assignments for the classification of main problems could be related to the requirement that the reported diagnoses were to be made within the first 3 sessions. Patients possibly speak more easily about external factors influencing their lives, at the beginning of therapy. Another reason might be that a significant proportion of the cases does not get refunded by health insurances and therefore a diagnosis "proving illness" is not necessary for formal reasons. Nevertheless, the symptom profiles still exhibited a high proportion of clinically relevant impairment at the beginning of therapy.

Since this is only a preliminary report, the data base is not sufficient yet for a final evaluation of treatment processes. Especially the results from the end of therapy (n = 21) can only be taken as pointing to an increasing effectiveness of outpatient body psychotherapy during the course of the treatment. It seems, however, that statistically significant improvement can be found not only on a group level: treatment also seems to produce clinically relevant symptom reduction for individual cases. Already within the first 6 months significant improvement is achieved that becomes markedly stronger towards the end of therapy. Apart from a reduction of symptoms in mental, somatic, and interpersonal areas, the increase of expected self-effectiveness is remarkable. Self-effectiveness is considered to be an important resource in handling stress and emotional problems. It is also

regarded as a stable personality dimension (Schwarzer 1994). The effect size for the expected self-effectiveness at the end of therapy is lower than the effect size for the total score of the symptom checklist (d(SWE) = 0.82 vs. d(SCL) = 1.18). Nevertheless, it is of high practical value, since it represents a change on a personality dimension. This suggests that body psychotherapy does not merely reduce symptoms but also gives impetus for positive personality development. The results for interpersonal problems demonstrate that positive changes in interpersonal areas occur during the course of therapy.

It remains to be determined if the promising results will be confirmed by the end of the study and if the patients' gains will have been maintained at the one-year follow-up.

So far, body psychotherapy schools have kept their distance from academic research. Only the increasing pressure on all treatment approaches to prove their effectiveness in recent years has made possible an outcome study like the present one.

A multi-centered study of the effectiveness of (body) psychotherapy under natural conditions demands high organisational capability, as well as patience and endurance from all participants. Especially when standardized measurements of effectiveness are not an integral part of therapy, the extra amount of time spent with the evaluation is considerable. Since participation in the study was voluntary, it became obvious that therapists were reluctant to have their practical work scientifically evaluated. Furthermore, motivation was a problem, since for the therapists involved the extra work was honorary. This caused data collection, which started in January 1998, to proceed rather slowly.

The idea to include a "waiting-list" control group (as originally intended) was dropped, partly for practical reasons (psychotherapists are rarely in the position to make waiting lists) and partly for ethical reasons (people seeking therapy should be allocated to treatment as quickly as possible – recommended to colleagues). Also, there exist many evaluation studies of other treatments by now, so that the achieved results can be compared to them.

Prospectively, more collaboration between professional researchers and psychotherapists is desirable, and the dialogue among the different therapeutic schools should be intensified.

For body psychotherapeutic schools this study demonstrates that there is no need to fear comparison using standardised instruments of therapy research. For the future, the task emerges to formulate specific therapeutic goals and to develop suitable measuring instruments. If these were available, the indices for effectiveness discussed here could be augmented by indices that are specific to body psychotherapy. In addition, the disorder-specific effectiveness of body psychotherapy should be investigated.

The preliminary results from this study demonstrate that body psychotherapeutic approaches can claim an adequate position in mental health care.

References

Beck A T, Epstein N B G, Steer R A (1988) An Inventory for Measuring Clinical Anxiety. Psychometric Properties. Journal of Consulting and Clinical Psychology 56 (6) 893-897.

Bergin A E (1971) The Evaluation of Therapeutic Outcomes. In: Bergin A E, Garfield S L (eds) Handbook of Psychotherapy and Behavior Change. Wiley, New York: 217-270.

Boadella D (1990) Die somatische Psychotherapie: Ihre Wurzeln und Traditionen. Boadella D, Maul B (Hrsg) Energie und Charakter: 3-41 in Band 1 der deutschen Ausgabe.

Boadella S, Boadella D (2002) Internationales Institut für Biosynthese, Forschung -Entwicklung - Ausbildung (IIBS) Psychotherapie Forum 10 (2) 96-97.

Bortz J (1984) Lehrbuch der empirischen Forschung. Springer, Berlin.

Boyesen G (2001, 9.Aufl.) Über den Körper die Seele heilen. Kösel, München.

Chambless D L, Sanderson W C, Shoham V, Johnson S B, Pope K S, Crits-Christoph P, Baker M, Johnson B, Woody S R, Sue S, Beutler L, Williams D A, McCurry S (1996) An Update on Empirically Validated Treatments. The Clinical Psycholgist 49: 5-18.

Cierpka M, Orlinsky D, Kächele H, Buchheim P (1997) Studien über Psychotherapeutinnen und Psychotherapeuten. Psychotherapeut 42: 269-281.

Collegium Internationale Psychiatriae Scalarum (CIPS, Hrsg 1996). Internationale Skalen für Psychiatrie, 4. Aufl. Beltz Test, Göttingen.

Cohen J (1977) Statistical Power Analysis for the Behavioral Sciences. 2nd ed. Academic Press, New York.

Dilling H, Mombour W, Schmidt M H (1993) Internationale Klassifikation psychischer Störungen. ICD-10. Huber, Bern.

Ehling M, von der Heyde C, Hoffmeyer-Zlotnik J H P, Quitt H (1992) Eine Deutsche Standarddemographie. ZUMA-Nachrichten 31, Jg. 16, November 1992: 29-46.

European Association for Body Psychotherapy – Schweiz / CH-EABP (2000) Körperpsychotherapie – Schweiz. Die wichtigsten Psychotherapieformen. Unveröffentlichte Broschüre. Bern. www.eabp.org

Ferenczi S (1984) Bausteine zur Psychoanalyse. Bd. 1-4. Huber, Bern.

Fischer M (2002) Institut für Integrative Körperpsychotherapie (IBP). Psychotherapie Forum 10 (2) 90-91.

Franke G H (1995) Die Symptom-Checkliste von Derogatis SCL-90-R. Hogrefe, Göttingen.

Franke G H (2002) Die Symptom-Checkliste von Derogatis SCL-90-R. 2. Auflage. Beltz Test, Göttingen.

Fydrich T, Laireiter A-R, Saile H, Engberding, M. (1996) Diagnostik und Evaluation in der Psychotherapie: Empfehlungen zur Standardisierung. Zeitschrift für Klinische Psychologie 25: 161-168.

Geiser-Juchli C (2002) Ausbildungsinstitut für Klientzentrierte Gesprächs- und Körperpsychotherapie (GFK). Psychotherapie Forum 10 (2) 88-89.

Geissler P (1999) Körperpsychotherapie als Kurzzeittherapie: Therapeutische Arbeit im Spannungsfeld zwischen Übertragungen und korrigierenden Neuerfahrungen. Psychotherapie Forum 7 (1) 21-32.

Geuter U (1996) Körperbilder und Körpertechniken in der Psychotherapie. Psychotherapeut 41: 99-106.

Geuter U (2000) Historischer Abriss zur Entwicklung der körperorientierten Psychotherapie. In: Röhricht F (Hrsg) Körperorientierte Psychotherapie psychischer Störungen. Ein Leitfaden für Forschung und Praxis. Hogrefe, Göttingen.

Grawe K, Donati R, Bernauer F (1994) Psychotherapie im Wandel. Von der Konfession zur Profession, Hogrefe, Göttingen.

Groddeck G (1988) Verdrängen und Heilen. Aufsätze zur Psychoanalyse und zur Psychosomatischen Medizin. Fischer, Berlin.

Gudat U (1997) Bioenergetische Analyse als ambulante Psychotherapie - Anwendungsbereiche und Wirkungen. Psychotherapie Forum 5: 28-37.

Hahn P (Hrsg 1979) Psychosomatik, Kindlers Psychologie des 20. Jahrhunderts, Kindler Zürich.

Hautzinger M, Bailer M, Worall H, Keller F (1994) Beck Depressions Inventar (BDI). Testhandbuch. Huber, Bern.

Hessel A, Schumacher J, Geyer M, Brähler E (2001) Symptom-Checkliste SCL-90-R: Testtheoretische Überprüfung und Normierung an einer bevölkerungsrepräsentativen Stichprobe. Diagnostica 47(1) 27- 39.

Horowitz L M, Strauss B, Kordy H (2000) Inventar zur Erfassung Interpersonaler Probleme – Deutsche Version IIP-D. 2. Aufl. Beltz Test, Weinheim.

Jacobson N S, Follette W C, Revenstorf D (1984) Psychotherapy Outcome Research: Methods for Reporting Variability and Evaluating Clinical Significance. Behavior Therapy 15: 336-352.

Jacobson N S, Truax P (1991) Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research.Journal of Consulting and Clinical Psychology 59: 12-19.

Janet P (1924) Principles of Psychotherapy. Freeport, New York.

Koemeda-Lutz M, Carle L, Steinmann H, Müller V, Ventling C (2002) Schweizerische Gesellschaft für Bioenergetische Analyse und Therapie (SGBAT). Psychotherapie Forum 10 (2) 106-107.

Kurtz R (1994) Hakomi, Kösel Verlag, München.

Laireiter A R, Vogel H (Hrsg 1998) Qualitätssicherung in der Psychotherapie und psychosozialen Versorgung. Ein Werkstattbuch. DGVT-Verlag, Tübingen. Darin S 18-46: Laireiter A R, Vogel H, Qualitätssicherung in der Psychotherapie.

Linden M (1987) Phase-IV-Forschung. Springer, Heidelberg.

Linden M (1989) Die Phase IV der Therapieevaluation. Der Nervenarzt 60: 453-461.

McGaw B, Glass G V (1980) Choice of Metric for Effect Size in Meta-Analysis. American Educational Research Journal 17: 325-337.

Meyer V, Buchmann R, Haldimann C, Lichtenegger E (2002) Das Schweizer Institut für Körperorientierte Psychotherapie (SIKOP). Psychotherapie Forum 10 (2) 116-117.

Michel I, Koemeda-Lutz M (2002) Stammbaum zur Geschichte der Bioenergetischen Analyse. In: Koemeda-Lutz (Hrsg) Körperpsychotherapie – Bioenergetische Konzepte im Wandel. Schwabe Verlag, Basel: 12-26.

Müller-Braunschweig H (1997) Zur gegenwärtigen Situation der körperbezogenen Psychotherapie. Psychotherapeut 42: 132-144.

Müller-Hofer B (2002) Klientenzentrierte Körperpsychotherapie (GFK-Methode) Ergebnisse einer Praxisevaluation. Dissertation, Universität Salzburg.

Röhricht F (2000) Körperorientierte Körperpsychotherapie psychischer Störungen. Hogrefe, Göttingen.

Rudolf G (1998) Taxonomie der Psychotherapieforschung. In: Psychotherapie Forum 6 (2) 80-91.

Sanderson W C, Woody S (1995) Manuals for Empirically Validated Treatments. The Clinical Psychologist 48: 7-11.

Schatz D S (2002) Körperarbeit in der klientenzentrierten Körperpsychotherapie. Psychotherapie Forum 10 (1) 38-45.

Scheidt C E, Seidenglanz K, Dieterle W, Hartmann A, Bowe N, Hillenbrand D, Sczudlek G, Strasser F, Strasser P, Wirsching M (1998) Basisdaten zur Qualitätssicherung in der ambulanten Psychotherapie. Ergebnisse einer Untersuchung in 40 psychotherapeutischen Fachpraxen Teil 1: Therapeuten, Patienten, Interventionen. Psychotherapeut 43: 92-101.

Schulte D (1993) Wie soll Therapieerfolg gemessen werden? Zeitschrift für Klinische Psychologie 22 (4) 374-397.

Schwarzer R (1994) Optimistische Kompetenzerwartung: Zur Erfassung einer personellen Bewältigungsressource. Diagnostica 40 (2) 105-123.

Schwarzer R, Jerusalem M (Hrsg 1999) Skalen zur Erfassung von Lehrer- und Schülermerkmalen. Dokumentation der psychometrischen Verfahren im Rahmen der wissenschaftlichen Begleitung des Modellversuchs Selbstwirksame Schulen. Freie Universität, Berlin.

Schweizer Charta für Psychotherapie. http://www.psychotherapiecharta.ch/

Schweizer M, Budowski M (2001) Versorgungsdokumentation. Gesamtbericht. Neuchâtel, CH, Schweizer Charta für Psychotherapie.

Schweizer M, Buchmann R, Schlegel M, Schulthess P (2002) Struktur und Leistung der Psychotherapieversorgung in der Schweiz. Erhebung der Schweizer Charta für Psychotherapie. Psychotherapie Forum 10 (3) 127-146.

Seidler K-P, Schreiber-Willnow D, Hamacher-Erbguth A, Pfäfflin M (2002) Die Praxis der Konzentrativen Bewegungstherapie. Psychotherapeut 47: 223-228.

Seligman M E P (1995) The Effectiveness of Psychotherapy. The Consumer Reports Study. American Psychologist 50: 965-974.

Soeder U, Kaschke M, Scherrmann T, Dobiasch U, Weiss H, Revenstorf D (1999). The Outcome of Body psychotherapy – an Evaluation Study. 7th European Congress of Body Psychotherapy, Travemünde.

Stattman J (1987) An Introduction to Unitive Psychotherapy, Part I and II in Polaris 1(1) and 1 (2), Amsterdam.

Strauss B M, Kächele H (1998) The Writing on the Wall – Comments on the Current Discussion about Empirically Validated Treatments in Germany. In: Psychotherapy Research 8 (2) 158-170.

Ventling C, Gerhard U (2000) Zur Wirksamkeit bioenergetischer Psychotherapien und Stabiltität des Therapieresultats. Eine retrospektive Untersuchung. Psychotherapeut 45: 230-236.

Vessey J T, Howard K I (1993) Who seeks psychotherapy? Psychotherapy 30 (4) 546-553.

Von Uexküll T (1979) Psychosomatische Medizin. Hrsg: Adler R H, Herrmann J M, Köhle K, Schonecke OW, Von Uexküll T, Wesiack W, Urban und Schwarzenberg, München, Wien.

Von Weizsäcker V (1947) Körpergeschehen und Neurose. Klett, Stuttgart.

Willutzki U, Botermans J-F, SPR Collaborative Research Network (1997) Ausbildung in Psychotherapie in Deutschland und der Schweiz und ihre Bedeutung für die therapeutische Kompetenz. Psychotherapeut 42: 282-289.

Wuchner M, Eckert J, Biermann-Ratjen E M (1993) Vergleich von Diagnosegruppen und Klientelen verschiedener Kliniken. Gruppenpsychotherapie und Gruppendynamik 29 (2): 198-214.

Biography

Martin Kaschke, Dipl. Psych., Dipl. Biol., Hakomi-Therapist, university education and therapy training at Heidelberg, is working as research co-ordinator in the present study and is preparing his dissertation on the evaluation of body psychotherapy. Contact at martinkaschke@web.de

Margit Koemeda-Lutz, Dr. rer. soc., Dipl. Psych., clinical psychologist (Universities of Konstanz and Zürich), co-worker in a neuropsychological research project (DFG) at the University of Konstanz for several years, founding member of the "Breitensteiner Therapiewochen" (Annual

Psychotherapy Conferences at “Breitenstein”, 1981-2000); psychotherapist SPV, Boenergetic Analyst in private practice, faculty member of the Swiss Society for Bioenergetic Analysis SGBAT; member of the executive committee SGBAT (1994-2001). Contact at Koemeda@bluewin.ch

Dirk Revensdorf, Prof. Dr. rer. soc., Dipl. Psych. (University of Hamburg), personality and psychotherapy research at the Max-Planck-Institute for psychiatry at Munich and at the University of Konstanz. Professor of clinical psychology at the University of Tübingen and the Universidad de las Americas Puebla (Mexico). Chairman of the Milton Erickson Society (Germany). Special psychotherapeutic education: Behaviour therapy, Gestalt therapy, Hypnotherapy, Body psychotherapy. Working areas: Theory of personality, methodology of research, psychotherapy research, hypnosis, therapy for couples, psychotherapy. Contact at DRevenstor@aol.com

Thomas Scherrmann, Dr. rer. soc., Dipl. Psych., doctoral theses on stress-coping strategies in families of schizophrenic patients. Head of research projects and educational trainings with relatives of endogeneously psychotic patients. Approbation for Behaviour Therapy and Clinical Hypnosis. Certified Hakomi-therapist. Psychotherapy and Shiatsu in private practice at Tübingen, independent researcher. He can be contacted at t.scherrmann@t-online.de

Ulrich Soeder, Dipl. Psych. (University of Heidelberg), scientific co-worker at the University of Technology of Dresden in the fields of clinical psychology and medical psychology from 1996-2002, Hakomi-therapist. Working emphasis: psychiatric epidemiology, research on psychotherapeutic services, prevention of back-pain, evaluation. Contact at ulrichsoeder@t-online.de

Halko Weiss, Dipl. Psych. (University of Hamburg). Psychological psychotherapist and supervisor (BDP). Founding member and senior trainer of the Hakomi Institute of Europe, e.V. at Heidelberg. Psychotherapy in private practice and in several institutions; trainer for people in leading positions; trainer for body psychotherapy in Europe, North-America, New Zealand and Australia. Contact at halkohd@aol.com

Listening to the Body
Pragmatic Case Studies
Of Body-Centered Psychotherapy

Amelia H. Kaplan, Psy. M. and
Laurie F. Schwartz, M.Th., M.S.

Abstract

Body-centered Psychotherapy (BcP) is a developing field of academic investigation. The present research employed the Pragmatic Case Study Method ("PCS Method") for systematically studying how verbal and somatic interventions are combined in a single therapy in two 12-session cases seen by an experienced BcP therapist. Following the PCS Method, the cases begin with a presentation of the therapist's theoretical approach, or "guiding conception," and a description of how it is applied to each client. The data analyzed in each case include videotapes and transcripts of selected therapy sessions; pre- and post-therapy scores on standardized, quantitative measures; a pre- and post-treatment goal-setting interview; and a semi-structured, post-therapy, outcome interview. The results revealed substantial progress and statistically-significant quantitative changes in both clients. Additionally, distinctly different patterns of progress occurred, as the therapist tailored therapy in accordance with the needs of each client.

Body-centered Psychotherapy (BcP), also known as "Body Psychotherapy" and "Somatic Psychology," is a developing branch of psychology based on the vital connection between psychological symptoms and physiological states. Although many non-BcP therapies attend to bodily experience, what distinguishes BcP as a unique subfield within psychology is the centrality of somatic sensory experience throughout diagnosis, formulation, and treatment (e.g., see such pioneer therapists in the field as Ferenczi, 1953; Kurtz & Prestera, 1976; Lowen, 1958; Reich, 1945). Additionally, physical touch is more often used by BcP therapists, even though many BcP therapists do not use touch or only introduce it tangentially.

The most comprehensive set of references to BcP exist on a CD-ROM Bibliography developed by the European Association of Body Psychotherapy (Young, 2005). There exists extensive literature on the healing power of touch (Field, 2001; Harlow, 1974; Montagu, 1971) and on touch in psychotherapy (Hunter & Struve, 1998; Smith, 1985; Smith, Clance, & Imes, 1998), yet Somatic Psychology has mostly been developed clinically. May (2002) conducted a comprehensive literature search over the previous 30 years and found 23 empirical BcP studies. A brief review of such studies follows.

The first major prospective clinical trial is currently underway in Germany and Switzerland (Koemeda-Lutz et al., 2003). In this study, eight major BcP outpatient clinics are measuring clients to study the effectiveness of BcP under natural conditions. Preliminary results are promising, finding that after six months of BcP treatment (n=78), small to medium effects were reported across all clinical categories.

Ventling and Gerhard (2000) conducted a retrospective study of 319 former patients to study outcome and stability of the efficacy of Bioenergetic therapy with adults in a private practice setting. Drawing from the patients of sixteen certified Bioenergetic therapists, the authors collected data from former patients who had a mean of 91 sessions (modal 26-50 sessions), and who terminated therapy between 6 months and 6 years previously. The responses demonstrated that for 107 (75%) of the patients, Bioenergetic therapy proved effective to very effective and that the results had lasted from at least 6 months to 6 years.

Several studies have investigated the outcome of BcP using case study designs. Bourque (2002) collected pre and post-test data on four chronic pain clients who engaged in eight weekly "Somatics" sessions and found statistically significant decreases in pain and increases in pain-free activities in three of the four subjects. Employing a qualitative analysis of a single case, Bridges (2002) found that Bioenergetic therapy addressed the client's "somatic defenses against affect" and significantly increased affective expression in a short-term psychodynamic treatment (McCullough et al., 2003a). Finally, also studying a single case, Price (2002) examined the effects of adding an 8-week adjunctive BcP therapy alongside an ongoing verbal psychotherapy for a woman with childhood sexual and physical abuse. The client demonstrated significant improvement on such standardized quantitative measures as the SCL-90-R (also used in the present study) in such areas as depression, anxiety, and obsessive symptoms, as well as decreases in her physical symptoms. In addition, the client qualitatively reported improvement in "feelings of safety, ability to tune in to internal processes, and ability to access emotion."

A recent meta-analysis of massage therapy (MT) research, drawing from a wide range of sources (psychology, nursing, medicine, and kinesiology), found MT significantly effective for both physiological and psychological outcomes (Moyer, Rounds, & Hannum, 2004). Additionally, reductions in trait anxiety and depression were MT's largest effects, similar to those found in psychotherapy meta-analyses. The authors speculate that combining massage and psychotherapy may significantly increase effectiveness more than either alone.

The present research builds on previous systematic, empirical studies to help fill the need for many more such investigations in BcP in order to create a solid scientific foundation for the field. Specifically, this investigation

includes in-depth, systematic case studies involving qualitative process compared with standardized quantitative measures to examine how BcP integrates the body into psychotherapy, as seen through the work of Laurie Schwartz, M.S, L.M.T. (Licensed Massage Therapist), a widely known BcP practitioner with 25 years of practice in the field. The main questions guiding this study include: What does BcP therapy look like? What themes in BcP therapy are unique or distinguishing? And how does BcP therapy integrate talk and touch in a unified therapy? In addition, by looking at what is distinctive about a BcP approach, this study can begin to contribute to the questions of whether it is effective to combine talk and touch in a single therapy, and if so, what are the mechanisms of change in such a therapy.

METHOD

Conceptual Design

The present study uses the Pragmatic Case Study Method (The "PCS" Method) to study BcP systematically in detail and in context (Fishman, 1999; 2005; Peterson, 1991). Through methodical and rigorous case studies, the PCS Method offers a structured way to investigate what about BcP treatment is distinctive and useful. It does this through the process of Disciplined Inquiry, a method of action-research that includes both quantitative and qualitative data in order to study how a psychological service such as a BcP practitioner can meet the needs of clients.

As shown in Figure 1 below, the Disciplined Inquiry Model calls for description of a client's situation and presenting problems (A), then a setting forth of the practitioner's "guiding conception" (B). The guiding conception is the overarching theory a practitioner brings to his or her work, as informed by previous research and clinical experience (C). The guiding conception is then traced as it interacts with the specific needs of the client, through the steps of assessment (D); formulation, including treatment plan (E); action, or intervention (F); monitoring evaluation and feedback (G); possible recycling through earlier steps (H-K); and concluding evaluation (L). The feedback processes are essential, action-research components of the Disciplined Inquiry Model. In the present project, the methodology is being pilot-tested with three case studies, however due to space limitations, only two cases are outlined in this paper.

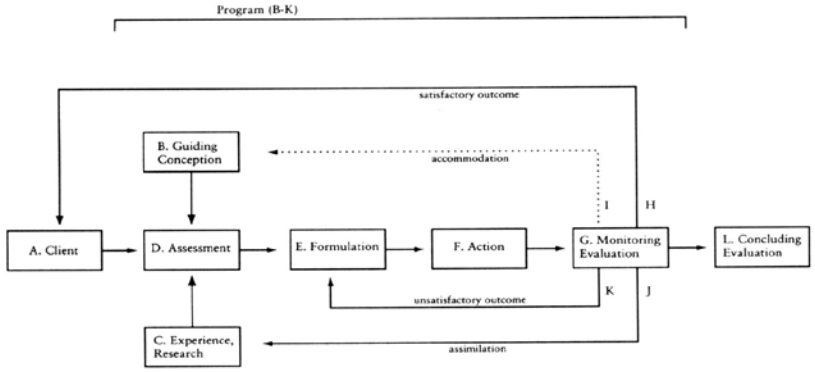


Figure 1. Professional Activity as Disciplined Inquiry
(adapted by Fishman (1999) from Peterson, 1991).

Following the PCS Method and Disciplined Inquiry model, the first step in this investigation was explicitly documenting Laurie Schwartz' "guiding conception," which includes her theoretical assumptions concerning problem assessment, goal setting, techniques, treatment plan, and intervention (Peterson, 1991). This documentation was completed by the first author based on a series of interviews with Ms. Schwartz, hereafter referred to as "the therapist." The second step was examining how the therapist's guiding conception played out in three of her cases, two of which are included in the present report.

Research Design

The two research subjects are individuals from the therapist's referral network. To participate in the research, these individuals could not have crisis conditions, e.g., suicidality, severe depression, and intense difficulty with separation. The first 12 sessions of therapy were offered at a reduced fee in exchange for participating in the research protocol. When the client was suitable for the study, the researcher (the first author) met with the subject to review the consent form as well as administer the assessment measures. Subjects were also apprised of the role of videotaping sessions. In writing up the cases, all names and identifying information

have been changed. The study was approved by the Institutional Review Board of Rutgers University in September, 2003.

Before treatment began, the subjects met individually with the researcher. At that time, they each completed several self-report measures, which included: the Treatment Evaluation and Management (TEaM) Scales for assessing symptomatology and life functioning (Grissom, G.R., Lyons, J.S., & Lutz, W., 2002); the Symptoms Checklist 90-Revised (Derogatis, 1993); a Scale of Bodily Connection (Price, 2004); and an interview-based goal measure, Goal Attainment Scaling (Kiresuk, Smith & Cardillo, 1994). Since treatment was meant to occur naturalistically, at the initial interview, subjects were instructed that if the measures evoked any reactions or clinical details, they should explain them directly to the clinician.

Within the study, each subject received 60 minutes of treatment per week for 12 weeks. Although treatment in the cases was open-ended, only the first twelve sessions were included in the research. The BcP sessions consisted of focused, body-oriented psychotherapeutic techniques and psychoeducation, e.g., subjects were asked to attend to their internal physical sensations for cues to their mental states.

At the end of the treatment (or the end of 12 sessions), subjects were administered the same measures to evaluate their current level of functioning and whether they experienced any changes from the treatment. Subjects were also interviewed to determine their subjective experience of the treatment process and symptom change. The objective measures (both pre- and post- treatment) were sealed and kept in a locked cabinet until the completion of the case analysis, after which they were viewed and compared with the other data as a source of reliability information and quality control. In other words, the quantitative measures functioned as an independent source of data with which to compare the qualitative results.

Data consisted of a series of process and outcome measures, as well as transcripts of the videotaped sessions. The videotapes themselves were a crucial source of information (Alpert, 1996; McCullough et al., 2003b) – both as independent sources of data and additionally through the therapist and researcher together reviewing the videotapes of these sessions to articulate how the therapist's guiding conception interacted with the presenting problems and goals of the subject, and how she integrated that information into her theoretical intent which guided the next interventions.

Data Analysis: A Framework for Presenting and Analyzing Each Case

For the qualitative analysis, selected sections of each subject's treatment sessions were reviewed together by the therapist and researcher during which the practitioner discussed her guiding conception and elaborated on the treatment process. The researcher and clinician identified 19 themes that are involved in the theory of a BcP treatment. The researcher selected three core themes related to the interaction of verbal and somatic interventions to guide cross-case analysis. Due to the extensive amount of data, the narrative analysis was limited to sessions 1, 6, and 12, which were analyzed in depth. For the pre- and post-therapy quantitative data, the statistical test that was most appropriate to the case study was the Reliable Change Index (RC) developed by Jacobson and Truax (1991).

Laurie Schwartz's Guiding Conception ("B" and "C" in Figure 1)

A Model of Health

As mentioned above, following the PCS Method, the first step in understanding a case is to set forth the guiding conception of a therapist, including related research and experience. In the therapist's theory of BcP, the ideal of health is for a client to move towards a more related way of being with one's self and body, aware of sensations, feelings, and thoughts, while staying related to other people. This therapeutic model draws from psychodynamic developmental theory, including object relations and self-psychology elements focusing on the mother-infant dyad (Aron & Anderson, 1998; Schore, 1994).

In the therapist's theoretical framework, individuals have a core essence which, given supportive conditions in infancy, guides the person's development into a fully-formed healthy adult. If children are loved and nourished, then they can be creative, feel seen, have social engagement; they learn that their needs can be met, that they can express themselves, and successfully follow their impulses. If the parent is relaxed and grounded and gives the infant a feeling of containment, the infant has a chance to become "oneself" – a person who learns that there is a boundary around itself as separate and not just as an extension of another person. All of these help a child feel happy.

As studies have shown (Porges, 1997; Tronick, 1989), much regulation of affect occurs between caretaker and infant (Schore, 1994). A large part of a child's self, including the ability to self-regulate its own nervous system, develops in this dyadic connection (Schore, 1994; Tronick et al., 1998). It is through this relational process that children develop a sense of self as well as a self in relationship, a concept which forms the backbone of the therapist's method of BcP work.

Since much communication between mother and infant is somatic and non-verbal, it is in this early stage of development that persons learn to self-regulate, i.e., modulate their affective levels within their nervous systems. The goal is to encourage health by helping people self-regulate and enjoy emotional resiliency (Caldwell, 1997). Biological self-regulation means that a person's nervous system can fluidly go through states of activation and discharge (Levine, 1997). Emotional resiliency means the ability to let emotions flow through one's system without having to act on them impulsively or deny them by blocking or repressing. Health also has an interpersonal aspect, as well as a somatic component. Health is being able to "be" in one's body, name feelings verbally, move in a fluid way from one feeling state to another, discriminate and make decisions freely, tap into creative inspiration, and self-regulate one's nervous system. Therefore, health involves learning to remain in one's body consciously while staying in relation to others.

Dysfunction in Development

Due to genetic, biological, societal, and emotional factors, many people grow up not to be embodied or grounded. This means these people do not allow (or do not know how to allow) their selves to be nourished. Often the results of inadequate "holding" by caretakers, lack of mirroring, and not enough experience of feeling separate and contained are found in the body, which must overcompensate in order to hold the "self" together. The "armoring" of the body – the holding patterns that often make up a person's rigid or collapsed body posture – can result from these early psychological deficits (Kurtz, 1990; Reich, 1945). One of the therapist's main tenets of practice is making characterological patterns conscious through mindfulness.

Based on Buddhist meditation practice and a central tenet of Hakomi therapy (Kurtz, 1990), mindfulness is an awareness-based state of consciousness in which a person has heightened attentiveness to his or her inner states, without judgment. Mindfulness usually occurs with clients' eyes closed as they look inward and stay present for whatever thoughts, feelings, memories, images, impulses, and sensations emerge moment-to-moment. The therapist's theory of change focuses on helping a person understand and heal the wounds of an infant/caretaker breach by encouraging clients to witness, experience, and understand their habit patterns and how they are organized, in order to change them. If a person can get into a state of mindfulness, she or he can come to observe beliefs and habit patterns manifest in the body through physical behaviors and gestures -- and in doing so access a core self (Kurtz, 1990).

Yet clients who cannot access mindfulness often have serious trauma histories resulting in severe hypervigilance (e.g., the case of Jan). In the therapist's model, trauma is conceptualized as energetic impulses frozen in the nervous system without discharge (Levine, 1997; van der Kolk, 1994). When events cause enormous "shock trauma" (e.g. rape, violent attacks, military action, disasters, accidents, etc.), they flood and override the coping of the nervous system. Levine (1997) describes how unlike animals who shake off the freeze through twitching, shaking, or moving, which helps them regain their normal function, often humans do not move through the survival response to resolution. People impacted by traumatic experiences, if they cannot metabolize them cognitively, emotionally, and sensorily, remain "frozen in time" (van der Kolk, 1994).

The focus of trauma-oriented work is therefore to bring the nervous system back into biological self-regulation by completing the frozen response. The therapist follows Levine's model of going step-by-step through the "felt sense" of bodily sensation so clients learn to stay in their bodily sensations as well as learn the language of sensation (i.e., tingling, freezing). The therapist believes clients can be helped to resolve trauma by slowing them down so their bodies can complete defensive orienting motor responses (Levine, 1997). Unblocking frozen trauma in the nervous system often involves such physical discharge as heat, sweating, palpitations, shaking, and twitching.

It is not, however, enough to experience one's bodily sensations. A lot of the therapist's work therefore involves helping clients to relax in their bodies, because if a client cannot access relaxation, then they cannot work at the levels of high excitation of trauma without fear and tension overtaking them. Therefore, the first aspect of the therapist's work is to teach her clients to access their inner resources, i.e., experience positive feelings of relaxation and grounding. If they were to tell their stories without such bodily grounding, they would merely be reliving the trauma sensations without any healing effect.

Physical Touch

To understand the role of touch in the therapist's guiding conception, it is important to understand there is a direct connection between mindfulness, awareness of sensation (for healing trauma) and touch. Awareness of

inner bodily sensations does not come naturally to many people who are traumatized or characterologically cut off from their bodies and bodily sensations. Touch is used as an important technique for teaching clients awareness of their own body sensations, i.e. their "felt sense." Often without any physical touch, people can stay largely cognitively oriented, cut off from much of their experience. Touch can therefore help clients develop a sense of their inner sensory world, and thereby develop kinesthetic and body ego.

At the beginning of therapy, the therapist prepares clients for the touch component in her treatment, and revisits their comfort and safety frequently. As discussed in the therapist's consent form: "Touch may be used as an 'experiment in mindfulness' to support ('take over') physical protective posture. Nothing will be done without your approval and your sense of feeling safe and right about it. You are invited and encouraged to discuss openly and freely with me any question or concern you might have about the process we are in together at any time."

It is unusual for the therapist to touch a client within the first few sessions, as it takes time for appropriate safety to develop in the alliance and to understand how touch technique will interact with a client's needs. The therapist emphasizes being in the moment with the client and following the needs of her client, trying to let the client's unconscious lead the way. In the therapist's own words, "I don't force myself to diagnose or analyze a client right away – if you are in the present moment and have implicit trust in the body, and you partner them moment to moment, then memories that are stored in the cells of the body will reveal when the person is ready."

Assessment

The researcher categorized aspects of the therapist's assessment of a client's embodiment:

Essence: Where is this person in relationship to self? To caretakers? How far is this person from the ideal notion of health?

Biological: Is this person able to regulate biologically? Does this person know what self-regulation looks like and feels like?

Embodiment: How are they connected to and with their body? Where is energy moving or not moving in their body? Are they able to stay in their body?

Sensation: Are they aware of sensation? –e.g., my jaw is tight, my upper body feels empty, my lower body feels like lead. Are they able to ground in sensation?

Affect: Can they be in a feeling state? Can they articulate a feeling state? Do they have emotional resiliency? Can they be in touch with all their feelings and still function?

Cognitive: Can they identify thoughts and beliefs that are influencing their daily life?

Family systems: What are the developmental experiences and memories that are affecting their sense of self? What affecting them might be generational?

Goals/Intentionality: What would you like to work on today? i.e. where are they in their life journey and what would be helpful in this stage?

Consciousness/Awareness – How much awareness does this person have? Where is their awareness of their feelings, my presence – who am I to them?

Mindfulness: Are they capable of mindfulness? Are they capable of tracking? How do they feel about going into mindfulness, especially closing their eyes?

Formulation and Diagnosis

To create a formulation, the therapist uses four kinds of questions: Does the client know how to be grounded? What is missing for the client at the level of bonding? What is the intention of the client? Can the client access mindfulness? Due to the therapist's holistic focus, she does not use traditional DSM-IV-TR diagnoses. The diagnoses in the cases were formulated by the researcher.

Treatment Plan

The therapist focuses her BcP treatment plan on four different levels:

The Developmental Level: The therapist identifies and supports clients' unmet developmental needs, to learn to nourish and develop in ways they were not able to at a young age (i.e., a person who did not have enough contact learns to "hold herself" and someone without enough mirroring learns to affirm himself). She helps clients make the unconscious conscious.

The Trauma/biological Level: She works with clients to come out of trauma reactions and re-regulate their nervous systems.

The Characterological Level: She often works to attend to habit patterns so clients can understand their characterological organization.

The Dream/Spirit Level: She works with dream analysis and imagery to access formerly inaccessible beliefs, feelings, and behaviors. She follows the psychodynamic principle that such access leads to more healthy control and life choices.

RESULTS

Case Analysis Themes

From the initial analysis of the case material, the researcher and therapist inductively derived 19 themes. Three themes were chosen due to their salience in addressing how to combine talk and touch in a single therapy.

Theme 1: Helping Clients Feel "Nourished" by Their Internal Resources

This theme refers to the therapist bringing clients' awareness to a positive, nourishing aspect of their lives (e.g., loving feelings, a calming image of the ocean). It could be through thought, feelings, imagery, etc. As discussed above in the section on the therapist's guiding conception, only when people are grounded in a way that they can connect with their internal resources can they tolerate the difficult sensations of trauma and enjoy nourishment without trauma. Too often the work of verbal psychotherapy has been problem or deficit-focused. BcP's emphasis on working with the bodily experience of positive feeling and the sensations that get in the way of enjoyment offers a major paradigmatic shift in treatment. Empowering clients with tools to access nourishment and find inner resources themselves appears to be one of the most important aspects of BcP.

Theme 2: Using Physical Touch

The hypothesis that touch can provide a healing modality which is different or adjunctive to talk is the theme that originated the study. Some questions: How does a BcP therapist use touch in a therapy? When does she touch the client, at what points in treatment, and what is the client doing that leads to wanting to touch? What are the constraints? How does the therapist introduce it? Does that change as clients get used to touch?

Theme 3: Working with Narrative Versus Body

This theme involves how much to focus on body-oriented techniques versus working within a client's narrative in the treatment. The therapist's guiding conception includes the belief that a client must be adequately grounded before telling a trauma narrative, yet at times clients will seem more inclined to "figure out" through talk, which may appear at odds with the therapist's body-orientation. Often some struggle exists between therapist and client around talking versus focusing on the body.

The Case of Jan

Jan, a 49-year old Caucasian Catholic twice-divorced professional woman, presented with long-term symptoms of tension and anxiety around sexual and physical abuse by her father. She had no explicit memories of sexual abuse, but had vague memories of being struck from behind by her father, as well as strong fear sensations in her body of possibly having been a victim of incest. Jan suffered from chronic anxiety and neck pain. She was a successful professional woman, yet had been in two failed marriages. Several years previously, Jan made a commitment to "get off toxic relationships" and heal herself. At the time of referral, Jan had been in verbal therapy for about five years, and additionally was seeing a bodyworker for about two years for chronic neck pain. With consent of Jan's two other therapists, the therapist worked alongside them as a co-therapist offering her sensory-oriented, trauma orientation. Jan maintained all three appointments weekly; and all therapists were informed of the activities of the others.

Jan's tense and rigid posture and flat affect were important themes throughout treatment. Jan chose this treatment at a time when she was trying to turn her life around. She had a long-term interest in artistic and spiritual pursuits; and during the treatment she remained focused on her art and her spiritual growth, including planning a career change to the healing arts. During the early sessions of therapy, the therapist described what became a

recurring theme: "Jan's decided to stop the re-enactment. She is just learning to trust people. She's dealing with trust, love, and mutuality. Can she allow more emotional connection?" Jan showed little affect and made few relational comments except when she was discussing her artwork. At those times she would begin to laugh and beam with joy. Of the three clients examined in this study, the therapist assessed that Jan appeared the most impaired, most traumatized in her body as well as interpersonally.

Jan's case is distinctive for this type of work since she was expert at tracking and articulating her bodily sensations. In fact, she often got so involved in her moment-by-moment sensory experience that there was little place for emotion or relationships. Therefore, unlike the psychoeducation around finding sensation that often involves much of the treatment, in this case much of the therapist's work was to bring Jan to a feeling of safety within her body so that she could begin to relate externally with others again.

History of Client ("A" in Figure 1)

Jan was the youngest of three siblings of an intact family. Her father was a well-respected medical doctor, who due to his professional career, caused the family to live for several years on the grounds of a mental hospital. Jan has come to understand that she probably suffered in childhood from some kind of anxiety disorder, which remained undiagnosed despite the fact that both parents were in the mental health field. She remembers her father as being cruel and short with her; her few memories of outright physical abuse are being hit from the back. Her mother she considered the enabler; she would watch and not intervene.

She has functioned well professionally, but has had unsuccessful relationships, keeping two husbands solvent, as they remained gainfully unemployed. Several years ago, after her second husband emptied their bank account, she finally resolved to bring her attention and energy to herself. She entered verbal therapy, which led to a conjoint referral for energy/body work to relieve some of her intense neck pain. Over the course of this treatment, she found the therapist, and embarked on a third journey into healing her trauma.

Assessment ("D" in Figure 1)

Qualitative Assessment

The therapist's assessment was that Jan was not calm and grounded: her body seemed frozen and constricted. Jan appeared to live in her body "with a lot of tension in her joints and tissues" suggestive of long-held trauma. Her speaking style was rapid and flat, without much affect or relational sensibility, often interjecting comments throughout the therapist's speech. The therapist assessed that Jan must be able to find her internal calm and remain grounded before she could open up her trauma narrative (Theme 1). A major challenge would be to learn how to work with Jan's rigidity and how physical touch might be useful and appropriate (Theme 2). At the same time, however, Jan was very aware of her bodily sensations. She had an amazing ability to track her sensations. Yet Jan would often stay almost entirely in her bodily experience, unconnected to her narrative or relationships in her life (Theme 3).

Quantitative Assessment and Goals for Treatment

On the SCL-90, Jan's initial scores according to the computer-generated clinical report were in the "clinical range" of at least ten points above the mean on several subscales, including Anxiety, Paranoid Ideation, and Psychoticism. (See Tables 1 and 2 for Jan's pre and post treatment scores.) Her high levels on all three symptom indices: the Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total Index reflected the severity of her initial symptoms. Her TEaM responses reflected Jan's high levels of vocational, social, and personal functioning, which was consistent with her active professional life. On the Scale of Bodily Connection, Jan's scores reflected hypervigilance of her internal sensations and a difficulty with experiencing inner pleasure.

Jan identified three goals in the Goal Attainment Scaling procedure. The first involved connecting more with actual, vivid childhood memories of her abuse instead of her previous vague sensations. She also hoped to be able to express her anger in constructive ways, by speaking up in her relationships. Third, she found that one way she monitored her obsessive fear was "making lists" upon waking in the morning. Jan's goal was to feel less of this anxious fear, which she would know when she made fewer lists.

Formulation ("E" in Figure 1)

The therapist formulated that Jan lived in a state of hypervigilance prepared for intense threat, fearing that if she were to relax and enjoy herself, her father might enter the room and hurt her. This hypervigilance and interpersonal fear kept Jan from feeling safe in relationships. These dynamics were reflected in the Paranoid Ideation and Interpersonal Sensitivity scores of the SCL-90. In terms of a treatment plan, the therapist

hypothesized that in order for the therapy to address the interpersonal part of Jan's experience, first Jan had to come back into biological self-regulation.

DSM-IV-TR Diagnosis

Axis I: Generalized Anxiety Disorder 300.02
Post-traumatic Stress Disorder, Chronic 309.81
Axis II: R/O Schizotypal Personality Disorder 301.22
Axis III: Neck pain
Axis IV: Memories of childhood physical and sexual abuse
Axis V: GAF= 55 (Current)

Action ("F" in Figure 1)

Session 1: "Creating a Manger of Safety"

In this session, Jan was very hypervigilant, saying immediately "yes" or "right" after the therapist's sentences. The therapist's dominant strategy for this session was to join with Jan in an attempt to educate and slow her down so she could get into mindfulness. The therapist used her tone of voice to help Jan access her felt sense, and together they discovered how Jan was organized. The therapist used a lot of imagery with Jan. They worked on helping Jan find her inner resources (Theme 1) through an image of Jan inside the Christmas manger she had created with a community of healers, as well as getting in touch with a bodily based "energy fluid" that Jan described. By the end of the session, Jan is able to voice: "My whole being hurts."
Laurie: And you think your neck hurting is connected to that?
Jan: Mm-hmm. **And I keep thinking that my father's going to show up and tell me that, you know...there's something wrong with what happened, and I should be happy** and I should be taking...you know...doing something for them, or something like that. [sigh]
L: So that's the thought you have. Your father will show.
J: That he'll appear… and he'll…
L: And if he would appear, he would say to you?
J: Yeah…or 'What the hell do you think you're doing?!' That's what he usually…'What the hell do you think you're doing?!' I don't know where he would go after that. I mean…the thing about it is, he'd have to…**He's in his late 70's and he would have to fly here. And then he would have to get past my doorman...I mean, you know [laughs] But it doesn't help me any. I continue to have that emotional sense that he's going to do that. It's an intellectual...Yeah, intellectually I know that…** but **emotionally, my body…it's really my body**…It isn't even my emotions, **but it's my body is just, like, getting ready for him to come**. **And so I can't enjoy myself. I can't relax and just be in the present.**
L: So you're always anticipating being threatened.
J: Mm-hmm.
L: That someone is coming…
J: Mm-hmm. Yes.

Session 6: "Fear of the Naked Lady"

By this session, Jan is fully engaged in the treatment. She has experienced some important shifts in her awareness. In the beginning of this session, Jan comes in with a memory of father coming to hit her, which indicates an important change for Jan. This was one of the first vivid specific memories she has ever had of her father abusing her. Jan is excited by the spontaneous way it emerged, which also indicates a change in the therapy.
L: Okay. So it's a big week?
J: Yeah, yeah. Just a lot. Yeah, and I wanted to tell you about this memory that I had this morning…it was really unusual because the other memories that I had before I would describe as body memories where I physically remember the impact of it, like you know in the past I'll be laying on the floor or sitting in a chair resting comfortably and then I'll feel in my flesh how my flesh felt when he was hitting me. I don't have a recollection of when or where or anything else but I just feel it in my flesh. Okay, and so I write that down.
L: And when did you…?
J: But today, so today this is a different thing. So here I am walking to come here and thinking about what's going on and all of a sudden I get this, I have this really clear recollection of a minute, a second and a half or two seconds of him being here, so I can see his head and I see his hand coming at me and hitting this side of my head really hard and then I keep…what I wrote down is my neck creaks so I didn't break my neck but I can sense and

hear my neck creaking with this. Ok. It's very much from the hits coming this way and going like that. Remember how we were going like that?
L: Yeah.
J: It's like I see . . . What's really startling for me is that this is a visual, there's a sense of it, but I see him. Yeah, kind of what's been really noticed this week is that I feel, the way I said it, it's hard for me to articulate, but to try to say it is that I feel more connected to my fear, to my frenzy. From the past, whatever this is, I recognize there's nothing to be afraid of right this minute. So I feel more connected to this. It's sort of like I feel much better because I'm more connected but I feel I'm really aware of how agitated I am and how afraid I am, so it's kind of like…So I've been kind of in this place where I feel agitated and yet I feel much more peaceful on the other hand because thank god I'm more connected.

Also in this session, Jan has a powerful memory of being a small girl living on the mental hospital grounds and being startled by a mentally-ill naked woman. She remembers not shrieking, instead remaining silently afraid. Here is an important example of a trauma symptom frozen in the nervous system: It is as if all these years Jan was shrieking on the inside, yet never actually expressed or completed the shriek.

J: See now I'm having the, well I can just hear myself shrieking and just screaming.
L: Okay, so we're going to go slow. So as you start to feel the comfort in the palms of your hands and in your ankles you can remember or hear the voice of you shrieking.
J: Mm-hmm.
L: And do you have a sense of what age? Were you a little girl?
J: Mm-hmm. I don't know if I really shrieked or if it's just like I wanted to shriek and it's sort of like, I don't know you know what I mean, I can't tell that…

Jan is starting to understand how remaining frozen in this silent, never-spoken shriek has cut her off from a lot of nourishment (Theme 1), and how she had to be vigilant since no one was protecting her. The therapist works with her to imagine the healthy parent. The therapist also initiates physical contact by suggesting it, but given Jan's high level of arousal merely sits next to her on the couch without any touch contact (Theme 2). In working in mindfulness, the therapist sat next to Jan, who is tense and rigid, without touching her. With her level of somatic trauma and rigidity, that's enough contact for Jan. They do not discuss it and simply talk about Jan's body sensations (Theme 3) as she becomes more grounded.

Session 12: "Moving into a New House"

In this final session for the study, Jan reported feeling in a "new house" of her body. She described feeling a different sense of embodiment, in which she is "lower on the treadmill." Finally, to illustrate how the alliance and Jan's experience in her body has shifted, Jan allowed the therapist to initiate physical touch with Jan's neck and the occipital base of her skull (Theme 2). By the end of the session, Jan felt physically "contained" and was able to access her positive internal resources throughout a difficult focus on fearful memories of her father (Theme 1).

Concluding Evaluation ("L" in Figure 1)

Quantitative Results

Table 1
Jan SCL-90-R Results*

	Jan 1	Jan 2	Pt diff	RC**	Sig at p≤.05
Global Severity Index	67	58	9	-1.59099	
Positive symptom distress index	66	47	19	-3.35876	*
Positive Symptom Total	63	61	2	-0.35355	
Somatization	63	55	8	-1.41421	
Obsessive-Compulsive	57	57	0	0	
Interpersonal Sensitivity	69	60	9	-2.06474	*
Depression	60	58	2	-0.4	
Anxiety	74	63	9	-2.45967	*
Hostility	54	40	14	-2.6943	*
Phobic Anxiety	58	54	4	-0.83406	
Paranoid Ideation	71	57	14	-3.3955	*
Psychoticism	79	60	19	-3.96177	*

*All scores are T-scores with a mean of 50 and a standard deviation of 10. The SCL-90-R was normed on a nonpatient sample, with lower scores indicating healthier functioning
** Reliable Change Index (Jacobson & Truax, 1991).

Table 2
Jan TEaM results*

Subscales	Jan 1	Jan 2	Pt diff	RC	Sig at p≤.05
Subjective Well-Being	59.48	65.44	5.96	0.993333	
Depression	63.57	60.08	-3.49	-0.74407	
Anxiety	47.84	57.49	9.65	1.489027	
Phobia	46.75	50.71	3.96	0.571577	
Obsessive-Compulsive	49.48	53.32	3.84	0.64	
Somatization	59.65	59.65	0	0	
Panic Disorder	56.67	52.49	-4.18	-0.81977	
Post Traumatic Stress Disorder	45.11	49.16	4.05	0.640361	
Symptom Checklist	53.04	55.58	2.54	0.567961	
Personal Functioning	68.03	57.57	-10.46	-1.61401	
Social Functioning	62.24	58.01	-4.23	-0.56526	
Vocational Functioning	67.87	54.55	-13.32	-1.81262	
Functional Disability	68.09	56.05	-12.04	-2.12839	*
Behavioral Health Status Index	61.49	60.16	-1.33	-0.27149	

*All scores are T-scores with a mean of 50 and a standard deviation of 10. The TEaM was normed on an outpatient sample, with higher scores indicating healthier functioning. Because test-retest reliabilities were not available for the TEaM, internal consistency reliability of coefficient alpha was used to calculate RC, which is likely to be higher.

At the end of the 12 sessions, Jan's clinical profile on the SCL-90-R had gone down dramatically. Of the 12 scales, at post-treatment 11 decreased, and all 10 were under clinical levels (below 61). At the beginning of therapy, Jan's symptom picture had been in the clinical range. In the words of the SCL-90 computerized interpretive report, her Somatization had been "unquestionably in the clinical range"; her Anxiety was "consistent with the emergence of a psychiatric disorder of serious magnitude"; her Paranoid Ideation was "almost certainly associated with a formal psychiatric disorder which possesses clear paranoid overtones"; and her Psychoticism (indicating a withdrawn lifestyle) suggested profound alienation or "intense confusion." After treatment, she experienced statistically significant decreases in six subscales: Positive Symptom Distress Index, Interpersonal Sensitivity, Anxiety, Hostility, Paranoid Ideation, and Psychoticism.

Although Jan's results must be considered within the context of Jan's combined therapies, it can be noted that the mitigating variable within the twelve week time period was the introduction of the BcP therapy. Such statistically significant changes, which are consistent with her qualitative results, illustrate how Jan may have changed through BcP. For example, Jan experienced a significant decrease in her Anxiety scale, which included many somatic aspects of anxiety such as trembling and tension, as well as terror, apprehension and dread. This was a main focus for Jan in her work with the BcP therapist, thus providing an important corroboration of their therapeutic work. Jan's reduction in Psychoticism from 79 to 60 – her biggest change in T-scale points – could have been from the therapist's "validating" her body awareness and helping her to put this in perspective and not to be as upset by it. Additionally, Jan's Interpersonal Sensitivity subscale, referring to her self-consciousness, feelings of inadequacy, and marked discomfort during interpersonal interactions, decreased significantly at post-treatment. Given the centrality of relational problems for Jan, her significant drop is an important finding across her work in therapy. At post-therapy, Jan's Anxiety score of 63 is still "slightly elevated," suggesting continued difficulty, again consistent with the qualitative findings, but not to the extent it had been previously.

On the TEaM scales, six subscales increased and seven decreased, which indicates no clear pattern. The decrease in Jan's Functional Disability subscale was the only statistically significant finding. As often the case in psychotherapy studies, it is possible to interpret this finding as indicating that Jan may have been doing better by doing worse. Specifically, she was increasing her awareness of her symptoms, and in the past two weeks spending less time socially and more time experiencing her symptoms (crying, sleeping less). This interpretation is consistent with her qualitative data, which indicated that Jan was going through dramatic shifts in her awareness and internal experience at the end of the twelve sessions. It is for this very reason that the study allowed for a continuation beyond the twelve weeks. Jan intended to continue treatment. Allowing herself to feel "worse" seemed to indicate her commitment to working-through in the therapy.

While the Scale of Bodily Connection does not allow for statistical analysis, a content analysis of Jan's responses indicated an increase in her connectedness to her bodily experience. Additionally, Jan showed much more integration of her physical and emotional world in her responses. For example, on the item "I notice how my body changes when I am angry," she moved from "most" to "all of the time."

Results on the Goal Attainment Scaling indicated that Jan improved in relation to all three of her goals. She was more able to experience and express her anger in a healthy way by speaking up once a week, as compared with her baseline at the beginning of therapy of once every 3 months. She felt more relaxed and in control upon awakening, going from a baseline of obsessively making lists every day to three or more days per week not making such lists. Additionally, concerning memories of early abuse, she had a more complete memory of some of the early abuse than at baseline.

Qualitative Outcome Results: Exit Interview

Jan was ebullient about the therapy and the effects it has had on her experience of herself in her body. Particularly salient in Jan's analysis of her treatment was her emphasis that no single therapy alone would have been enough: "I feel much different than I did in December – a profound difference. I think the change is a result of my commitment to healing in combination with the variety of therapies that I am doing. I firmly believe it is the combination – one or another as a stand-alone would not have given me the results."

What was distinctive about the therapist's work with Jan was its emphasis on positive feeling and calmness. "What Laurie is doing is help me feel calm, deeply feel calm. What I notice is that I have a much greater sense of peace, calmness in myself." In her outside life, Jan noticed that she found herself having to lie down and relax, in a way she finds "very, very healing." At these times, she finds that, having internalized aspects of the therapist's work, her body is leading her.

Reviewing the Narrative Themes

Theme 1: Helping clients feel "nourished" by internal resources. At the beginning of treatment, the therapist witnessed how, immediately upon feeling happy or satisfied, Jan would freeze as if her father were about to come upon her. The therapist formulated that Jan was largely unable to access her internal resources without fear. Her treatment plan largely focused on: a) bringing Jan's awareness to her rigidity and embodied fear and b) helping Jan access an internal sense of calm and nourishment without feeling under threat.

Theme 2: Using physical touch. This case illustrates how, with minimal actual physical contact, a BcP therapist can still work with a body-orientation, using physically oriented language and imagery to help a client become embodied. Jan was often overwhelmed by the experience of physical closeness, so the therapist worked on just sitting next to Jan instead of actively touching her. Much of the contact involved the therapist placing her feet on top of Jan's for several minutes, to help her relax and feel grounded by connecting with her feet on the floor. Imagery also proved to be an important aspect of "feeling touched" without physical contact, which was very important in Jan's treatment. The therapist used imagery of protection to help bridge this gap in contact. Jan immediately responded every time, for example, one time bringing fantasy animals close to her; and in another, surrounding herself with her three therapists and religious monks, who protect her and soothe her.

Also noteworthy was the high frequency of language of discharge that Jan spontaneously used to describe her sensory experience in the sessions. As previously discussed, in Levine's (1997) theory, ending traumatic "freeze" in the nervous system includes sensations such as shaking to discharge tension. Jan instinctively described in very specific language feeling "jerks" and "a warm fluid" moving through her body.

Theme 3: Working with narrative versus body. Jan told very few details of her life story in the treatment, e.g., in only one session does she give factual history. Most important in Jan's case, however, was that she also had a concurrent verbal therapist whom she met with weekly throughout this treatment. Jan emphasized at the end of treatment that she could not have imagined having the progress or doing this work without her combination of therapists. Jan was aware that without the narrative component that she obtained from her verbal therapist, she might not have had the tools to translate what she learned with the therapist (a concern that appeared in Terry's treatment). "If I only did [BcP], it would have taken me to a certain point, and then I'd want something else. I am sure it's the combination that was best for me." Therefore, although she did not use much narrative in the BcP treatment, perhaps this was because telling her story did play an important part in her simultaneous verbal treatment.

Summary and Integration of Jan's Outcome Results

As the quantitative and qualitative data corroborate, after the 12 sessions Jan appeared calmer and more accepting of her inner experience in comparison to before the study, important shifts which were corroborated by the quantitative data as well as her own description: "My day to day living is calmer. I'm more at peace. I'm not distracted so much by being upset or worried or in pain. So I'm more engaged in the present." She feels more able to assert herself with others and speak up more, yet still wishes she could "let loose." She is making fewer obsessive lists. And most importantly, she feels more alive and present, with less generalized "vague pain" and fear. "I feel calmer when I wake up. I feel calmer all the time." This calmness reflects the therapist's guiding

conception, which largely focused on helping Jan access inner resources in order to confront her traumatic memories and sensations. Jan remarked on the success of this work, as she experienced many inner bodily changes as well as cognitive, as she reported her "head (ie., thinking) is slowing down." Jan cited this change in her relationship to her own sensory experiences as the unique contribution of BcP.

The changes Jan gleaned from the sessions were translated as well into actions in her outside life. Since she underwent BcP therapy, she decided to look for a new job, which she found and successfully changed jobs. She was accepted at graduate school in religion and art. In the last four months, she functioned at a high level: she saw three therapists concurrently, took two classes, went regularly to the gym, church, and applied to graduate school. At a three month follow up, Jan continues to function in a happier and more related way, as she is turning her career towards a helping and people-oriented profession.

The Case of Terry

Terry, a 60 year-old Caucasian professional divorced woman, was referred to the therapist by a colleague who had been a client of the therapist's. Terry had been married twice, had one now-grown son from her first marriage, which she described as horribly violent and abusive, and was currently in a less-than-satisfying relationship. She felt blocked, unsure of next steps in her life. She presented for therapy to address some of the pain and sadness that she had been carrying for years. She was also a chain smoker, a habit she detested yet found herself unable to control. She had briefly tried therapy before, but had not engaged in treatment. Unlike Jan, Terry was a newcomer to psychotherapy. Her treatment involved a lot more fear; she was afraid of the painful feelings that would emerge in treatment, and felt ashamed of taking this time for herself.

History of Client ("A" in Figure 1)

Terry was the eldest child of married parents. She was born while her father was on duty during WWII, and after the war, he was a traveling salesman and often away. She described her mother as a very anxious woman who dealt with her nervous energy by moving constantly. From her mother, Terry learned that it was not acceptable to relax. Terry also remembered that her mother often compared her unfavorably to others, sending a message that she was "never good enough." Terry compensated by always being a caretaker. She has vivid memories of caring for her younger sister and two brothers (six and ten years younger) – feeding them, putting them to bed, reading them stories. She remembers enjoying taking care of them, but "I never really got to be little."

This theme of learning to take care of others remains the most salient aspect of her personality. It allowed her to function well when working with the feelings of others, but left her without the inner ability to allow herself joy and nourishment. Terry also recently fell in love with her high school sweetheart, Jack, who, unfortunately for Terry, seems unwilling to have a full relationship with her. Most of their connection occurs through an intense email correspondence. The two see each other rarely, and have never consummated their relationship. Terry yearns for more connection with him, yet knows she will probably never get it. When asked at intake about her goals for treatment, she never mentioned this relationship. Only after several sessions did Terry admit to the therapist that her "missing attacks," in which she would feel intense pain at not having her desire for closeness with Jack fulfilled, were really the reason for her coming to therapy now.

Assessment ("D" in Figure 1)

Qualitative Assessment

The therapist described Terry with "softness, yearning, longing, and melancholy" in her appearance. She got a feeling of Terry seeming "worn out." Terry admitted to having a lot of sadness in her. There was a sense that she did not feel empowered to nurture herself. Terry showed great difficulty receiving help and nourishment without immediately moving into the role of caretaker. The therapist assessed that Terry was not able to sense her inner resources and feel relaxed and nourished. This would become an important theme in the treatment (Theme 1).

Quantitative Assessment and Goals for Treatment

Consistent with Terry's presentation at intake, she appeared depressed, lonely, and anxious on the quantitative measures. (See Tables 3 and 4 for Terry's pre and post treatment scores.) On the SCL-90-R, several of her subscales were reported on her computer-generated report as in the "clinical range." Particularly Terry's Depression level at 68 was "manifestly elevated, and evidence suggesting a true depressive disorder may be present." She agreed "Quite a bit" with items such as "Feeling lonely" and "feeling blue." Her Anxiety score of 63 suggests a level "significantly elevated and clinical in nature." Terry's record also indicates some social alienation "which should be explored further." Her TEaM scales indicated a high level of personal and vocational functioning,

which was consistent with her successful professional position. Her social functioning was lower, which reflected her difficulties with relationships. On the Scale of Bodily Connection, Terry's scores reflected a relatively low degree of bodily awareness and comfort with her inner sensations, e.g., "When I am tense, I take notice of where the tension is located in my body," she endorsed "a little bit," and "I feel separated from my body," she indicated "some of the time."

Terry identified three goals for therapy in the Goal Attainment Scaling procedure. She wanted to quit smoking, something she had long wished to do but had never done successfully. She was realistic in that twelve weeks may not be sufficient to have quit; she wanted at minimum a plan in place for quitting. Second, instead of always professionally writing for others she recognized that she wanted to do more writing for herself; her second goal involved spending more time journaling on her own. Finally, she admitted that she felt somewhat lost in her life, and needed a new life goal to be excited about. She hoped that through the treatment she may identify some new goals for the future. As she admitted later, this goal really described trying to find a way out of the "missing attacks" she felt with Jack, but at the time of this intake, these are the goals she listed.

Formulation ("E" in Figure 1)

The therapist formulated Terry's dynamics as suffering from an early developmental trauma in which she was not adequately contacted, held, and joined with when she was very young. The therapist described how Terry's demure, deferent and exceptionally other-oriented style (in which she often becomes so worried about the other that she forgets herself entirely) suggests a breech at the level of existence: can I belong? The therapist formulated that Terry coped with this anxiety by creating the belief: "My survival depended on loving other people. Giving love was my life." Therefore, the therapist hypothesized that Terry has mostly worked hard to love others, and is not very capable of loving and nurturing herself without guilt and self-attack.

Since Terry appeared nourishment-starved, the therapist wanted to create some new nourishing experiences which might be very beneficial for her. Therefore, she planned to help bring Terry back into her body, in order to access her inner resources (Theme 1). The therapist formulated that for this type of deprivation-based trauma, Terry would probably benefit considerably from physical touch in the therapy (Theme 2). The therapist also hypothesized that Terry often used her telling of her story as a defense: "to go into the story without spending much time in her body." Therefore, as described above, the therapist's interventions were intended to keep Terry focused on her inner awareness and experience and less in narrative disclosure (Theme 3).

DSM-IV-TR Diagnosis

Axis I: Dysthymia, Early Onset 300.4
Axis II: None.
Axis III: Eczema; blindness in one eye; shoulder pain; chain smoker.
Axis IV: Unrequited relationship; history of physical abuse.
Axis V: GAF= 65 (Current)

Action ("F" in Figure 1)

Session 1: "Linking Her Body to Feeling"

In this session, Terry talked a lot about who she is and what brought her to treatment (Theme 3). She appeared to have a great deal to share about her long life lived without much support. Terry described herself as having "a genuine capacity for joy, but a lot of sadness," and put her hands up to her chest a lot during this session, perhaps physically indicating some of her sadness. The therapist worked a lot to slow Terry down and make some of the patterns more mindful. Terry took this education a step further, and associated to her own characterological pattern which relates to her physical gesture.

Laurie: When we do body-centered work, we often slow time down. So, you will hear me at times just letting you slow down time, to stay with nourishment. And then we want to keep some sort of being sensitive to what happens when you can just rest in the peacefulness.

Terry: Yeah, and I was noticing that I felt really completely relaxed, except for my hands. And it was as if the tension…and I mean, sometimes my hands hurt, but, um, I don't usually, it's as if they were the only parts of me that were not relaxed.

L: And everything was relaxed, but underneath your wrist?

T: Yeah.

L: The tension that was normally in your shoulders seemed to be in your hands?

T: Yes.
L: So you felt that impulse…So, could you do that movement slowly? I just invite you to relax into the experience.
T: I feel peaceful….and it's interesting to hear you talk about slowing things down because…I come from a long tradition of…I didn't found the tradition but I inherited the tradition of coping via acceleration.

As Terry entered mindfulness, she remembered an important mind/body experience from her very early life. As she described her painful early childhood eczema, they worked on connecting this memory with her current character patterns.
T: You know, it's very interesting to me about that…. **I don't know why I never really thought about this before, because once I started thinking about it…but it was partly about coming to see you and something else triggered it,** I don't know what it was, but. When I, um, **there was a question there about the earliest childhood memory…**and, uh, I've been thinking about how few childhood memories I can, you know, dredge up and it suddenly hit me ….I was at work and I was doing an article on eczema and they made a new discovery and they were talking about how debilitating eczema was and that they found that it was this autoimmune disease and stuff. **And I was born with really terrible eczema,** I mean, I really terrible…uh….and my earliest memories are of having tar, you know, on my arms and legs and ace-bandages and having my hands tied, so I couldn't scratch myself…
L: Oh boy.

Session 6: "Finding Her Feisty"

This middle session turned out to be a very important illustration of body-centered "working through." Terry reported that the previous session, in which she had contacted intense sadness within herself, had been very powerful for her: "Grief in every cell of my body." The therapist worked with Terry to experience more nourishment (Theme 1), including using physical touch by having Terry lie down on a pad on the floor and receive touch (Theme 2). At the end, they did an experiment of saying thank you to Terry's mother which elicited a great deal of unexpected anger in Terry. Note how Terry's strong sighs may indicate important bodily discharge.
T: That was something that last session…that was really something. **I was really sad afterwards.**
L: Mmm.
T: **[Sigh]… I think I wrote down at one point I just had this sensation that there was grief in every cell of my body**. But it was **just such an incredible thing being able to go there** and not just say out loud, you know, because there isn't much I have allowed myself to think that I haven't said out loud to somebody. **But there is some stuff that I hadn't gotten around to allowing myself, and it was the feeling of being unwanted**, you know? And uh [big sigh] I think that I was so tired, you know, **Monday night I was like cooked spaghetti, but the amazing thing was that I really felt as if I touched bottom, and I think I wasn't really sure there was a bottom, which is one of the reason I wasn't very eager to go down there**…[Laughs]. **If I go down there I might not get back up.**
L: So there's space, that there is a…
T: So, I really want to thank you. I mean, it was just a, that was just a huge, it's so huge that I haven't really processed it yet. You know, I just sort of ahhh... [big sigh].

Session 12: "Coming Home to Myself"

Terry was very activated in this session. Prior to this session, her colleagues had offered her a spa vacation as a gift. Illustrating a change in her ability to take in nourishment (Theme 1), Terry thoroughly enjoyed the spa and was able to verbalize her pleasure. She also reported feeling more connected to herself in her body, which (similar to Jan) she described as "coming home to myself."
T: My weekend was great. I went to the spa, you know.
L: That's right!
T: Oh my goodness, [Laughs]. That was some experience, I have to tell you. Oh! It was just wonderful. It really was. It was just great, it really, just to stop and swim and lie around and get a massage and eat like a pig [Laughs]. It was great. **And I thought of you a lot because I really was, you know, I turned my head off pretty much, I mean, for me, anyway. [Laughs].**

Here is a beautiful shift in Terry's object relations. Although it is still hard for her to feel entitled to spontaneous joy, she has internalized the therapist as a helper in reframing her ability to nourish herself. Terry then tells a story of associating from her sensations in her body at the spa, to having spontaneous memories of all the houses she's lived in and how she could only imagine them externally. Now however she felt herself sensing the inside of these houses for the first time, which she describes as "coming home to myself."

T: **There was a meditation room, I was just lying there, very sort of dark and quiet. And uh, for some reason, I started thinking of all the places I had ever lived.** And, it turns out there are 20 of them. Which is a pretty good number, I mean even for how old I am, I guess. And then I tried to go inside the different places and I could see everything very vividly from the fourth place on. **But I have absolutely no recollection of inside the house.**
L: So, what does that mean to you when you think about it?
T: I was wondering. You know, because I have some very vivid memories of my siblings and friends and school. I can see school clear as a bell. **So, something, the only thing I could think of, was that I didn't really live there…you know, in my**…
L: You didn't feel alive or present.
T: Yeah.
L: You didn't feel like you really existed.
T: It's amazing. I was glad it came to me while I was in a quiet place while lying down, because it didn't glom me, but…
L: Does that feel related to the sense of emotional turmoil that's emerging for you?
T: I think. I don't know if I get the connection exactly, **but I have a feeling, I guess of um, coming home to myself, you know.**

The image of Terry "coming home to myself" is a statement often articulated in BcP therapy. No longer experiencing herself as disgusting and stared at for her eczema or only through her ability to do for others, Terry invokes feeling more "at home" in her body. Finally, Terry reported with pride how she had allowed herself to feel her anger at a friend and set a healthy boundary for herself. The therapist supported this important shift by using physical touch to push their hands together in order to feel the boundary and connectedness while saying "enough!" This exercise in embodying the boundary also helped Terry experience in a felt sense that anger could be a connector, which was a major breakthrough for Terry.
L: Uh huh. I want to feel you push through, push into the earth. That's it, relax your back, so you're not hurting yourself. What's happening in your arms, your spine?
T: I'm just really, I'm pushing
L: How does it feel to make contact and say, "That's enough!?"
T: That felt good.
L: Keep pushing out.
T: Okay, now, you know one thing I just noticed. Like, it feels like I don't need to push that far. It feels…as if…I don't need you to go to the other side of the world.
L: Just a little bit. Just dance with it.
T: Yeah. And I keep thinking that, you know, if I'm a charitable, forgiving person…What was amazing about that, it didn't feel selfish to defend myself with you and it didn't feel bad with [my friend] either.
L: And sometimes, you know, sometimes in relationships, people push because they really want connection. And when you push back they feel connection. Which is the unmet need is connection.
T: [Big Sigh]. Wow.

Concluding Evaluation ("L" in Figure 1)

Discussion of Quantitative Results

Table 3
Terry's SCL-90-R Results

	Terry 1	Terry 2	Pt diff	RC	Sig at p≤.05
Global Severity Index	61	56	-5	-0.88388	
Positive symptom distress index	53	50	-3	-0.53033	
Positive Symptom Total	63	58	-5	-0.88388	
Somatization	53	53	0	0	
Obsessive-Compulsive	57	49	-8	-1.46059	
Interpersonal Sensitivity	62	60	-2	-0.45883	
Depression	68	62	-6	-1.2	
Anxiety	63	59	-4	-0.89443	
Hostility	40	40	0	0	
Phobic Anxiety	58	54	-4	-0.83406	
Paranoid Ideation	49	41	-8	-1.94029	

Psychoticism	60	53	-7	-1.4596	

Table 4
Terry's TEaM results

Subscales	Terry 1	Terry 2	Pt diff	RC	Sig at p≤.05
Subjective Well-Being	47.33	54.42	7.09	1.67113	
Depression	56.60	63.57	6.97	2.10153	*
Anxiety	57.49	60.71	3.22	0.70266	
Phobia	62.62	62.62	0	0	
Obsessive-Compulsive	61.00	64.84	3.84	0.9051	
Somatization	59.65	59.65	0	0	
Panic Disorder	56.67	60.84	4.17	1.15655	
Post Traumatic Stress Disorder	57.26	57.26	0	0	
Symptom Checklist	60.86	63.96	3.10	0.98031	
Personal Functioning	68.03	68.03	0	0	
Social Functioning	60.13	66.46	6.33	1.19626	
Vocational Functioning	67.87	67.87	0	0	
Functional Disability	67.53	69.21	2.32	0.42	
Behavioral Health Status Index	59.66	64.10	4.44	1.28172	

Terry's clinical profile on the SCL-90-R changed from clinical to within normal limits after the 12 sessions. Pre-study, she appeared clinically depressed, as well as lonely and anxious. After treatment, Terry's scores were mostly "within normal range." Although none of her SCL-90-R scores were statistically significant using the RC calculation (which may be due to her lower initial symptom levels), a trend can be noted in which 10 of 12 subscales decreased, with some of more than one standard deviation difference. These findings suggest a trend towards decrease of symptomology, which is consistent with Terry's qualitative findings.

Terry still suffers from depressive symptoms and some social alienation, which is understandable given only twelve sessions of treatment. However, her final profile on the SCL-90-R indicated someone in the normal range, distinct from the clinical levels of her initial profile. Her Depression subscale of 62 is still elevated, which suggests continuing difficulty with painful feeling – as even her relationship with Jack is largely unaltered – but not at the extent it had been previously. Her Anxiety remains at 59 in a "moderate level," yet this may be Terry's normal range of functioning, which appears consistent with her own statements. On the TEaM scale, 9 scales increased, which suggests an overall trend toward improvement. There was also a significant decrease in Depression, which appeared her main source of symptomology. She had admitted early in the treatment that she had "a lot of sadness" within her, and thus such a shift corroborates the work that she did in therapy to address this depression.

On the Scale of Bodily Connection, her items shifted towards more awareness of herself. For example, "When I am tense, I take notice of where the tension is located in my body," she earlier endorsed as "a little bit" and now "most of the time. With "I feel separated from my body," she previously indicated "some of the time," and now "a little bit."

Terry enjoyed success in her treatment goals as indicated by the Goal Attainment Scaling. She was able to develop a concrete plan to stop smoking. She also began to write more for herself, another important goal in helping her find her own voice. As for her final objective of "finding a new life goal," Terry admitted it was really a substitute for dealing with her "missing attacks" with Jack. Sharing her real goal with the therapist, as well as expressing her difficulty discussing it, were important indicators of the successful aspects of the treatment.

Qualitative Outcome Results: Exit Interview

Terry praised the therapy: "It's been a very meaningful experience for me." Initially, she explained, she had enormous resistance to treatment. A year prior to this study, she had therapy, yet found it unsuccessful as the person was "quite aggressive" and "it just made me shrink." Terry described being deeply moved by the early memories she accessed in the treatment, which were "very unexpected." The change in Terry's acceptance of herself is striking. She spoke with great clarity about her character organization, ("The caretaking is the only thing I know how to do.") and with compassion about the lack of nurturance in her life:

> I think what emerged from these twelve sessions is how much I was taught and taught myself to surmount those things. I had a fair amount [of hardship] and I got pretty adept at it. There is something about going into something instead of going over something that was very revealing. For example, I have a lot of pain in my shoulder. And Laurie said something about 'breathing into it.' That was very helpful.

The treatment appears to have helped Terry develop more compassion for herself: "My relationship to my flaws has changed. I don't feel guilt for the flaws. Guilt has been a full-time job for me. I don't feel shame. I feel some level of compassion for myself. And that's a very different relationship."

One place to see the change in Terry is in her relationship to smoking. In the treatment she learned how much she depended on smoking to soothe herself. Making the connection between the addiction and her own need for nurturance allowed her to find other ways to nurture herself. When offered the spa invitation before the last session, she was able to accept without guilt, and she brought a patch for quitting smoking to the exit interview.

Another important change for Terry was in her relationship to anger. Allowing herself to express anger with her co-worker and then experiencing it physically as a connector by pushing hands with the therapist were both major breakthroughs: "I always thought of anger as something so diabolical and wounding. My associations are of hiding under something or behind something. This idea of anger as connection just blew me out of the water. It really, really did."

When asked about what was not helpful about treatment, Terry expressed that sometimes it had a "New Agey" feeling. She explained that she finds some aspects of U.S. culture too self-centered, which the treatment invoked: "I'm lying on this mattress in this womb-like place…what am I doing?! That was hard for me." Yet despite her strong resistance, she found that she experienced some of her most important changes from the body-focused work.

Reviewing the Narrative Themes

Theme 1: Helping clients feel "nourished" by their internal resources. The therapist assessed that Terry appeared "depleted," with not enough activation in her nervous system. The therapist helped Terry learn how she is organized around taking in nourishment through caring for others, and through that awareness, learn to take in nourishment by accepting love and letting others care for her. Finding ways for Terry to find her internal nourishment to replace smoking or caretaking became a central theme for how Terry changed in this treatment. When Terry was offered a spa weekend right before the end of treatment, she enjoyed herself without guilt.

Theme 2: Using physical touch. Touching in this treatment offered an important example of how The therapist's guiding conception interacted with Terry's needs. The therapist wanted to use touch as an intervention to help Terry access nourishment without fear. However, physical touch for Terry brought up powerful feelings of longing, as well as fear of selfishness; all difficult emotions that needed a lot of resources to work through. Working slowly and with great sensitivity to timing and safety in treatment was crucial in maintaining their treatment alliance.

Finally, as Terry uncovered feelings of anger and sadness, she was more able to experience herself as entitled to positive feeling. Therefore, her relationship to her body changed, which led to change in her experience of touch. It can be hypothesized that she may not be willing to accept a relationship without contact for much longer. However, although this has shifted, the therapist noted that Terry still needs a lot of reassurance. It is unclear if she has sufficiently internalized the change to be able to assert herself in her relationship with Jack.

Theme 3: Working with narrative versus body. How the therapist intervened with Terry's narrative remains an important illustration of how The therapist's theoretical framework interacts with the needs of the client. Terry had never been in therapy before, was 60 years old, survived a violently abusive marriage, and was currently in an unfulfilling "long distance relationship." She needed to talk. To the therapist, a lot of Terry's storytelling was a defense against connection. How to get Terry out of "story mode" was a challenge for the treatment. The therapist holding Terry to her body versus allowing her space to talk was a central friction in the treatment. Although Terry's learning to support herself through finding and holding nourishment in her body was crucial, telling her narrative may have also helped Terry develop resources. "Sometimes I wanted to skip the whole body thing and just talk," Terry admitted. How much to interrupt talking to focus on the body illustrated the difficulties of combining verbal narrative and body-oriented techniques in a single treatment and requires much further research.

Another area that Terry spoke frankly about was the difficulty of switching from the verbal to the more physically-oriented modes. Terry admitted that sometimes the transition between talking and working in the body was hard to manage. There were times when she was frustrated with the therapist cutting her off when she was talking. "Sometimes I'd be talking and I would be in 'breakthrough territory.' What do you mean stop?!." She came to accept it, but it never got easier for her to integrate the work. "I had a sense of discomfort and frustration at first. But then I came to see it that I'm not liking it, but it will be good for me [small laugh]." Knowing when a therapist is

working with resistance versus pushing a client's boundaries too far is very important in BcP work and demands further research with appropriate feedback from clients. Ultimately, it mattered less what the technique was than the strength of the alliance: "Frankly, there's a quality that Laurie has…she created a space where I felt safe. I think the nature of the therapy mattered less to me than the quality of her presence."

Summary and Integration of Terry's Outcome Results

Terry worked on a major identity shift in this treatment. She has become much more able to access her inner resources by herself (Theme 1). Her acceptance of the spa is an important example of her being able to accept such body-oriented nourishment. Through their work Terry became more flexible, able to see herself as one who gives and also feels entitled to receive. Both the quantitative and qualitative data suggest that as a result of this BcP work, Terry has become less depressed. This shift could be seen in the therapy room: Unlike early sessions in which Terry had little bodily awareness, over time Terry began to adjust her own pillows, which suggests she felt more entitled to access comfort. And with that comfort seemed to come a greater love and compassion for herself. Overall, Terry came to know herself and accept herself. The power that was unleashed for Terry in the treatment was in finding out she was knowable. "I always thought if I had the courage to go down there, I thought I'd find a monster chained in the basement. When I went down there, I found there wasn't anything that evil. That was a really nice discovery."

The treatment also helped Terry work on her anger. The therapist formulated that a lot of Terry's sadness, grief, and melancholy came from her freeze around anger. As Terry became angry, she also felt a new sensation of power; she discovered a new way of being in connection with people such that she was finally able to feel safe enough in her own skin to set a boundary with others. Through the treatment she experienced she could be angry and assertive and still survive.

As both the quantitative and qualitative data indicate, Terry made some important strides through the therapy, yet her work was not yet done. Terry intended to continue working with the therapist. Whether she will continue these sessions for herself now that the study is over is still an open question. Has she shifted enough to be able to give freely to herself? It remains to be seen.

DISCUSSION

Combining qualitative and quantitative data was valuable in developing a method for studying Body-centered Psychotherapy. The cases demonstrated that consistent with Peterson's Disciplined Inquiry model, the therapist adjusted her techniques based on the needs of each client in ways that appeared beneficial to them. It is important to remember the large number of limitations in the present research: only three clients were studied (two of which are described in this article), there were no control subjects, only one therapist was involved, one of the clients was simultaneously in two other therapies, and so forth. Thus, the findings must be interpreted cautiously and may be most useful as guides for subsequent research. With these caveats in mind, the results suggest that BcP's emphasis on clients' sensations alongside emotion, cognition, and behavior appears to be a powerful contribution to change processes, particularly with trauma (van der Kolk, 1994).

Another major contribution of BcP is the focus on helping clients experience internal resources through calm, relaxing images, sensations, and feelings. The two clients in this study spoke about experiencing newfound "calm" in their bodies as a major impact of the therapist's treatment. Mindfulness, progressive muscle relaxation, and other techniques are entering the psychological mainstream (Dimidjian & Linehan, 2003; Teasdale, Segal, & Williams, 2003). What remains particularly noteworthy in BcP treatment is the seamless integration of this relaxation-focused work within the therapy – not as an added technique, but woven through the core narrative work, moving back and forth without pause.

Additionally, the "New Age" aspects of BcP work must be confronted for this work to become palatable to the majority. Since BcP uses interpersonally complex, verbal interventions as well as physical touch, this work requires more training of therapists, not less. The issues of training and quality control in BcP are crucial. Currently, there are inadequate BcP training resources in many areas of the country, as well as too many BcP-oriented professionals working without advanced degrees and little accountability. There is a great need for more rigorous, accredited training programs, as well as education for the public.

Finally, the question of BcP as a stand-alone therapy remains open. The data from Jan's case suggest that an adjunctive talk-based therapy in combination with BcP might be particularly helpful. Future studies might include replication of the PCS Method examining numerous BcP therapists in practice. Additionally, more quantitative sampling across the sessions would allow for single case design research and greater statistical analysis. Further research designs are needed that employ videotaping, as well as combine qualitative and quantitative measures. Rigorous methods for analyzing videotapes will also help BcP develop methods for determining treatment efficacy. Larger controlled studies are necessary to help demonstrate efficacy for insurance reimbursement. The United States Association of Body Psychotherapy is in the process of developing a

"videotape database" of various BcP styles (Psychotherapy, 2004). Such a rich database would support analysis of multiple techniques and encourage understanding common factors across BcP cases and therapy types. Practitioners and clients need to be educated further about the potential benefits and risks of "listening to the body.

References

Alpert, M. (1996). Videotaping psychotherapy. *Journal of Psychotherapy Practice and Research, 5*(2), 93-105.

Aron, L., & Anderson, F. S. (Eds.). (1998). *Relational perspectives on the body* (Vol. 12).

Bourque, G. B. (2002). *Somatic psychotherapy for people with chronic pain.* Paper presented at the United States Association of Body Psychotherapy, Baltimore, MD.

Bridges, M. R. (2002). *Enhancing therapeutic emotional expression and experience by the use of body-focused psychotherapy: A single case design utilizing empirically validated methods.* Paper presented at the United States Association of Body Psychotherapy, Baltimore, MD.

Caldwell, C. (1997). The somatic umbrella. In C. Caldwell (Ed.), *Getting in touch: The guide to new body-centered therapies* (pp. 7-28). Wheaton, IL: Quest Books.

Dimidjian, S., & Linehan, M. M. (2003). Defining an agenda for future research on the clinical application of mindfulness practice. *Clinical Psychology: Science and Practice, 10*(2), 166-171.

Ferenczi, S. (1953). *The theory and technique of psychoanalysis*. New York: Basic Books.

Field, T. (2001). *Touch*. Cambridge, MA: MIT Press.

Fishman, D. B. (1999). *The case for pragmatic psychology*. New York: New York University Press.

Fishman, D. B. (2005). Editor's introduction to PCSP -- From single case to database: A new method for enhancing psychotherapy practice. *Pragmatic Case Studies in Psychotherapy [Online], 1*(1).

Harlow, H. F. (1974). *Learning to love*. New York: Jason Aronson.

Hunter, M., & Struve, J. (Eds.). (1998). *The ethical use of touch in psychotherapy*. Thousand Oaks, CA: SAGE Publications, Inc.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.

Koemeda-Lutz, M., Kaschke, M., Revenstorf, D., Scherrmann, T., Weiss, H., & Soeder, U. (2003). Preliminary results concerning the effectiveness of body-psychotherapies in outpatient settings - A Multi-center study in Germany and Switzerland. *Psychotherapie Forum, 11*, 70-79.

Kurtz, R. (1990). *Body-centered psychotherapy*. Mendocino, CA: LifeRhythym.

Kurtz, R., & Prestera, H. (1976). *The body reveals: An illustrated guide to the psychology of the body*. New York: Harper and Row.

Levine, P. (1997). *Waking the tiger*. Berkeley, CA: North Atlantic Books.

Lowen, A. (1958). *The language of the body*. New York: The Macmillan Company.

May, J. (2002). *A review of the empirical status of body-oriented psychotherapy.* Paper presented at the United States Association of Body Psychotherapy, Baltimore, MD.

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. L. (2003a). *Treating affect phobia*. New York, NY: Guilford Press.

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. L. (2003b). *Videotaping and rating your own sessions: Two valuable ways to improve the quality of therapy*, from http://www.affectphobia.org/docs/VideoATOS/VideoATOSArticle.pdf

Montagu, A. (1971). *Touching: The human significance of the skin*. New York: Columbia University Press.

Moyer, C. A., Rounds, J., & Hannum, J. W. (2004). A meta-analysis of massage therapy research. *Psychological Bulletin, 130*(1), 3-18.

Peterson, D. R. (1991). Connection and disconnection of research and practice in the education of professional psychologists. *American Psychologist, 46*, 422-429.

Porges, S. (1997). Emotion: An evolutionary by-product of the neural regulation of the autonomic nervous system. *Annals of the New York Academy of Sciences, 807*, 62-77.

Price, C. (2002). Body-oriented therapy as an adjunct to psychotherapy in childhood abuse recovery: A case study. *Journal of Bodywork and Movement Therapies, 6*(4), 228-236.

Reich, W. (1945). *Character analysis*. New York: Farrar, Straus, and Giroux.

Schore, A. N. (1994). *Affect regulation and the origin of the self*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Smith, E. W. L. (1985). *The body in psychotherapy*. Jefferson, NC: McFarland & Co., Inc.

Smith, E. W. L., Clance, P. R., & Imes, S. (Eds.). (1998). *Touch in psychotherapy: Theory, research, and practice*. New York: Guilford Press.

Teasdale, J. D., Segal, Z. V., & Williams, J. M. G. (2003). Mindfulness training and problem formulation. *Clinical Psychology: Science and Practice, 10*(2), 157-160.

Tronick, E. Z. (1989). Emotions and emotional communication in infants. *American Psychologist, 44*(2), 112-119.

Tronick, E. Z., Bruschweiler-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., et al. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal, 19*(3), 290-299.

van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of post traumatic stress. *Harvard Review of Psychiatry, 1*(5), 253-265.

United States Association of Body Psychotherapy (2004). Real sessions research project. *The United States Association for Body Psychotherapy, Spring 7.*

Ventling, C. D., & Gerhard, U. (2000). Zur Wirksamkeit bioenergetischer Psychotherapien und Stabilität des Therapieresults: eine retrospektive Untersuchung. *Psychotherapeut, 45*, 230-236.

Young, C. (Ed.). (2005). *The EABP Bibliography of Body Psychotherapy on CD-ROM, 2nd Edition*: European Association of Body Psychotherapy.

Biography

Amelia Kaplan, Psy.M. graduated from Harvard University with a B.A. in History and Literature. She is currently completing her doctoral requirements in Clinical Psychology at Rutgers University, as an intern at VA Northern California HealthCare System in Martinez, CA. Ms. Kaplan pursues interests in mind-body psychology, STDP, group therapy, and human sexuality. She has also trained in massage and Zen Bodytherapy. Her original dissertation research studied three cases of Body-centered Psychotherapy with practitioner Laurie Schwartz.

Laurie Schwartz is a Counseling Psychologist and Licensed Massage Therapist in private practice since 1982 integrating somatic and psychotherapy modalities including Rubenfeld Synergy, Hakomi, Jin Shin Jyutsu, Somatic Experiencing, Modern Group Analysis, and Hellinger Constellations. Ms. Schwartz is also a photographer and African Drummer who has created sacred ceremonies for the restoration of healing and consciousness in community.

This project was conducted as dissertation research for Ms. Kaplan's Doctor of Psychology (Psy.D.) doctoral dissertation at the Graduate School of Applied and Professional Psychology, Rutgers University. For correspondence regarding this article, please contact Amelia Kaplan at akaplan@post.harvard.edu. Laurie Schwartz can be contacted at nyhakomi@aol.com

Women and Bioenergetic Analysis

Alice Kahn Ladas, Ed.D.
Harold S. Ladas, Ph.D.

Abstract

A questionnaire was mailed to 198 women, the total female membership in 1977 of The Institute for Bioenergetic Analysis, a neo-Freudian body-oriented psychotherapy training organization. Sixty-eight percent (134) returned valid replies. The areas covered by the questionnaire included the effects on themselves and patients of the therapy, an assessment of their views of Bioenergetic theory, and their sexual beliefs, experiences, and practices. This paper focuses primarily on heterosexual experiences and beliefs.

As predicted, 81 percent of the respondents reported improvement in their sexual life following therapy. Unexpectedly, up to 87 percent of the respondents disagreed with one or more of the theories of Alexander Lowen, M.D., founder of Bioenergetic Analysis, as they apply to female sexuality. Although 73 percent of the respondents reported experiencing vaginal orgasm, 87 percent felt, nonetheless, that the clitoris is important and should not be ignored.

Reasons for the Study

The main impetus for the study was the meetings held by women at the International Conferences of The Institute for Bioenergetic Analysis, first in Aspen in 1975, then in Waterville Valley in 1977, and then locally in many places around the United States. Women Bioenergetic analysts in New York held nine meetings. No conclusions were reached, but many questions were raised and most of the items in the questionnaire came directly from those meetings.

A second reason was the need for research in Bioenergetic Analysis (hereafter B.A.)[1] On the cover of Lowen's recent monograph *Stress and Illness*, he quotes the Nobel-Prize winning bio-chemist, Szent-Gyorgyi, "Research is to see what everyone sees, but to think what no one has thought." [2]

William James declared, "We must draw a fine line between believing too much and believing too little."[3] In the well-tended garden of science, there must be a balance between broadcasting new seeds and weeding. If B.A. is to attain full status as a creative scientific endeavor, there is a need for greater emphasis on weeding. Clinical findings must have the confirmation of epidemiological data. This study is a small step in that direction.

A third reason for the study was to see whether we could bring to the surface differences between B.A. theory (1977) and the actual beliefs, practices and experiences of women in B.A.. One of the women in answering the questionnaire said:

> I don't believe that anyone knows what truly constitutes normalcy or self-actualization for a woman. I believe the current theories are wish and fear fulfillment fantasies of men and are not grounded in the physical and mental reality of women. Certainly Bioenergetic Analysis is particularly suited to looking into menstruation, menopause, childbearing, and I will be very angry personally if these aspects of life are not dealt with in my training.

A mail questionnaire was used because it was less expensive than individual interviews and because it was confidential. The questions were formulated directly from the minutes of the meetings in Waterville Valley and the New York group. Harold Ladas helped with research design and statistics and obtained the use of the computer and library facilities at Hunter College. The questionnaire was examined by experts on the Hunter faculty in women's issues, questionnaire design, and statistical analysis. The project passed Hunter's stringent rules concerning the ethical treatment of human subjects.

Confidentiality was insured by separating the background data from the body of the questionnaire even though this means losing valuable data. Nevertheless, one respondent wrote

> Since you know precisely who I am, I would not call this a confidential type of questionnaire. I resent the mis-representation and refuse to answer further questions. I don't care that you know I answered the questions, but I object strenuously to your methods.

---

[1] The original Trust Agreement (1956) said that the purposes of the Institute are: "To promote research and education in the fields of emotional and physical health. The focus of interest is on the biological energy processes involved in health and illness. Therapeutic techniques are being developed which combine the fundamental principles of psychoanalysis with direct work on the somatic level, a bioanalytical approach to the treatment of illness." Bioenergetic Analysts have done a lot of education, developed many important therapeutic techniques and taught them to many people. But there's no published research apart from clinical observation.

[2] Lowen, Alexander, Stress and Illness, International Institute for Bioenergetic Analysis, New York, 1980.
[3] James, William, The Varieties of Religious Experience, Modern Library, 1929, 1936, p. 51.

It was a confidential questionnaire but we can understand why some people may not have thought so. We sent out a follow up memo about three months after the first mailing to women who had not yet answered the questionnaire (See Appendix C). We never knew who those people were, but Alice did sign the letter which was then addressed and mailed by the independent secretarial service.

It was a long questionnaire (See Appendix A) and we are gratified that so many women answered all of it. To supplement the written data, individual interviews were conducted in New York, Connecticut, and Oklahoma.

Since all the respondents were still involved with B.A. and had invested much time, money, and energy in it, we assumed that the answers would favor B.A.. Any uniform pattern of affirmative answers could thus be questioned. The questionnaire could tell us nothing about the experiences of women who had left B.A.. We presume that any pattern of disagreement or negative answers would, therefore, be additionally significant.

This particular sample of women, although small, is unique and important because the women have all studied the theories of Freud, Reich, and Lowen, experienced individual therapy, and most of them have given therapy to individuals and groups. Although by no means typical of women generally, they have both objective and subjective experience with the matters being investigated.

Characteristics of the Population Studied

The respondents are highly educated. Eighty percent have graduate degrees. They are native born as were most of their parents. They are not traditionally religious. Three-quarters are not economically dependent on a man, and three-quarters live with sexual partners. Sixty percent were wanted children but close to 60 percent were not as highly valued as men in their families of origin. More than 50 percent were breastfed (a surprisingly high percentage although we do not know for how long). Over half were involved in B.A. for more than four years and three-quarters believed that there are special "women's issues." Most were between 30 and 50. There is little data about their children because many of the respondents who had children bore them before becoming involved in B.A. and some hadn't had any yet. Personal needs were the primary reason why women became involved in B.A., but 50 percent also had professional reasons. Most of the reasons were not related to their gender, but women's issues surfaced after they became involved in B.A.. A major theme was the need for more women Bioenergetic therapists because they felt that women need to work with women.

Results

Based on responses to the questionnaire, women's issues fell roughly into these categories: biological, social and cultural, organizational, sexual and therapeutic. Some of the biological issues named were: a woman's first love relationship is with a woman and she must transfer this to a man; menstruation, childbirth, breastfeeding, menopause, and energy issues. One woman said, "If the idea that woman is energetically receptive because of her biology and anatomy is valid, then there have to be special women's issues." Women also referred to the experience of losing their sexual organs, a type of loss which few men must face. Social issues mentioned included: B.A. theory is primarily formulated by men, there are cultural and family messages about being a woman, assumptions about mothering and childrearing. Under organizational and therapeutic, the following were mentioned: the Institute is dominated by men and male thinking, there are incorrect sexual assumptions, and therapeutic techniques are overly influenced by the male viewpoint.

Most of the issues, while affecting B.A., are not limited to B.A., but apply also to the culture in which it functions. Here are a few of the comments women made about these issues:

- Men, in lovemaking, can return to the breast but women in heterosexual relationships can't. Sucking a penis is not the same.
- I don't like the emphasis on motherhood as the most fulfilling thing a woman can do.
- I don't like the emphasis on where the orgasm should be felt.
- The state of the art now is, there are two kinds of humans – people and women. When a woman tries to be a person, she's accused of acting like a man.
- The relationship of oppression to depression is an issue.
- Bioenergetic Analysis was originally dominated by psychiatrists. There are very few women psychiatrists and they didn't actively seek or allow women in leadership positions.
- Much about women's sexuality is written by men and a lot of these men lack the understanding of women. I think maybe in Bioenergetic Analysis, some of that has been carried along. There are the same attitudes about women and some of the people, particularly the men in Bioenergetic Analysis, need to change their attitudes and maybe bring some of their ideas up to the 20th century.
- Understanding their own sexual experience and role is important, not to let men tell them how they feel and function but to find out for themselves. Only women can solve their own problems.

•A man, no matter how learned or sensitive, is still a man and can never feel what a woman feels. Why has it taken so long to realize this?
•Most of the literature is written from a male perspective and most of the training is done from a male perspective.
•I fell very paranoid about male therapists, even when their conduct is proper. I feel them and experience them in group work as pushing an unnatural view of normal womanhood on me.
•How is the suppression of women seen in our bodies?
•We need to study the difference in the energy flow between males and females generally and each of the character types specifically.
•I feel that the dominance of male trainers is a detriment to the movement. This is inherent in using any professionally-based organizational model, but I feel nothing is being done to even try to counteract this. Most women are afraid to say this for fear of being kicked out.
•There are no female leaders in our area. A lot of the male trainers are blind to their own unresolved issues and often dump a lot of sexist baggage on women in the program.
•I strongly disagree with the idea that there is a vaginal versus a clitoral orgasm. Masters and Johnson have shown otherwise. It's impossible to have intercourse without getting some clitoral stimulation by pulling and stretching skin and muscles. See *The Nature of Female Sexuality* by Mary Jane Sherfey.
•It's more difficult to work with men to whom I'm sexually attracted and vice versa.
•I feel reluctant to touch men who are attracted to me. Most of my male clients are.

TABLE 1
Effect of Bioenergetic Analysis on Women in the Study (N=134)

Outcome	Relative Percent Finding It Helpful	Adjusted Percent Finding it Helpful[B]
Self Assertion	89	94
Breathing	89	94
Self Esteem	86	93
Capacity to Experience Pleasure	86	92
Capacity to Love	83	89
Physical Health	79	74
Ability to Cope with Depression	79	84
Diminished Chronic Muscle Tension	77	83
Energy Level	77	83
Unification of Sexual and Tender feelings in relationship	68	73
Involuntary Movement in Orgasm	63	67
Finding a Partner	45	49
Sleep Problems	33	38
Menopause[A]	17	18
Menstruation	16	17
Interaction with Infants[A]	7	7
Coping with Unwanted Habits e.g.		
Overeating	23	30
Smoking	12	17
Enjoyment in Breastfeeding[A]	5	6
Chosen Manner of Infant feeding[A]	5	6

Notes: - Most subjects responded "Not Applicable" b - Adjusted by subtracting Ss who did not answer.

Many respondents checked items marked "a" not applicable for the reasons listed below. Open-ended comments indicated that B.A. was very useful to a few women in these areas. Since most women in the study were between 30 and 50, many had not yet experienced menopause. Also many had not breastfed since becoming involved with B.A., so they said it didn't influence their enjoyment of breastfeeding or their chosen manner of infant feeding.

One thing about Table 1 is important. Even though the respondents were all women who had remained in B.A., this is not a case of true believers who check everything as improved. For example, B.A. helped with self-assertion but didn't help as much with modifying habits. Here are a few statements women made about how B.A. affected them generally:

•I'm more fully alive and healthier than I ever believed possible.
•I can stand on my own, back up what I do, and feel OK about myself.
•I'm focused now on contact and sexuality in the here and now.
•Through ups and downs, my body is continuing to feel more alive and vibrant.
•I've become more creative, emotionally and physically expressive and more loving.
•I used to be plagued by constipation and now I never give my bowels a second thought.

•My allergies simply vanished.
•I always had low blood pressure, usually 100 over 60 and my metabolism was on the very low side too. Now both are normal.
•When I met my Bioenergetic Analyst, I was sick in my body with severe arthritis. That disease is a kind of cry for special caring and understanding that I knew nothing about as a result of the verbal therapies that I participated in. But when I got my clothes off and stood on my feet, I got a whole lot of data that I had not even considered during the many years of giving and receiving traditional therapies. It is like a rebirth, getting a second chance at life, getting my body back again.
•Not only did I get rid of colitis and severe headaches, but I also suddenly began a whole new career. It was no effort. It just flowed out of me.

TABLE 2
Effect of Bioenergetic Analysis on Sexual Responses

Outcome	Before B.A.		After B.A.		Percent
	Yes	No	Yes	No	Change
Has your experience of sexual climax changed since B.A.?			81	19	81
If yes, how					
More generalized body experience			59		
Breathe more deeply			62		
Pelvis moves more freely			54		
Pelvis moves more involuntarily			43		
Fantasize less			23		
Experience more sweet feelings			45		
Feeling centered more deeply in the Vagina			41		
Have you experience orgasm (as contrasted to sexual climax)?	51	49	80	20	29
Have you experienced turning in of energy along walls and deep in your vagina?	44	56	66	34	22
Have you experienced streamings?	36	64	76	24	40

Note: Percent adjusted by eliminating missing cases on a given item.

From this table it is clear that a change in sexual functioning took place as a result of B.A. therapy according to the reports of the women in this study. Eighty-one percent reported changes in their experience of sexual climax and the specific kinds of changes they report are all in the direction predicted by Lowen for people having this kind of therapy.[4] For example, the experience of climax involved more of the body, the women breathed more deeply, fantasized less, the pelvis moved more freely, and involuntarily, feelings were centered more deeply in the vagina and they were sweeter. After B.A., 80 percent believed they had experienced orgasm as contrasted with sexual climax[5] an increase of nearly 30 percent from before B.A. therapy. Twenty-two percent more, experienced the inward flow of energy deep in the vagina and 40 percent more experienced "streamings", a concept introduced by Wilhelm Reich, describing the pleasurable sensation of energy moving through the body.[6]

There are a few more facts about sexuality not included in Table 2. After B.A., women tended to be more monogamous in their relationships. Eight percent more experienced multiple climaxes, making a total of 72 percent of the women in this study that experienced multiple climaxes. Of these, three-quarters believed the experiences were orgastic and 42 percent believed that B.A. favorably changed the way they experienced multiple climax.

Here is a sample of the statements by women about their sexual experiences:

•Climax, orgasm, and release of sexual energy are possible now. They never were before.
•I have less need to tense my legs or other muscles.
•I'm more aware of orgasm moving up and down my body. I no longer try to stop that from happening.
•I feel free to climax several times and to insist on cooperation from my partner.
•There's more connection between my heart and genitals.
•It's a more intense total body experience without interference from my mind.
•When I began to work, I could hardly hang onto a horse with my legs. Four years later, with no riding in between, it was easy for me to stay on using my legs.

[4] Lowen, Alexander, Betrayal of the Body, MacMillan Company, New York, 1967.
[5] According to Bioenergetic theory, an orgasm is different from a climax because of the involvement of the whole body in clonic contractions, because of the presence of streamins and involvement of the heart. By contrast, a climax is a localized genital release. This concept is derived from Wilhelm Reich. Reich, Wilhelm, The Function of the Orgasm. Orgone Institute Press, New York, 1942.
[6] Ibid.

•I have a deep desire to take in and to contact.
•I can keep my eyes open more in the sexual act.
•I feel streamings.
•I'm able to experience, reach orgasm more easily with my husband. It's a global experience.
•After three and half years of work, my orgasm got deeper and my husband became jealous. It was nourishing to work with a woman and she provided a role model for me with regard to sexuality.
•Sexually, Bioenergetics was really important to me. From having no orgasms I became orgasmic with clitoral stimulation. Then I began to have vaginal orgasms in intercourse with clitoral stimulations, but there was not much movement involved. At this point there's no clitoral stimulation required. When I let go with the man I love, there's a melting in my vagina. It is a physical sensation, a feeling I love you and it is vaginal. There is not tensing of muscles and the feeling is not the same as letting the sensation build.
•I now find multiple climaxes much less deep and satisfying.
Bioenergetic Analysis affected my general sexual experience, not just multiple climaxes.
•I think I had more sexual pleasure before B.A. because I was more disassociated from that part of my body. As I connected with it in therapy, I feel more fear, more tension, and periods of frigidity.
•I count on having more than one climax now.
•I do not pretend to have climaxed when I haven't.
•The need to strain for multiple orgasms decreased.
•I've had only one multiple climax because I pushed myself to find out what everyone was talking about. I prefer one big orgasm and then I want no more.
•Through my deeper breathing and less contracted pelvis, I have the ability to have multiple climaxes.

The contradictory comments above about multiple climax or orgasm merit further investigation.

TABLE 3
Women Consider the Role of the Clitoris

	Before B.A.		After B.A.		Percent Change
Outcome	Yes	No	Yes	No	
Have you experienced a sexual climax through intercourse without any special clitoral stimulation?	60	40	73	27	13
Through intercourse with clitoral stimulation by partner?	78	22	81	19	8
Through intercourse with clitoral stimulation by yourself?	42	58	51	49	9
Through clitoral stimulation, no intercourse?	83	17	87	13	4

Note: Percent adjusted by eliminating missing cases on a given item.

Looking at Table 3, it appears that 13 percent more women were able to enjoy a sexual climax through intercourse without any special clitoral stimulation after B.A., making a total of 73 percent of the women in the study. This is a change in the direction predicted by Lowen for women having this type of therapy. Because fewer women answered "after B.A." than "before B.A.," perhaps because they were still in B.A., the percentage may be somewhat misleading. There is also some evidence that more women learned to respond to clitoral stimulation without intercourse (four percent more) through intercourse with clitoral stimulation by themselves (nine percent more and several commented, "I wish I had dared to") and a few more (three percent) during intercourse with clitoral stimulation by the partner. From the high percentage (81 percent) who reached a climax through intercourse with clitoral stimulation by the partner, and 87 percent who reached a climax through clitoral stimulation without intercourse, one can say that the clitoris is of major importance to this group of women.

TABLE 4
Agreement with Bioenergetic Analytic Theory

Theoretical Statement	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree	Total
"Man is woman's bridge to the outside world"[7]	82	24	4.5	3.0	1.5	86[B]
Stimulation of the clitoris (directly or indirectly) in intercourse is not important for the mature woman[8]	51	36	2.4	10.3	5.3	87[B]
"The clitoral orgasm is felt on the surface of the vagina like a trickle of sweet pleasure. There is no satisfying release."[9]	43	35	5	10	1.5	78[B]
"Tactile stimulation in itself is not a causative factor in erotic arousal."[10]	17	53	4	17	2.	70[B]
It is often helpful if a man can postpone his climax until a woman approaches hers.[11]	6	5	10	58	19	77[B]
Many women require direct or indirect clitoral stimulation in order to reach a sexual climax[12]	2	1	3	62	26	88[B]
For the well being of both, men would do well to help their women get direct or indirect clitoral stimulation when desired.[13]	-	2	4	56	30	86[B]

Notes: Percent adjusted by eliminating missing cases on a given item
a - As formulated by Alexander Lowen in *Love and Orgasm*.
b - Total of strongly disagree plus disagree
c - Total of strongly agree plus agree

To inquire about theoretical issues, quotes from Lowen's *Love and Orgasm*, were randomly interspersed, without identification, with other statements, which pertain to the literature of Bioenergetic Analysis.

There were two chief areas of theoretical difference with Lowen's writings. One has to do with the general relationship between men and women. "Man," wrote Lowen, "is woman's bridge to the outside world."[14] Eighty-six percent of the respondents disagreed with that statement. The other area had to do with the importance of the clitoris. "Stimulation of the clitoris directly or indirectly in intercourse is not important for the mature woman."[15] Eighty-seven percent of the women disagreed with that statement. There is disagreement with many other statements about the clitoris and these disagreements are significant, particularly in view of the change in sexual

[7] Lowen, Alexander, *Love and Orgasm*, MacMillan Company, New York, 1965, p 159.
[8] Questionnaire, Women and Bioenergetic Analysis, Appendix A p. 3
[9] Lowen, Alexander, *Love and Orgasm*, p. 217.
[10] Ibid, p. 218.
[11] Questionnaire, Women and Bioenergetic Analysis, Appendix A, p. 3
[12] ibid
[13] ibid
[14] Lowen, Alexander, *Love and Orgasm*, p. 159
[15] Questionnaire, Women and Bioenergetic Analysis, Appendix A, P. 3

functioning that women experienced as a result of B.A. in *Love and Orgasm* Lowen quotes a patient, "The clitoral orgasm is felt on the surface of the vagina like a trickle of sweet pleasure. There's no satisfying release."[16] Seventy percent of the women found this an incorrect statement. "Many women require direct or indirect clitoral stimulation in order to reach sexual climax."[17] Eighty-eight percent of the women agreed with that statement. "For the well being of both, men would do well to help their women get direct or indirect clitoral stimulation when desired."[18] Eighty-six percent agreed with that statement. And, 77 percent agreed: "it's often helpful if a man can postpone his climax until the woman approaches hers."[19] There were open-ended comments indicating this was not true for everyone. One woman commented that if a man would really let go and move the way he wanted to, she could come on top of his orgasm.

Another area of disagreement is with Lowen's statement that, "Tactile stimulation in itself is not causative factor in erotic arousal."[20] Seventy percent of the women disagreed with that statement while at the same time agreeing with Lowen (72 percent) that vaginal orgasm is felt deep within and extends to all parts of the body.

Although only two percent of the women had had homosexual relationships, 40 percent did not agree with Lowen's statement that homosexuality is a sign of arrested development.

Here are some statements women made about their sexual functioning:

> Before Bioenergetics, I had had intense sexual pleasure and orgastic experience, but it was all clitorally oriented. After four years of B.A., I began to have vaginal orgasm. There was not any longer the need for manual clitoral stimulation though there might have been clitoral stimulation in the process of intercourse. The orgasm was completely fulfilling and I do not feel I missed out on anything. Now I wouldn't want to be told that I couldn't have clitoral stimulation because there are times when it's very pleasure giving and I want it. But, what is true now is that it isn't necessary for me to have clitoral stimulation in order to have orgasm.
>
> One of the things I discovered quite by myself was that there is a cul-de-sac at the end of the vagina that for me at least is a sweet kind of thrilling keen pleasure place. As I began to be able to ask for more, and as I got into contact with that place and the pleasure it gave me, I was able to say, stop, don't go so fast, pause at the end of the thrust, that kind of thing, the kinds of things I wouldn't have done earlier in my life. I began to explore the sensation and that was the seat of the orgasmic experience for me.
>
> Before B.A., I had just been dead. I really clamped down on those feelings I'd always been constipated and found out how tight and tense I am in that whole area, or was, and how much anxiety I've experienced. I began to feel feelings that I never had and I got scared to death because there was no one to tell me that's what happens when you begin to unfreeze and to have all those marvelous feelings. I began to have a sex life and have orgasms and it was just fantastic.

(This woman lived in a place where there weren't always B.A. therapists available. She would go through some of these experiences as a result of groups and then have to handle them herself.)

Another woman said that her friends were prejudiced against B.A. because of Lowen's writings and because we don't have any women in B.A. who are writing from a woman's viewpoint.

> The majority of women did not know how to assert themselves and could not assert themselves in their lives because they were so tense in their pelvic area. They could not move and weren't aware that they would find out how much it actually hurt to do it and how guilty they felt when they did it. Then they would bring up the whole issue what you were told about your body and the issue of what you were told about your body and sex. That would bring up the whole relationship with their fathers. Besides teaching them to move their pelvises or to stamp their feet and say, "No, I won't." and just stand there in an assertive way. I also taught them how to let their tummies hang out because all women were told to hold their tummies in. I would have them stand like that, like they were taught to, the way they usually do, and then to stand the other way so they could feel the difference and find out how rigid they were and how much they were holding in that area. I began to have reports that their sex lives were improving, that they were having more frequent orgasms, that they were more relaxed, particularly in man/woman situations.

[16] Lowen, Alexander, *Love and Orgasm*, p. 217
[17] Questionnaire, Women and Bioenergetic Analysis, Appendix A, P. 3
[18] ibid.
[19] ibid.
[20] Lowen, Alexander, *Love and Orgasm*, p. 218

> Women are socialized differently than men. It is OK for a little boy to take out his penis, wee wee on the grass, or show it. It is not for the woman. She's told to keep her legs crossed and the men out of her pants and to sit on her sexual feelings, hold them in, and that's what she does. I think a male therapist would be reluctant to get into that and it would take a long time. A woman can get into that issue right away because she shares a similar experience.

How can we explain these seemingly contradictory statements? Here is a group of women, many who experienced personally, what it means to have a "vaginal" orgasm – an experience centered in the vagina, involving a generalized body feeling and contractions, freedom of pelvic movement, and the experience of sweetness and streamings. Yet this same group insists that the clitoris is important, that stimulation of it in intercourse is important, and that men should help their partners get this when it is desired, and that the clitoral orgasm provides a satisfying release. In *The Human Ground*, Stanley Keleman says:

> I differentiate between four orgastic states: two for men, and two women. From a woman's point of view, there is a clitoral orgasm and a uterine orgasm. From the man's there's the tip of the penis experience which is homologue of the clitoral experience and there's the more global experience which he feels starting from high up in the region of the solar plexus.[21]

That is a better beginning than many men have made in comparing the sexual experience of men and women. In our culture, despite differences in conditioning, men as well as women have difficulty surrendering in the sexual act. No one would suggest, however, that because a man is not able to surrender fully, he should receive no stimulation on the tip of his penis. Many women, for one reason or another, find the clitoris is ignored. Eighty-six percent of the women in this study think that is not good for men or women. While Keleman's statement is one of the better, written by men, it's not a complete description. According to women in this study, there are not two climatic states, but an infinite number. There is a continuum of experience ranging from a climax that is on the surface and specifically clitorally triggered to orgasm that arises deep inside where clitoral stimulation may or may not be present. Depending on the intensity of the relationship, the time of the month, the particular partner, the shape and size of his penis, the range of his and her movement, the state of the women, and other factors, the clitoris may or may not be important.

An excellent summary of the history of the controversy about clitoral versus vaginal orgasm is in *An Analysis of Human Sexual Response* by Ruth and Ed Brecher.[22] In a chapter entitled, "Three Sexual Myths Exploded," myth number two is that women can have two kinds of orgasm, one clitoral and the other vaginal. This either/or view, which is also espoused by Keleman, is contradicted by the findings of the present study. More than 70 years ago, Freud wrote that little girls discover their clitoris, but after marriage they must transfer their sexual responses to the vagina. Women who fail to make this transition are "frigid." Lowen is much kinder to women. He said in *Love and Orgasm*, that if a male is not considered impotent if he has an erection, then a woman who lubricates should not be considered frigid.[23] Since Freud's time, there has been a lot of writing on the subject, most, but not by any means all of it, by men. Marie Bonaparte considered that, "The displacement of the masculine libido of the clitoris to the purely feminine channels of the vagina is a most remarkable biological feat."[24] But still she says that women who experience both clitoral and vaginal stimulation have the advantage over those who only have vaginal stimulation, since preliminaries can lead to end pleasure. However, Deutsch,[25] Robinson,[26] and Bychowski,[27] go along with the more orthodox Freudian view. Bergler goes so far as to consider that every woman who does not have a vaginal orgasm is frigid.[28] A number of analysts have taken exception to the Freudian position. They include Horney[29], Thompson[30], Marmor[31], and Rado[32]. Said Rado, "By suppressing her clitoral sensations, the female cannot possibly augment her vaginal responses, she can only reduce her capacity for sexual performance, her health, and her happiness.[33]

---

[21] Keleman, Stanley, *The Human Ground*, Science and Behavior Books, Palo Alto, CA, 1975, p. 34.
[22] Breecher, Ed and Ruth, An Analysis of Human and Sexual Response, Signet Books, New American Library.
[23] Lowen, Alexander, Love and Orgasm, p. 170.
[24] Bonaparte, Marie, Female Sexuality, International Universities Press, New York, 1953, p. 59.
[25] Deutsch, Helena, The Psychology of Women, Vol. I & II, Grune and Stratton, New York, 1945.
[26] Robinson, Marie, The Power of Sexual Surrender, Doubleday, Garden City, New York, 1959.
[27] Bychowski, G., "Some Aspect of Psychosexuality in Psychoanalytic Experience," P..H. Hoc and J. Zubin, Eds., Psychosexual Development in Health and Disease, Grune and Stratton, New York, 1949.
[28] Bergler, Edmund, "The Problem of Frigidity," Psychiatric Quarterly, Vol. 18, 1944, pp. 374-390.
[29] Horney, Karen, "the Denial of the Vagina," International Journal of Pschoanalysis Vol. 14, 1933, pp. 47-70.
[30] Thompson, Clara, Psychoanalysis: Evolution and Development, Hermitage, New York, 1950.
[31] Marmor, Judd, "some Considerations Concerning Orgasm in the Femal," Psychosomatic Medicine, Vol. 16, 1954, pp. 240-245.
[32] Rado, Sandor, "Sexual Anesthesia in Female," Quarterly Review of Surgery, Obstetrics and Gynecology, Vol. 16, 1959, p. 251.
[33] Breecher, Ed and Ruth, *An Analysis of Human Sexual Response*, pp. 143-144.

In this regard, the work of Kegel is significant.[34] He treated thousands of women for urinary incontinence. He taught them to contract the pubococcygeal muscle as a non-surgical means of controlling incontinence and discovered, serendipitously, that the exercise also improved the sexual responses of his patients. Many women experienced orgasm for the first time. Kegel came to the conclusion that the physiological basis of vaginal orgasm involves highly specialized nerve endings in that muscle (often called the Kegel muscle) which is stimulated by the penis during intercourse. Women who have weak or atrophic Kegel muscles cannot gain satisfaction through intercourse. Kegel found that a third of women have serious weakness and another third have some weakness in that muscle. Therefore, he began to treat pre-orgasmic women through daily exercise of the Kegel muscle. Six out of ten women that he treated responded favorably.

Another group of sex researchers emphasized the central role of the clitoris. Their argument is based on the fact that this organ is richly endowed with sexual receptor cells which they claim the vagina lacks. Together they (Ellis, Kelly and Kinsey)[35] talked about "the myth of the vaginal orgasm." Our research subjects testify to the fact that the vaginal orgasm is no myth. But one of the findings of Masters and Johnson may be relevant, namely that thrusting of the penis and the movement of women's hips cause indirect stimulation to the clitoris during intercourse[36] Helping women (and men) in B.A. learn to move the pelvis probably facilitates indirect stimulation of the clitoris. It also may help contact that "sweet spot" in the vagina which some women in our study found so special.

Conclusion

Women in B.A. are clearly not true believers, which gives additional credence to the positive findings of the study. Respondents certainly believe that they and their clients have benefited from B.A. therapy although they disagree with some items of theory. Despite this, and in spite of the fact that one of the main benefits women report from B.A., is the increased capacity to assert themselves (89 percent) they did not find it easy to express these disagreements either verbally at meetings or in writing. Perhaps this is partially a political problem. Women's comments on the questionnaire indicate they are afraid to disagree openly for fear of being thrown out, for fear of loss of referrals and for fear of not being allowed to become trainers.

Fundamentally, the problems which occur in the Institute for B.A. and its local societies are a reflection of the kind of difficulties which women encounter in our society generally. This is a period when all of us are rethinking our sexual roles. Our thinking is heavily influenced by the ideas with which we live and also our actions and our perceptions are influenced by these ideas. It will take time before we begin to change them and, as a result, to perceive and act differently. One way to start that process is to speak with each other, listen to each other, and begin a dialogue. Perhaps this study will facilitate that process.

New York City
1980

Biography

Dr. Alice Kahn Ladas, Ed.D. CBT helped to found the Institute for Bioenergetic Analysis. A licensed psychologist in New York and New Mexico, she is coauthor of the NY Times best seller, "The G Spot and Other Discoveries About Human Sexuality". Published in 18 languages and 28 countries, it was recently reissued after 22 years. Alice practices in Santa Fe and New York and is on the staff of the Pastoral Counseling Center in Santa Fe. She is the Board member of USABP in charge of research. Alice is also a Humanist Celebrant. She can be reached at 917-863-8303, 505-471-6791 and 212-873-1067l or Aladas@aol.com

Harold S. Ladas, PhD, was a much beloved Professor at Hunter College in New York. His speciality was teaching teachers what is relevant from psychology for the classroom. An award is given each year in his name by the Department of Educational Foundations for excellence in teaching. He was a meticulous researcher without whose expertise Women and Bioenergetic Analysis would never have happened. Bioenergetic therapists know him best for the enormous Sheephead he spear fished at the First International Conference in Isla Mujeres.

Apendixes

The following pages are reprints of the orignial surveys used in this study.

[34] Ellis, Albert, "Is the Vaginal Orgasm a Myth?" A. P. Pillay and Albert Ellis, Eds, Sex, Society, and the Individual, Bombay, India, International Journal of Sexology, Publ. 1953. Kelly, G.L., Sex Manual Eight Edition, Southern Medical Supply Company, Augusta, GA 1959.
[35] Thompson, Clara, Psychoanalysis: *Evolution and Development*, Hermitage, New York, 1950.
[36] Masters, W.H. and Johnson, Virginia, "anatomy of the Female Orgasm," Albert Ellis and Albert Abarbanel, Eds., *The Encyclopedia of Sexual Behavior*, Hawthorne, New York, 1961.

Appendix A

BACKGROUND DATA
(Please separate from rest of your questionnaire.) Card 1 1

Your age: 1. ☐ under 21 2. ☐ 21-30 3. ☐ 31-40 4. ☐ 41-50 5. ☐ 51-60 6. ☐ over 60 2

Your current marital status: (CHECK ONE) 1. ☐ married 2. ☐ single 3. ☐ divorced 4. ☐ widowed 5. ☐ separated 6. ☐ remarried after divorce 7. ☐ remarried after widowhood 3

Your current living situation: (CHECK ONE) 1. ☐ living alone 2. ☐ living with family of origin 3. ☐ living with husband 4. ☐ living with husband and child(ren) 5. ☐ living with child(ren) 6. ☐ living with male partner 7. ☐ living with female partner 8. ☐ living with roommate (not sexual partner) 9. ☐ other (specify) _____ 4

Your country of birth: 1. ☐ U.S.A. -state_____ 2. ☐ other(specify)_____ 5

Mother's country of birth: 1. ☐ U.S.A.-state_____ 2. ☐ other(specify)_____ 6

Father's country of birth: 1. ☐ U.S.A.-state_____ 2. ☐ other(specify)_____ 7

Your religious background: (CHECK ANY THAT APPLY)
8 ☐ Catholic
9 ☐ Protestant
10 ☐ Jewish
11 ☐ Greek or Russian Orthodox
12 ☐ Christian Science
13 ☐ no formal religion
14 ☐ agnostic
15 ☐ atheist
16 ☐ other (specify)_____ 8-16

Are you an active member of any religious group today: (CHECK ONE) 1. ☐ yes 2. ☐ no 17

Where do you live: (CHECK ONE) 1. ☐ city of 1 million or over 2. ☐ city under 1 million 3. ☐ suburban town 4. ☐ non-suburban town 5. ☐ rural 18

Where do you work: (CHECK ONE) 1. ☐ city of 1 million or over 2. ☐ city under 1 million 3. ☐ suburban town 4. ☐ non-suburban town 5. ☐ rural 19

Ethnic background: 1. ☐ Caucasian 2. ☐ Afro-American 3. ☐ Oriental 4. ☐ American Indian 5. ☐ Puerto Rican 6. ☐ Other (specify)_____ 20

Educational background: (CHECK ONE)
21 1. ☐ attended 2. ☐ now attending 3. ☐ completed
(CHECK HIGHEST LEVEL)
22 1. ☐ high school 2. ☐ vocational school 3. ☐ college 4. ☐ masters degree 5. ☐ Ph.D. or M.D. 6. ☐ R.N. 21-22

Are you working as a Bioenergetic Analyst:
(CHECK ONE) 1. ☐ yes 2. ☐ no (if no skip to line 31) 23
(CHECK ONE) 1. ☐ full time 2. ☐ part time 24
(CHECK ONE) 1. ☐ employed 2. ☐ self employed 25

If part time, do you have another occupation: 1. ☐ yes (specify)_____ 2. ☐ no 26

Are you affiliated with a clinic or hospital: 1. ☐ yes (specify)_____ 2. ☐ no 27

- 2 -

Do you do any low cost or free work: 1. ☐ yes 2. ☐ no 28

What is your fee policy: 1. ☐ one standard fee 2. ☐ range of fees depending on income 3. ☐ sliding scale depending upon income 29

What is your average fee per session: 1. ☐ $15 or under 2. ☐ $16-20 3. ☐ $21-30 4. ☐ $31-40 5. ☐ $41-50 6. ☐ $51-60 7. ☐ $61-70 8. ☐ $71-80 9. ☐ over $80 30

What is your yearly income: 1. ☐ under $5,000 2. ☐ $5,000-9,999 3. ☐ $10,000-14,999 4. ☐ $15,000-19,999 5. ☐ $20,000-29,999 6. ☐ $30,000-39,999 7. ☐ $40,000-49,999 8. ☐ $50,000-59,999 9. ☐ $60,000-69,999 10. ☐ $70,000 or over 31

Are you economically independent (not financially dependent on a man): 1. ☐ yes 2. ☐ no 32

Do you earn your own living: 1. ☐ yes 2. ☐ no 33

If no, do you believe you are now capable of earning your own living: 1. ☐ yes 2. ☐ no 34

Were women highly valued as men in your family of origin: 1. ☐ yes 2. ☐ no 3. ☐ don't know 35

Were you a wanted child: 1. ☐ yes 2. ☐ no 3. ☐ don't know 36

Were you breast fed: 1. ☐ yes 2. ☐ no 3. ☐ don't know 37

If yes, how long: 1. ☐ a few days or weeks 2. ☐ less than 6 months 3. ☐ more than 6 months 4. ☐ more than 1 year 5. ☐ don't know 38

Who did you observe breast feeding when you were growing up: 1. ☐ my mother 2. ☐ a relative 3. ☐ a friend of the family 4. ☐ a stranger 5. ☐ other - who? _____ 6. ☐ no one 39

Were any of your sisters or brothers breast fed: (answer no if you were an only child) 1. ☐ yes 2. ☐ no 3. ☐ don't know 40

Do you have a sexual partner you do not live with full time: 1. ☐ yes 2. ☐ no 41

Is that partner a: 1. ☐ male 2. ☐ female 42

How long have you been involved with Bioenergetic Analysis: 1. ☐ less than one year 2. ☐ 1-3 years 3. ☐ 4-6 years 4. ☐ 7-9 years 5. ☐ more than 9 years 43

USABPJ Vol. 4, No. 2, 2005

www.usabp.org

- 3 -

ID No. _____ 1-3
Card No. 1 4

THESIS - THERE ARE NO SPECIAL WOMEN'S ISSUES IN BIOENERGETIC ANALYSIS:
1. ☐ agree 2. ☐ disagree 5
If you disagree list areas that you believe are special issues for women in Bioenergetic Analysis (hereafter B.A.)

ADVD THEORETICAL STATEMENTS (CHECK ONE ANSWER FOR EACH STATEMENT)

	strongly disagree	dis-agree	no opinion	agree	strongly agree	
Stimulation of the clitoris (directly or indirectly) is inconsequse to most important for the mature woman.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6
Any kind of sexual climax is preferable to no climax.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	7
It is often helpful if a man can postpone his climax until a woman approaches hers.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	8
The compulsive quality of homosexuality arises from the need to stimulate the body and release suppressed sexual feelings.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	9
Sex is woman's bridge to the outside world.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	10
Most men feel the need to bring the woman to climax through clitoral stimulation is a burden.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	11
Masturbation is better than the homosexual experience.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	12
A woman can be sexually submissive only if she dissociates herself from her body.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	13
Lack of a sharper focal point for women's sexual excitation makes her somewhat dependent on the male or his image for full arousal.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	14
Promiscuity is the most common form of personality.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	15
The body pleasure of the child at the mother's breast or in contact with her body is the foundation upon which personality and intelligence will grow.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	16
Human beings are not primarily bisexual. Bisexuals are confused about their sexual role.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	17
The clitoral orgasm is felt on the surface of the vagina like a tickle of sweet pleasure. There is no satisfying release.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	18
A mature woman can reach a climax through means other than penile-vaginal contact but this is what she prefers.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	19

- 4 -

	strongly disagree	dis-agree	no opinion	agree	strongly agree	
Sex technique and with the man losing more than he gains and with the woman losing what she truly wants - a man.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	20
The mature woman wants to and does nurse her child at her breast.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	21
The emancipation of women is a hollow victory when it is obtained by the denial of her essential nature as the vessel that holds the mystery of life.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	22
Orgastic potency distinguishes the heterosexual from the homosexual.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	23
Homosexuality is a sign of arrested development.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	24
Sexual orgies are not sexual experiences but exercises in sensuality.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	25
Satisfactory masturbation requires self-acceptance which is lacking in the homosexual personality.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	26
A man can create the conditions that make possible a woman's self-fulfillment but the rest is up to her.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	27
Contact and friction cannot produce orgasm which is derived from movement alone.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	28
Pregnancy is one of the easiest ways to fill the inner emptiness.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	29
The ideal is the enemy of the good if by insisting on it you discourage people from enjoying what is available to them.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	30
Sexuality is primarily a function of movement and only secondarily a function of erotic contact.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	31
Menopause brings no diminution of a mature woman's capacity for sexual enjoyment.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	32
Any kind of a personal relationship involving affection and sexual release is better than no personal relationship.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	33
Few people today are orgastically potent.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	34
The sexually mature woman's identification with her body extends to childbearing and childrearing.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	35
A man is more hurt by the sexual infidelity of his wife than he is by the transfer of her affection to another man.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	36
In addition to a person's energy, feeling and motility, the size and positioning of the genitalia and pelvis are factors in sexual compatibility.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	37
Heterosexual love is better and more satisfying than homosexual love.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	38

- 9 -

	strongly disagree	dis-agree	no opinion	agree	strongly agree	
A woman can create the conditions that make possible a man's self-fulfillment but the rest is up to him.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	10
Vaginal orgasm is felt deep within the vagina and extends to all parts of the body.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	10
A woman is more hurt by the transfer of her husband's affection to another woman than she is by his sexual infidelity.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	11
For the well being of both, man would do well to help their women get direct or indirect clitoral stimulation when needed.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	11
An adequate period of breastfeeding is three years.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	12
There is no such thing as multiple orgasm - only multiple climax.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	12
Tactile stimulation in itself is not a causative factor in sexual arousal.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	13
The flow of sexual excitation in a woman turns inward.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	13
Homosexuality is related to the loss of the feeling of the self. Lack of adequate identification with the body and reduction in the effectiveness of the local personality.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	14
Motherhood is the final step in the progression towards the fulfillment of a woman's nature.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	14
It is easier for an orgastically impotent man to reach a climax through intercourse than it is for an orgastically impotent woman to get the stimulation she needs through intercourse.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	15
For a man to govern the timing of his ejaculation according to the response of the woman destroys the natural flow of feeling that alone guarantees mutual satisfaction.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	15
Woman is man's bridge to the future via children.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	16
Many women require direct or indirect clitoral stimulation in order to reach a sexual climax.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	16
The failure of women to breastfeed is the most important reason for unfulfilled oral desires.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	17
Equality belongs to heterosexuality for only in that relationship can one partner fully respect the other.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	17
Only the relation of vagina to penis provides the condition for full orgastic discharge in the female.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	18

- 8 -

	strongly disagree	dis-agree	no opinion	agree	strongly agree	
Sexual fantasies during the sex act indicate an inability to make a full commitment to the sexual partner.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	19
Sexual orgasm is incongruous in the most satisfying sexual experience.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	19
The asexualist is a person who is unable to enjoy the full pleasure of the sexual experience.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	20
Homosexuality is the result of the neurosis not the other way around.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	20
After puberty a woman's intense genital feelings become located deep within the vagina.	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	21

SOME PERSONAL EXPERIENCE WITH BIOENERGETIC ANALYSIS

How did you first hear about B.A.: (CIRCLE ONE) 1. ☐ reading 2. ☐ lectures
3. ☐ workshop or conference 4. ☐ from a friend 5. ☐ from a colleague
6. ☐ other (specify) _____ 21

Was your reason for becoming involved in B.A. therapy: 1. ☐ related to your being a woman 2. ☐ not related to your gender 22

What influenced you to get involved with B.A. as a patient: (CHECK ANY THAT APPLY)
23 ☐ personal need
24 ☐ professional interest
25 ☐ other (describe) _____ 23-25
State briefly the specific reason(s)

How many B.A. therapists have you had for individual therapy:
(CIRCLE ONE) 0 1 2 3 4 5 6 7 more than 7 26

How many were male: (CIRCLE ONE) 0 1 2 3 4 5 6 7 more than 7 27

How many were female: (CIRCLE ONE) 0 1 2 3 4 5 6 7 more than 7 28

Do you think the sex of the therapist is important in B.A.: 1. ☐ yes 2. ☐ no 29
If yes, please elaborate.

Approximately how many hours of individual B.A. therapy have you had:
1. ☐ Less than 10 2. ☐ 10-49 3. ☐ 50-99 4. ☐ 100-199
5. ☐ 200-299 6. ☐ 300-399 7. ☐ 400-499 8. ☐ 500 or more 30

Are you still in B.A. therapy: 1. ☐ yes 2. ☐ no 31

Approximately how many B.A. workshops have you attended: (including training workshops)
1. ☐ none 2. ☐ 1-4 3. ☐ 5-9 4. ☐ 10-19
5. ☐ 20 or more 32

- 7 -

Do you do Bioenergetic exercises regularly: 1. ☐yes 2. ☐no 73

If yes, do you do them:(CHECK ONE) 1. ☐in a class 2. ☐alone 3. ☐both 74

Did you get what you wanted from B.A. as a patient: 1. ☐yes 2. ☐partially 75
3. ☐no (please elaborate)

If yes, when in your B.A. therapy did this occur: 1. ☐during first 25 hours
2. ☐after 25 hours and before 50 hours 3. ☐after 50 hours and before 100 hours 4. ☐after 100 hours or more 5. ☐after termination of therapy 76

Did you had prior experience in another type of therapy: 1. ☐yes 2. ☐no 77

If yes, approximately how many hours (CHECK ONE): 1. ☐less than 10 2. ☐10-49
3. ☐50-99 4. ☐100-199 5. ☐200-299 6. ☐300-399 7. ☐400-499
8. ☐500 or more 78

If yes, what kind of therapy: 1. ☐individual 2. ☐group 3. ☐both 79

(CHECK ONE OR MORE)
1 ☐psychoanalysis (traditional or other)
2 ☐analytically oriented psychotherapy
3 ☐gestalt
4 ☐Reichian or neo-Reichian
5 ☐family therapy
6 ☐Rogerian
7 ☐rational emotive
8 ☐T.A.
9 ☐other (specify)_____
ID.No:_____ 1-3
Card No: 2 4
5-17

Were you satisfied with the results of the therapy: 1. ☐yes 2. ☐partially 18
3. ☐no (please discuss)

Have you had other types of therapy since B.A. therapy: 1. ☐yes 2. ☐no 19

If yes, why: (describe)

If yes, approximately how many hours (CHECK ONE): 1. ☐less than 10 2. ☐10-49
3. ☐50-99 4. ☐100-199 5. ☐200-299 6. ☐300-399 7. ☐400-499
8. ☐500 or more 16

If yes, what kind of therapy: 1. ☐individual 2. ☐group 3. ☐both 17

(CHECK ONE OR MORE)
10 ☐psychoanalysis (traditional or other)
11 ☐analytically oriented psychotherapy
12 ☐gestalt
13 ☐Reichian or neo-Reichian
21 ☐family therapy
22 ☐Rogerian
23 ☐rational emotive
24 ☐T.A.
25 ☐other (specify)_____
18-19

Were you satisfied with the results of the therapy: 1. ☐yes 2. ☐partially 20
3. ☐no (please discuss)

- 8 -

Please rate the following: -- = very unfavorably; - = unfavorably; 0 = no effect; + = favorably; ++ = very favorably; N.A. = not applicable (CHECK ONE FOR EACH ITEM)

How do you believe your experience with B.A. affected your:	--	-	0	+	++	NA	
self esteem	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	21
capacity to earn a living	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	22
ability to assert yourself	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	23
physical health	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	24
capacity to love	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	25
ability to move your pelvis during sex	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	26
capacity to experience pleasure	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	27
breathing	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	28
body shape	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	29
physical appearance	1. ☐	2. ☐	3. ☐	4.	5. ☐	6. ☐	30
ability to cope with depression	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	31
energy level	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	32
experience of menstruation	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	40
handling of menopause	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	41
choice of where to live	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	42
amount of exercise	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	43
ability to find a suitable partner if desired	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	44
ability to eliminate unwanted habits (check only if habit unwanted by you)							
smoking	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	45
drinking (excessive)	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	46
taking of drugs	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	47
overeating	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	48
undereating	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	49
verification of sexual and tender feelings in relationships	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	50
enjoyment of masturbation	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	51
involuntary movement in orgastic response	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	52
chronic muscular tension	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	53
experience of pregnancy	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	54
experience of delivery	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	55
interaction with your infant(s)	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	56
enjoyment of breastfeeding	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	57
manner of feeding your infant(s)	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	58
interaction with your children)	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	59
sleeping habits	1. ☐	2. ☐	3. ☐	4. ☐	5. ☐	6. ☐	60

- 9 -

		Before B.A.		After B.A.	
Have you had or do you have a homosexual relationship(s)	41	1.☐yes 2.☐no	42	1.☐yes 2.☐no	41-42

If yes, do you believe your experience with B.A. has: (CHECK ONE)
1. ☐ helped you gain more pleasure from it
2. ☐ lessened your interest in homosexuality
3. ☐ diminished your desire for homosexual relationships
4. ☐ had no effect on me in this area
5. ☐ other (describe)

43

Have you experienced a sexual climax (CHECK ANY THAT APPLY)

		Before B.A.		After B.A.	
while asleep	44	1.☐yes 2.☐no	45	1.☐yes 2.☐no	
while masturbating without fantasy	46	1.☐yes 2.☐no	47	1.☐yes 2.☐no	
while masturbating with fantasy	48	1.☐yes 2.☐no	49	1.☐yes 2.☐no	
with a male partner without fantasy	50	1.☐yes 2.☐no	51	1.☐yes 2.☐no	
- " male partner with fantasy	52	1.☐yes 2.☐no	53	1.☐yes 2.☐no	
- " female partner without fantasy	54	1.☐yes 2.☐no	55	1.☐yes 2.☐no	
- " female partner with fantasy	56	1.☐yes 2.☐no	57	1.☐yes 2.☐no	44-57
other (describe)_____	58	1.☐yes 2.☐no	59	1.☐yes 2.☐no	

SU.No._____ 1-3
Card No. 4 4

		Before B.A.		After B.A.	
through intercourse without any special clitoral stimulation	5	1.☐yes 2.☐no	6	1.☐yes 2.☐no	
through intercourse with clitoral stimulation by my partner	7	1.☐yes 2.☐no	8	1.☐yes 2.☐no	
through intercourse with clitoral stimulation by myself	9	1.☐yes 2.☐no	10	1.☐yes 2.☐no	
through intercourse tensing leg muscles	11	1.☐yes 2.☐no	12	1.☐yes 2.☐no	
through intercourse tensing stomach muscles	13	1.☐yes 2.☐no	14	1.☐yes 2.☐no	
through counselingout	15	1.☐yes 2.☐no	16	1.☐yes 2.☐no	
through clitoral stimulation - no intercourse	17	1.☐yes 2.☐no	18	1.☐yes 2.☐no	
other (describe)_____	19	1.☐yes 2.☐no	20	1.☐yes 2.☐no	5-20

Have you experienced orgasm: (no contrasted with a sexual climax) 21 1.☐yes 2.☐no 21 1.☐yes 2.☐no 21-21

Have you experienced the running inward of energy along the walls and down in your vagina 23 1.☐yes 2.☐no 24 1.☐yes 2.☐no 23-24

Have you experienced "streamings": 25 1.☐yes 2.☐no 26 1.☐yes 2.☐no 25-26

Has your experience of sexual climax changed since B.A.:
1.☐ yes 2.☐ no 27

If yes, how: (CHECK ANY THAT APPLY)
28 ☐ it is a more generalized body experience
29 ☐ breathe more deeply
30 ☐ my pelvis moves more freely
31 ☐ my pelvis moves more involuntarily
32 ☐ fantasize less
33 ☐ experience more sweet feelings
34 ☐ the feeling is centered more deeply in my vagina
35 ☐ other (describe)_____ 28-35

- 10 -

		Before B.A.		After B.A.	
Have you experienced sex with more than one person at a time:	36	1.☐yes 2.☐no	37	1.☐yes 2.☐no	36-37

Do you believe B.A. changed your interest in this kind of activity: (CHECK ONE)
1. ☐ it increased
2. ☐ it decreased
3. ☐ it ceased
4. ☐ no change
5. ☐ other (describe)

38

Have you experienced multiple climaxes: 38 1.☐yes 2.☐no 40 1.☐yes 2.☐no 39-40

If yes, do you believe some of those were orgasmic experiences: 1.☐ yes 2.☐ no 41

Do you believe B.A. changed your experience with multiple climax: 1.☐yes 2.☐no 42

If yes, please describe:

Have you been promiscuous (in your own view) 43 1.☐ yes 2.☐no 44 1.☐yes 2.☐no 43-44

If yes, how do you believe B.A. affected your interest in this kind of activity:
1. ☐ it increased
2. ☐ it decreased
3. ☐ it ceased
4. ☐ no change
5. ☐ other (describe) 45

Have you had difficulty finding a suitable male partner to live with: 1.☐ yes 2.☐no 3.☐ didn't want one 46

If yes, did this occur in your: (CHECK ALL THAT APPLY)
47 ☐ teens 50 ☐ forties
48 ☐ twenties 51 ☐ fifties or older
49 ☐ thirties 47-51

Have you had difficulty findings a suitable male sexual partner (one to live with full time): 1.☐yes 2.☐no 3.☐didn't want one 52

If yes, did this occur in your: (CHECK ALL THAT APPLY)
53 ☐ teens 56 ☐ forties
54 ☐ twenties 57 ☐ fifties or older
55 ☐ thirties 53-57

Does your sexual desire vary according to the time of your menstrual cycle: 1.☐yes 2.☐no 3.☐don't know 58

Does your sexual desire vary according to the seasons of the year: 1.☐yes 2.☐no 3.☐don't know 59

- 11 -

Is your sexual desire greater in low humidity: 1. ☐yes 2. ☐no 3. ☐don't know 40

Is your sexual desire greater in warm weather: 1. ☐yes 2. ☐no 3. ☐don't know 41

YOUR EXPERIENCE WITH BIOENERGETIC ANALYSIS AS A THERAPIST

Why did you become involved professionally with B.A.: (CHECK ANY THAT APPLY)
42 ☐it is more effective than forms of therapy I received before
43 ☐it is more effective than forms of therapy I practiced before
44 ☐more interesting work than what I did previously
45 ☐more innovative than what I did previously
46 ☐enriched a profession
47 ☐other (describe)_____ 42-47

How many male clients do you have at present: (CIRCLE ONE)
0 1-3 4-7 8-11 12-15 16-19 more than 19 48

How many female clients do you have at present: (CIRCLE ONE)
0 1-3 4-7 8-11 12-15 16-19 more than 19 49

Do you work with: (CHECK ANY THAT APPLY) ☐ individuals ☐ groups ☐ couples ☐ families 50-53

Do you give exercise classes: 1. ☐yes 2. ☐no 54

Do you prefer working with: (CHECK ONE) 1. ☐men 2. ☐women 3. ☐both 55

(CHECK ONE) 1. ☐children 2. ☐adults 3. ☐teenagers 56

Are there special problems for you working in B.A. because of your gender: 57
1. ☐yes 2. ☐no 3. ☐don't know
If yes, please discuss:

Are there particular advantages to working in B.A. as a woman: 58
1. ☐yes 2. ☐no 3. ☐don't know
If yes, please discuss:

Has your experience as member of The Institute for Bioenergetic Analysis been: 59
(CHECK ONE) 1. ☐excellent 2. ☐good 3. ☐fair 4. ☐poor
Please comment:

- 12 -

Do you believe there are basic energetic differences between men and women: 60
1. ☐yes 2. ☐no (please discuss)

Id No. _____ 1-5
Card No. 2 6

Do you deal with men's bodies differently than you do with women's bodies: 7
1. ☐yes 2. ☐no (please discuss)

Do you believe a male therapist can perform a motherly function: 1. ☐yes 2. ☐no 8
(please discuss)

Do you believe a female therapist can perform a fatherly function: 1. ☐yes 2. ☐no 9
(please discuss)

Have you been or are you part of a women's Bioenergetic Group: 10
1. ☐yes 2. ☐no

If yes, has this been useful to you: 1. ☐yes 2. ☐no 11

Have you worked with any pregnant women: 1. ☐yes 2. ☐no 12
If relevant, please comment on your experience:

Do you believe couples with sexual or marital problems should be seen together in therapy 13
1. ☐yes 2. ☐when possible 3. ☐no

Please make any additional comments you would like to about how B.A. has affected your life:

Appendix B

ALICE K. LADAS, Ed.D.
[illegible] Road • Armonk, N.Y. 10504 • 914-273-6348

February 24, 1978

Dear Colleagues:

Enclosed is the questionnaire about women and Bioenergetic Analysis which some of you heard about earlier this Fall. Edora Waterville Kelley, women involved with Bioenergetic Analysis have been meeting in groups around the country to discuss the subject. The literature of Bioenergetic Analysis makes a number of statements about optimum female functioning. One purpose of this questionnaire is to discover the extent to which women who are professionally involved in Bioenergetic Analysis agree with those statements. Another is to learn who we are, and a third is to discover something about what that involvement has meant to us personally and professionally. Please remember that a questionnaire can only examine how a given population feels about a subject; it cannot determine what is true.

This is a preliminary study. If the percentage of returns is high, the answers should give us some clues about what to investigate further. In addition to providing information, answering the questionnaire may help you clarify your beliefs concerning aspects of Bioenergetic theory as they pertain to women. It has been proposed to report the findings at the Conference in Vancouver, British Columbia in July.

Please return your answered questionnaire in the enclosed, stamped, addressed envelope by March 15 or sooner. DO NOT sign it. Your responses are to be anonymous. That is why the questionnaires are to be returned not to me, but to a secretarial service. Thus the background data on pages one and two will be separated from the rest of your answers so there will be no possibility of identifying anyone by age, marital status, location, etc. The envelope with your return address will be thrown away. The open ended answers will be typed and the original answers blotted out so that they will never be seen by anyone who might recognize your handwriting.

Please ignore the small numbers. They are to assist the computer center where the answers will be processed. Please answer all questions even though they may not reflect your views exactly. Options are limited to facilitate processing. Check the closest approximation and use the open ended sections to be more precise.

The research design has been altered since the original proposal because some women's groups no longer meet. Therefore, most of you are receiving your questionnaire personally instead of through a group. The basic aim is still the same: to make a start at research in Bioenergetic Analysis and to get some data about women which we may not gather in meetings because of its private nature.

I know questionnaires seem a pain, but I hope you will answer promptly anyway. The format has been designed to take as little of your time as possible while still getting some relevant data.

Best wishes and my thanks to you,

Alice K Ladas

Alice K. Ladas, Ed.D.

Appendix C

ALICE K. LADAS, Ed.D.
[illegible] Road • Armonk, N.Y. 10504 • 914-273-6348

April 27, 1978

Dear Colleague:

In early March I sent a questionnaire to you. The secretarial service that is handling the questionnaires has told me that yours has not been returned. Perhaps it never reached you, perhaps you misplaced it, maybe you had no time to fill it out, perhaps it got lost in the mail on its way back.

I am asking the secretarial service to send you a second questionnaire together with an addressed stamped envelope. This will be handled in the same confidential manner as outlined in my first letter which is why the questionnaire is not being mailed back to me but to a secretarial service. Please fill out and return it, or if you do not wish to do that, would you write a sentence to that effect on the top and put it in the envelope unanswered. That will take only a few minutes of your time. If you wish to state why you do not want to answer it, I would be very interested. Maybe you haven't time, perhaps you don't believe in studies of this sort, etc.

As of last week about 55% of the questionnaires had been returned and more are still arriving. The higher the percentage of the returns the more valid our information will be. On behalf of myself and the Bioenergetic women's groups that are meeting around the country I hope you will decide to fill out the questionnaire and return it this time around.

Sincerely,

Alice K Ladas

Alice K. Ladas, Ed.D.

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 Petinnati'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.

McInerny (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 Rubenfeld 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.

References

Atwood, George, & Stolorow, Robert. (1993). Faces in a cloud: Intersubjectivity in personality theory. Northvale, NJ: Jason Aronson

Berube, Margery, et al. (1985). American heritage dictionary, second college edition. Boston: Houghton Mifflin.

Beutler, Larry, Machado, Paulo, & Neufeldt, Susan. (1994). Therapist variables. In A. Bergin & S. Garfield (eds.) Handbook of psychotherapy and behavior change, fourth edition. New York: John Wiley & Sons.

Campbell, Donald, & Stanley, Julian. (1963). Experimental and quasi-experimental designs for research. Boston, MA: Houghton Mifflin.

Corriere, Richard, & Karle, Werner. (1971). Neurophysiological measurements of patients undergoing Primal Therapy. In A. Janov, The anatomy of mental illness: The scientific basis of Primal Therapy. New York: G.P. Putnam's Sons.

Cote, Richard, Jobin, Jean, Larouch, Rene, Desharmias, Raymond, Dumont, Serge, & Trembley, Guy. (1991). Effects of radix neo-Reichian emotional and energetic programs and physical exercise programs on the self-actualization of post-myocardial infarction patients: Part II. Journal of the Radix Teachers Association, 5, (1), 26-51.

Davidson, Paul, & Parker, Kevin. (2001). Eye Movement Desensitization and Reprocessing (EMDR): A meta analysis. Journal of Consulting and Clinical Psychology, 69, (2), 305-316.

Djalali, Veis. (1978). Effects of Bioenergetic psychotherapy on poly-drug addicts, viewed from measures in body image and self-concept. (Doctoral dissertation, University of Southern California, 1978).

Downing, George. (1996). Korper und wort in der psychotherapie. Munich: Kosel, 1996.

Driver, Jane. (1985). A descriptive study of the client's perceptions of change through participation in Radix neo-Reichian education: A body-oriented psychotherapy. University Microfilms International, No. 8517985.
Fernandez, Fernando, Turon, Jose, Siegfried, Jurg, Meermann, Rolf, & Vallejo, Julia. (1995). Does additional body therapy improve the treatment of anorexia nervosa? A comparison of two approaches. Eating Disorders: The Journal of Treatment, 3, (2), 158-164.
Field, Tiffany. (1998). Massage therapy effects. American Psychologist, 53, (12) 1270-1281.

Foulds, Melvin, & Hannigan, Patricia. (1974). Effects of psychomotor group therapy on ratings of self and others. Psychotherapy: Theory, Research, and Practice, 11, (4), 351-353.
Foulds, Melvin, & Hannigan, Patricia. (1976). Effects of psychomotor group therapy on locus of control and social desirability. Journal of Humanistic Psychology, 16, (2), 81-88.
Fox, Nathan, & Card, Judith (1999). Psychophysiological measures in the study of attachment. In J. Cassidy & P. Shaver Handbook of attachment: Theory, research, and clinical applications. New York: Guilford Press.
Garfield, Sol. (1994). Research on client variables in psychotherapy. In A. Bergin & S. Garfield (eds.) Handbook of psychotherapy and behavior change, Fourth Edition. New York: John Wiley & Sons.
Gerdes, Insa. (1993) Report of an investigation in Radix. Journal of the Radix Teachers Association, 7, (2), 13-20.
Giddens, Owen. (1984). The effects of body-oriented psychotherapy on self-concept and body image. University Microfilms International, #8512010).
Gudat, Ulrich. (2002). The efficacy of Bioenergetic Analysis as a method of psychotherapy. Bioenergetic Analysis, 13, (1), 21-56.
Hanratty, Patrick. (2002). Predicting the outcome of Holotropic Breathwork using the high risk model of threat perception. Dissertation Abstracts International , 63 (01), 527B. (UMI No. 3034572).
Hendricks, Marion. (2001). Research basis of Focusing-oriented/experiential therapy. In D. Cain and J. Seeman (Eds.) Handbook of research and practice in humanistic psychotherapies. Washington, DC: American Psychological Association. Also available online, www.focusing.org/research_basis.html.
Henry, Bill, Moffitt, Terrie, Caspi, Avshalom, Langley, John, and Silva, Phil. (1994). On the "rememberance of things past": A longitudinal evaluation of the retrospective method. Psychological Assessment, 6, (2), 92-101.
Holmes, Sarah. (1993). An examination of the comparative effectiveness of experientially and verbally oriented psychotherapy in the amelioration of client identified presenting problems. Dissertation Abstracts International, 54(10), 5390B, (University Microfilms International No. 9409408).
Johnson, Stephen P. (1974) A comparison of patients' assessments of behavior/eclectic, Bioenergetic, and psychoanalytic psychotherapies. University Microfilms International No. 7526139.
Karle, Werner, Corriere, Richard, & Hart, Joseph. (1973). Psychophysiological changes in abreactive therapy – Study I: Primal Therapy. Psychotherapy: Theory, research and Practice, 10, (2), 117-122.
Kasdan, Alan. (1998). Research design in clinical psychology, third edition. Boston, MA: Allyn & Bacon.
Koemeda-Lutz, Margit, Kaschke, Martin, Revenstorf, Dirk, Scherrmann, Thomas, Weiss, Halko, & Soeder, Ulrich. (2003) Preliminary results concerning the effectiveness of body psychotherapies in outpatient settings – a multi-center study in Germany and Switzerland. Website of the European Association for Body Psychotherapy: www.eabp.org/results/ergebnis. html, 4/26/04.
Krishna Rao, P.V. (1995). Yoga: Its scientific and applied aspects. Journal of Indian Psychology, 13, (2) 1-12.
May, John. (1997). Measured psychological change in members of an outpatient body-oriented psychotherapy group. Unpublished manuscript. Available from John May, Gateways: A Growing Place, 222 W. Argonne Dr., St. Louis, MO 63122.
May, John. (1998a). A review of the empirical status of body-oriented psychotherapy. In P. Bernhardt, Creating our community: Proceedings of the First National Conference of the United States Association for Body Psychotherapy.
May, John. (1998b). Research on body psychotherapy. In Caldwell, C. (Chair), . Researching the body, and the body in research. Symposium conducted at the First National Conference of the United States Association for Body Psychotherapy, Boulder, CO.
May, John, & Swafford, Katy. (2000). The effects of a Radix workshop on anxiety and anger. Journal of the Radix Institute, 11, 29-42.
May, Philip, Wexler, Milton, Salkin, Jeri, & Shoop, Trudi. (1963). Non-verbal techniques in the re-establishment of body image and self identity - a preliminary report. Psychiatric Research Reports, 16, 68-82.
McInerny, B.P. (1974). Research with primal patients – Vital signs. Journal of Primal Therapy, 2, (1), 51-63.
Miller, Barry. (1979) An exploratory study of the relationship between psychological growth, psychopathology, and affective mood states during the process of psychotherapy using a Bioenergetic approach. Dissertation Abstracts International # 40(03), 1377B, (University Microfilms International No. 7918859).
Mollon, Phil. (2005). EMDR and the energy therapies: Psychoanalytic perspectives: Chapter 11, Research conclusions. London: Karnac Books.
Moran, M.; Watson, C.G.; Brown, J.; White, C. and Jacobs, L. (1978). Systems Releasing Action Therapy with Alcoholics: An Experimental Evaluation. Journal of Clinical Psychology, 34, (3), 769-774.
Nathan, Peter, Stuart, Scott, & Dolan, Sara. (2000). Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? Psychological Bulletin, 126, (6), 964-981.
O'Grady, Daniel. (1986). The effects of adding a somatic intervention to the Gestalt two-chair technique. University Microfilms International No. 8616196.
Petinatti, Pamela. (2002). The relative efficacy of various complimentary modalities in the lives of patients with chronic pain: A pilot study. USA Body Psychotherapy Journal, 1, (1), 6-15.
Pine, F. (1990). Drive, ego, object, and self: A synthesis for clinical work. New York, NY: Basic Books, Inc
Pressman, Todd. (1993) The psychological and spiritual effects of Stanislav Grof's Holotropic Breathwork technique: An exploratory study. Dissertation Abstracts International # 54(08), 4403B (University Microfilms International No. 933165).
Price, Cynthia. (in press). Body-oriented therapy in recovery from child sexual abuse: An efficacy study. Alternative Therapies in Health and Medicine.
Ritter, M. & Low, K. (1996). Effects of dance/movement therapy: A meta-analysis. The Arts in Psychotherapy, 23, (3), 249-260.
Ross, Barry C. (1982). A comparison of lower body and pelvic exercises versus upper body exercises in relation to sexual satisfaction in heterosexual couples. Dissertation Abstracts International, 43(04), 1266B, (University Microfilms International No. 8221794).
Seligman, Martin. (1995). The effectiveness of psychotherapy: The "Consumer Reports" study. American Psychologist, 50, (12), 965-974.
Seligman, Martin. (2002). Authentic happiness. New York: Free Press.
Strupp, Hans. (1978). Psychotherapy research and practice: An overview. In A. Bergin & S. Garfield (Eds.), Handbook of psychotherapy and behavior change, Second Edition. New York: John Wiley & Sons.
Sullins, Ellen. (2002). Effects of the Rubenfeld Synergy Method with fibromyalgia clients. Unpublished masters thesis, Prescott College.
Van Etten, Michelle, & Taylor, Steven. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis. Clinical Psychology and Psychotherapy, 5, 126-144.

Ventling, Christa (2002) Efficacy of Bioenergetic therapies and stability of the therapeutic result: A retrospective investigation. USA Body Psychotherapy Journal, 1, (2), 5-28.
Wagner, Russell F. (1981). The effects of Bioenergetics and progressive relaxation on the self-concept, locus of control, and social behavior of a hospitalized psychiatric population. Dissertation Abstracts International 43(02), 393B. (University Microfilms International No. 8215286).
Weigle, E. (1992). Integrated breathing. University Microfilms International, 9237720.
West, W. (1992). An investigation by questionnaire of some clients experience of bodywork psychotherapy. Unpublished masters thesis, Dept. of Applied Social Studies, Keele University, England.
West, William. (1994). Client's experience of bodywork psychotherapy. Counseling Psychology Quarterly, 7, (3), 287-303.

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.

Body Psychotherapy Modalities
Journal Articles and Online Sources

Colleen Campbell Barshop, B.A.

Abstract

This article is an alphabetized listing of the modalities within the body psychotherapy field which are currently practicing in the U.S. Each modality on the list includes the founder's name, an article quintessential in its description of the modality, and a summary of that article. The intention is to give the reader a summary of the history, theory, and process of each modality, when possible, and to be a resource for those who are interested in an overview of the body psychotherapy field.

Introduction

While the field of Body Psychotherapy has only formally been around for about sixty years it is a diverse field with many modalities. This collection of modalities is to be a resource for those who are interested in an overview of each of the modalities currently practicing and training in the United States.

This will include: one article that is a quintessential representation or explanation of each modality, from journals and online sources. This project required distinct boundaries because of the enormous amount of material that represented the various body psychotherapy modalities, such as journal articles, workshop handouts, websites, books, pamphlets, newsletters, magazines, compact disks, tapes, videos, etc. After looking through a range of mediums I concluded that it would be most useful to consider journal articles and articles posted online.

The procedure of finding modalities and building this list began in the library using electronic data bases such as CSA (which includes ATLA/ATLAS, ERIC, Medline, Philosopher's Index, PsycArticles, PsycInfo, Social Services Abstract, Sociological Abstracts), EBSCO, SpringerLink, and others. I ordered and read through the EABP annotated bibliography and utilized various lists from the USABP website. I realized then that there were many modalities that were doing work and training which were not within academia and so I began to employ various online search engines such as Google, Hotbot, Vivisimo, and Dogpile. I also spoke to individuals in the field and asked them to look over my growing list. In order to initially be as inclusive as possible I asked the USABP Newsletter to post my project in the December 2004 issue along with my contact information.

The question of what to include was challenging because there are healing modalities that in theory include the whole organism yet do not include the practice of psychotherapy. Additionally, there are body-based techniques that psychotherapists include or synthesize into their practices; yet these techniques alone, if practiced by a nonprofessional, are not body psychotherapy. Therefore this paper covers only body psychotherapy modalities as refined by the USABP (see http://usabp.org/displaycom-mon.cfm?an=1&subarticlenbr=9).

Once I had the name of a modality, I researched possible articles and then explored through the web for contact information. I interacted with each modality either personally or by contacting their main organization. Then I asked the organization or founding member either to suggest the article(s) that they felt were quintessential to their modality or sanction an article I chose. They also approved the annotations themselves. When the appropriate person could not be contacted you will see an asterisk next to the modality name. Modalities have not been included in this project for several reasons: the founders or their students could not be contacted, they did not have articles published or any material online, or their modality articles are only published in a language other than English. Because there is so much repetition and overlap of both theory and practice, another aspect of the process was meditatively clearing my mind and intending to read each article as though it was the first modality I was reading about. I had to maintain a fresh point of view with each modality.

The intention of this project has been to give the reader a summary of the history, theory, and process of each modality when possible from the article chosen. There are many articles, books, websites, and educational programs that support and describe each one of these modalities. One article alone is not enough. The best way to utilize this listing is to employ each article as a doorway into the modality it represents.

References

❖ Authentic Movement (Mary Starks Whitehouse)

Stromsted, T. (2001). Re-inhabiting the female body: Authentic movement as a gateway to transformation. *The Arts in Psychotherapy*, 28, 39-55.

Authentic Movement was developed by pioneer dance therapist Mary Starks Whitehouse as an integration of her studies at the C.G. Jung Institute in Zurich with her dance practice and training with German expressionist dancer Mary Wigman and myth-inspired dancer and choreographer, Martha Graham. In this article Stromsted describes her dissertation research on Authentic Movement and its transformative results for psychotherapy clients and group participants. Authentic Movement is a version of Jung's Active Imagination method embodied through movement. Marie Louise von Franz outlines Active Imagination in four steps: a) opening to the unconscious, b) giving it form, c) reaction by the ego, and d) living it. While Authentic Movement can be done in a group setting, at minimum it requires a mover/ client and a witness/ therapist. The mover does so with eyes closed to facilitate a connection and focus on the inner experience. This allows him/ her to engage in the inner experience, the inner impulse, listening to it respectfully and following it where it may lead. The witness observes the mover's experience while tracking her own somatic and imaginative processes. After the movement is finished the mover may wish to draw, write or work with clay to bring more form to the experience. This is followed by a discussion where the mover describes the experience and the witness "reflects on what she has seen and experienced, without judgment or interpretation, mindful of areas of potential projection." Benefits of Authentic Movement include an increased ability to be present, an experience of deeper layers of oneself, an opportunity for previously repressed aspects of the self to emerge, be acknowledged and transformed, and an experience of being whole—physically, psychologically, and spiritually.

For more information see http://www.authenticmovement-bodysoul.com/

❖ Biodynamic Therapy (Gerda Boyesen)*

Southwell, C. *Biodynamic psychotherapy: Meeting the psyche in the body*. Retrieved June 1, 2005 from http://www.positivehealth.com/permit/Articles/Bodywork/south66.htm

Boyesen developed Biodynamic Psychotherapy as an integration of her own insights along with classical psychology, Reichian body-psychotherapy and active bodywork (Adel Bulow-Hansen). The philosophical structure involves oneness of body, mind and spirit and the work utilizes talking, movement, hands-on, meditative and sensory awareness. Upon entering a Biodynamic Psychotherapy room one notices the variety of possibilities that will inform therapy; there are chairs, a massage table, room to move within, and a mattress on the floor. The article discusses how clients may use these items for their therapeutic purposes. The core of this theory is the knowledge that each individual has a dynamic, unique potential; Boyesen calls this the primary personality. It is this part of us that pulls us toward the fulfillment of our capacities. On the other hand this primary personality is frequently suppressed by the secondary personality—the attributes created to survive and function in a given environment. Armor is a part of this secondary personality. Biodynamic Psychotherapy helps people get in touch with the essential, often oppressed part of themselves. This therapy is also infused with the feminine. The focus of this therapy is more on encouraging the primary personality than on dissolving the armor (although this too is part of it). The therapist works with the primary personality like a midwife –the process is one of "active expectancy: inviting and receptive." In addition, throughout this article are pictures and examples of a therapy session. This helps further conceptualize the work.

For more information see http://www.biodynamicmassage.com/ and www.biodynamic.org

❖ Bioenergetic Analysis (Alexander Lowen and John C. Pierrakos)

Resneck-Sannes, H. (2005). Bioenergetics: Past, present, and future. *International Journal for Bioenergetic Analysis*, 15(1) 33-54.

This article was originally a keynote address from the 2003 Bioenergetic Analysis Conference in Brazil. Resneck-Sannes begins by taking the reader through the history of her involvement with Bioenergetic Analysis, effectively mirroring the development of Bioenergetic Analysis theory and practice. In this way the rich historical evolution of this body psychotherapy, with the legacy of Reich and Lowen at its roots, becomes clear. The article reviews many aspects of Bioenergetic Analysis work. The author spends time with the concept of affect and emotional expression, explaining how by opening up somatic holding patterns a client can then be with his/her feelings. Resneck-Sannes uses neurobiology to discuss the mind/body interface in scientific detail including the concept that the body is the access point to the unconscious. The importance of: working with both the holding patterns reflected on the outside of the body and the inside of the person, the prominence of the client/therapist relationship to the healing of the client, and the significance of different types of touch, are all examined. Most helpful is that throughout the article Resneck-Sannes gives numerous real life examples that clearly illustrate each point and give the reader an unobstructed view into Bioenergetic Analysis.

For more information see http://www.bioenergetic-therapy.com/

❖ Biosynthesis (David Boadella)

Boadella, D. *Biosynthesis*. Retrieved June 1, 2005 from http://www.biosynthesis.org/html/e_concept.html

Biosynthesis is a holistic method that creates a bridge between natural science and human sciences, by connecting the realms of pre and perinatal psychology, somatic and depth psychotherapy and transpersonal psychology. Boadella has been inspired by the energetic theories of Reich, the prenatal and perinatal discoveries of Francis Mott and Frank Lake, Keleman's formative process and emotional anatomy, David Bohm's soma significance, Rupert Sheldrake's morphogenetic fields and the spiritual theory of Robert Moore. Biosynthesis is a client-centered psychotherapy that has a multidimensional approach: affecto-motoric work with muscle tone and movement, energetic work on external and internal breathing rhythms-systemic work on behavior in relationships, psycho-energetic work on the spectrum of holding and releasing emotions, psycho-dynamic work with speech to eliminate communication problems, transformative work on restrictive ideas and images that limit our visions, transpersonal
development by using somatic meditation to link up with the voice of the heart

Polarity is a central concept in Biosynthesis; what could help one person could damage another. The therapist has multiple polarities to choose from and makes decisions centered on what is helpful for this client in a particular time. The main polarities are: internal work or external work, rising or falling energy levels, active leading or receptive following, regressive or progressive orientation, verbal or nonverbal communication. Biosynthesis was created by David Boadella and has been researched and developed over the past 40 years by David Boadella, Silvia Specht Boadella and leading members of the International Training Faculty of Biosynthesis. In Brussels, 1998, Biosynthesis was the first body psychotherapy method to receive scientific recognition from the European Association for Psychotherapy (EAP).

For more information see: http://www.biosynthesis.org/index.html

❖ Body-Mind Centering (Bonnie Bainbridge Cohen)

Cohen, B. (2001). *About body-mind centering.* Retrieved June 1, 2005 from http://bodymindcentering.com/About/

Body-Mind Centering helps individuals transform their experience of their bodies through movement re-education and hands on repatterning. This work is an integration of different perspectives including anatomy, physiology, psychophysical principles, and developmental theory. This experiential learning is considered an exploration of embodiment where each person is both the student and the subject. While this is a body psychotherapy, Body-Mind Centering can be applied in many other areas as well.

For more information see http://bodymindcentering.com/

❖ Body-Mind Psychotherapy (BMP) (Susan Aposhyan)

Aposhyan, S. (2001). Interactive psychobiological regulation. *Currents: A Journal of the Body-Mind Centering Association*, winter/spring, 29-35.

Body-Mind Psychotherapy is a modality that highlights physiology and early motor development, with an additional focus on embodiment. This article outlines the concept of interactive psychobiological regulation (IPR) and gives the reader an understanding of this inherent part of BMP. IPR is a term coined by Allan Schore, and parallels the neurological aspect of the embodied relationship in which the BMP therapist trains. In the beginning of life the caregiver and infant have a flow of nonverbal communication that serves as an interactive psychobiological regulator for the infant. In other words, the extending and receding of stimulation from the mother to the child, facilitates the child's future ability to regulate itself. Aposhyan refers to Schore's work and effectively connects this concept to the manner in which a body psychotherapist relates to a client. She does this by listing six detailed ways that these two ideas intersect. The result is an embodied means of working with a client; a union between the relational and the somatic. The article concludes with a case illustration.

For more information see http://www.bodymindpsychotherapy.com/index.html

❖ Bodynamic Analysis (Lisbeth Marcher)

Renshaw, B. (n.d.) *Bodynamics analysis: A new somatic psychology.* Retrieved June 1, 2005, from http://www.bodynamicusa.com/AboutBDYN.html#Bodynamic%20Analysis

When you go to this address you must scroll down a bit to get to the article. Throughout there are links that further explain certain concepts. Lisbeth Marcher studied physical therapy and psychotherapy before creating Bodynamic Analysis. An important part of the theoretical framework includes a developmental model. Marcher created a map of the psychological/ emotional content and development by age, of each muscle in the body, covering seven stages of childhood development. Using this developmental map, Bodynamics practitioners determinate muscles in clients that are blocked (hyper) or have sacrificed (hypo) their actuation. Then they develop these areas and work to actualize the missing psychological/ cognitive/ emotional purpose they represent, thereby expanding clients' body awareness. This modality views relationship and mutual connection as the primary human drive. Some of the tools used within therapy include collecting a relationship and trauma history. A body map is sometimes created that reflects the areas that will later be the focus of treatment. Clients are taught to build resources that were previously lost or stunted in their development. From this perspective, there is a natural flow in life and if this is interrupted then problems or illness arise. In other words, if a person is held back in their ability to sincerely connect with others then they will not be fully healthy. The idea is that the more a client can develop their body awareness the more able they will be to establish deep connections to others.

For more information see http://www.bodynamicusa.com/index.html

❖ Body Synergy® (Matthew & Ellen Cohen)

Cohen, M., & Cohen, E. (2000). Body psychotherapy: Learning the art of letting go. Retrieved June 1, 2005 from http://www.bodysynergyinstitute.com/bodytherapy.html

Body Synergy® combines Deep Tissue Bodywork inspired by Rolfing®, Patterning®, and Continuum® with an integrated blend of psychotherapy. The therapy process is a dialogue between the therapist and client, utilizing the mind and the body, creating a healing partnership. Body Synergy® involves a psychophysical re-education which comes about as the client becomes cognizant of old holding patterns in their body and the parallel customary way they process emotions and move into behavior. In this way, clients are empowered by learning to let go, to heal and enliven themselves. A Body Synergy® session normally begins with the client talking about their presenting issues and eventually moving to the massage table where bodywork will blend with psychological exploration. This article has two cases involving clients with very different issues, giving the reader an idea of the range of this work. Body Synergy® is a way for clients to move from a "non-relational stance of isolation to a relational stance of being open to self and others."

For more information see http://www.bodysynergyinstitute.com/index.html

❖ Braddock Body Process (Carolyn J. Braddock)

Braddock, C. (2004). *The braddock body process*. Retrieved June 1, 2005 from http://www.braddock-body-process.com/services.html

The Braddock Body Process has its foundation in the ancient art of Tai Ji and Qi Gong philosophy and movement. With this body psychotherapy, clients learn "tools," to get in touch with the many "body voices," which make up the distinctive patterns in the way a person breathes, moves and makes sound. Listening to these varied "body voices" helps to facilitate personal growth by integrating body, mind and spirit. Creative expression through music and body dialogue, and body-centered interventions are an essential part of the work. Braddock's purpose is "being with people on a deeper level, using breath, sound and movement to incorporate the emotional, physical, and spiritual body." The whole person is considered as shown in the focus on emotional, physical, and spiritual

trauma. Core personal concerns such as loss, life-threatening illness, addiction, sexuality and body image, relationships and career transitions are also a central part of the work.

For more information see http://www.braddock-body-process.com/

❖ Chiron (Bernd Eiden, Jochen Lude, and Rainer Pervoltz)

Carroll, R. (n.d.) *The Chiron approach*. Retrieved June 1, 2005, from http://www.chiron.org/

To get to this article go to the website, choose 'About Our Approach,' and then scroll down a bit. Immediately we learn that Chiron is eclectic; it integrates many different perspectives from body psychotherapy as well as from psychology and philosophy. Chiron emerged from the founders' creative integration of their own ideas and experiences along with influences including Biodynamic therapy, Core Energetics, Biosynthesis, Formative Psychology, Bioenergetic Analysis, Radix, Haikomi, Analytical Body Psychotherapy, Object Relations, and Somatic Trauma Therapy. This article itself is philosophically driven. It outlines Chiron's relationship with the physical body including the autonomic nervous system and the energetic body and their perspective on touch, breathing, movement, holism, integration, humanism, and the transpersonal. As therapists they take an active role in the therapeutic relationship and view the relation between client and therapist as an essential transformative element. Rather than a focus on techniques there is a focus on the therapeutic relationship. Another important aspect of this modality is the mind body split. People become unhealthy because of the struggle between the body and mind. In other words, as humans we have natural impulses that we at times repress, all the while not considering where these urges come from. When we can learn to get in touch with these impulses we can learn about ourselves and heal.

For more information see http://www.chiron.org/

❖ Core Energetics (John C. Pierrakos)

Wilner, K.B., (1999) *Core energetics: A therapy of bodily energy and consciousness*. Retrieved September 1, 2004, from http://www.coreenergeticseast.org/

Core Energetics looks at human beings from a holistic perspective, which is to say as physical, emotional, intellectual, and spiritual beings. Two major elements of Core Energetic theory are energy and consciousness. Energy flows through the five levels of being: body, emotion, mind, will, and spirit. When something is blocking energy from flowing, illness is the result. Action methods are used by Core Energetic therapists to release energy blockages. The techniques used are designed to help clients through the four stages of therapy: 1. the identification and confrontation of the mask, 2. the exposure and release of the lower self, 3. reunion with one's authentic self, 4. recognition of one's universal life task. One crucial aspect that sets this modality apart is the consideration of spirituality as part of the therapeutic system. Core Energetics also welcomes resistance which it utilizes as part of the therapy. This article describes and gives two case models of the basic and the advanced staccato breathing technique as taught during a therapy session. These examples give the reader a clear idea of how a session might precede. The reader also learns about the Core Energetic requirements for professional training.

For more information see www.coreenergeticseast.org

❖ Dance/ Movement Therapy (Marian Chace and Blanche Evan)

This is a field in and of itself and simultaneously, it is a body psychotherapy. Marion Chace began pioneering dance therapy with psychiatric in-patients and Blanche Evan created insight oriented dance therapy for the neurotic client. Mary Starks Whitehouse is also a pioneer in the movement therapy field; she is listed in this bibliography under Authentic Movement. Because of the vastness of this field (a bibliography of modalities within Dance/ Movement Therapy may be on the horizon) I have briefly annotated three articles that give an overview of different aspects of this therapy.

Pallaro, P. (1996). Self and body-self: Dance/movement therapy and the development of object relations. *The Arts in Psychotherapy*, 23(2), 113-119.

Dance/movement therapy and object relations have certain parallel assumptions and this article reviews these connections. In the process the reader not only gets to see how these two theories go well together but also learns about dance/movement therapy. See article for more information.

Schmais, C. (1985). Healing processes in group dance therapy. *American Journal of Dance Therapy*, 8, 17-36.

This article concisely reviews group therapy theory and then moves into group dance therapy, listing the eight healing processes within the therapy as: Synchrony, Expression, Rhythm, Vitalization, Integration, Cohesion, Education, and Symbolism. The article spends time with each of these elements and in this way we learn the theory behind dance therapy. See article for more information.

Tortora, S. (2004). Our moving bodies tell stories, which speak of our experience. *Zero to Three Journal*, 24(5), 4-12.

The title of this article is the essence of the work found within. The author shares her session with a single client (child) throughout the article to exemplify the powerful subtleties of nonverbal communication. She has created a particular set of tools for therapy called Ways of Seeing, which utilizes the principles of dance movement psychotherapy, authentic movement, and the Laban Movement Analysis (LMA). There are four principles of a session: 1) all activities in a session are there to give the child the opportunity to use their multi-sensory based, non-verbal movement to show who they are, 2) all nonverbal actions have the potential to be communicative, 3) nonverbal behaviors are the expression of self and can be used for meaningful communication, 4) the practitioner is always observing to understand what is being communicated by these nonverbal actions. See article for more information.

For more information see The American Dance Therapy Association at http://www.adta.org/ and The Southern California Chapter of the American Dance Therapy Association at http://www.sccadta.org/

❖ Eidetic Image Therapy (Akhter Ahsen)

Ahsen, A. (1980). Eidetic therapy: The picture approach to psychosomatics. *Somatics*, Spring, 4-11.

Eidetic Image Therapy is an approach to body psychotherapy that uses a special type of mental image called eidetic (eye-det-ic). This is considered a body psychotherapy because while the work is centered around mental imagery the body is considered an integral aspect of the theory and of the internal process. Akhter Ahsen formulated Image psychology from a melding of psychology, sociology, literature, philosophy and mythology. Out of this work he developed Eidetic Image Therapy as a therapeutic tool for working with the whole being and restoring wholeness. This modality is founded on the idea that mental images are either mechanistic or holistic. Memory is made up in part of an image that interprets the original experience through a rigid structure made up of a point of view that stems from our psyche. In other words, the image that holds a memory is one that has been created by our unique perspective, this is a mechanistic image and it is not a fully accurate representation of what actually happened in the original moment. The holistic mental image is stored in the imaginative core of each person; it is the memory of wholeness. Another important part of the theoretical foundation of Eidetic Image Therapy is the ISM. This comes out of the idea that image is a tripartite phenomenon; mental imagery has three parts that make up its whole. There is the image as a pictorial detail (I), and it involves the body of the experiencer through a somatic expression (S), which in turn generates a meaning (M). This theory reflects that mental imagery is not a one dimensional image but something made up of these three aspects. This article has a collection of case studies throughout that help elucidate this process in a practical context. While the theory is sophisticated the application is straight forward and approachable. This process begins with an exploration of childhood eidetic images called the Eidetic Parents Test and then eventually moves into the client correcting the mechanistic images by connecting with the holistic, accurate images. In this way psychological, physical, and spiritual issues are transformed as inaccurate images (thought constructs) are corrected and made whole.

For more information see http://www.eidetictraining.com/index.html and http://journalofmentalimagery.com/

❖ Eye Movement Desensitization and Reprocessing (EMDR) (Francine Shapiro)

Shapiro, F. (2004) What is EMDR? Retrieved June 1, 2005, from http://www.emdr.com/briefdes.htm

Eye Movement Desensitization and Reprocessing (EMDR) is a methodology that was first discovered in 1989 by Dr. Francine Shapiro, which has since proved to be a highly effective treatment for trauma victims suffering Post Traumatic Stress Disorder (PTSD). EMDR integrates aspects of psychodynamic, cognitive behavioral, interpersonal, experiential, and body psychotherapies into structured protocols created to maximize treatment effects. I have included EMDR in this bibliography because it works with trauma which is a body/psyche issue and because the transformation, the desensitization, is occurring within the body and then consequently healing the psyche. (Talk therapy is not as effective with trauma because the language centers of the brain are off-line during the trauma and again off-line during the recollection of the event). EMDR is an information processing therapy and has eight phases. In the first phase the therapist takes the client's history, determines if EMDR is appropriate, and if so, then they both discuss potential targets for EMDR processing. The second phase involves accessing coping skills and resources to ascertain that the client is stable. In phase three through six a target memory is identified and processed using EMDR procedures. Phase seven is closure with instructions to keep a journal throughout the week and phase eight occurs at the beginning of the next session by going over the last session and anything that may have occurred since. Articles with research involving EMDR and specific psychological disorders, efficacy, and validity can also be found on this website.

For more information see http://www.emdr.com/index.htm

❖ Feminist Body Psychotherapy (Lauree E. Moss)

Moss, L. E., (1996). After the crash: My journey to become a lesbian feminist body psychotherapist. *Women and Therapy*, 18(2), 61-70.

Dr. Moss began in this field with trainings in Gestalt, Bioenergetic therapy, and Reichian work. Also significant, were her experiences with the homophobic and sexist philosophies that lay behind the therapy and training she received. Later she was influenced by Elsa Gindler as she formed FBP. This influence and other experiences showed her that there were more gentle ways of working with the body, more feminist ways, if you will. One of the helpful aspects of this article is that it places the emergence of body psychotherapy within a historical context. In fact, context seems to be an important part of Feminist Body Psychotherapy. The historical place that women are living in as well as the individual context of what it means to be a woman in this world and the possibility of wounding and how a therapist must consider context when choosing the path back to wholeness for their clients. Feminist Body Psychotherapy is one that supports a clients' full emergence into wholeness, whether this includes an identity that is homosexual or heterosexual.

For more information contact Dr. Moss at laureemossphd@aol.com

❖ Focusing Oriented/ Experiential Psychotherapy (Eugene Gendlin)

Hendricks, M. (2001). *Focusing oriented experiential psychotherapy*. Retrieved June 1, 2005 from http://www.focusing.org/research_basis.html#Introduction%20and%20Overview

Focusing-Oriented/ Experiential Psychotherapy developed from a collaboration in the 1950s at the University of Chicago between Carl Rogers, the founder of Client-Centered Psychotherapy and philosopher, Eugene Gendlin. Coming from the philosophical tradition of Dilthey, Dewey, Merleau-Ponty and McKeon, Gendlin originated a philosophy of the "Implicit" and put it into the service of the work Rogers was doing. The question that prompted him was, what is actually going on when empathic conditions are present? Eventually his theory involved a foundational shift from looking at content—what the client discusses—to the manner of process—how the client is relating to experience. One of the hypotheses that was tested at this time by Gendlin and Zimring was that clients who are more successful in therapy will show an increasing ability to refer directly to bodily felt experience. What they found was that clients who were in touch with their felt experience (Experiencing Level) early in therapy had a more optimistic predicted outcome. So failure outcomes could be predicted already from the beginning sessions. In response to this research and the outlined "problem" specific instructions were formulated to teach people how to connect with their felt experience, and this is now called Focusing.
This article reviews eighty-nine studies involving Focusing. This exposes the reader to scientifically documented information that strengthens the theory behind this process. Then the article outlines the practice of Focusing. The fundamental measure of Focusing Oriented Psychotherapy is whether the client's experience is being carried forward in the moment in the interaction with the therapist. The interaction between the therapist and client should support the client's ability to contact the bodily felt sense of their experience. The article provides case examples

of sessions to elucidate the practice. Focusing Oriented Psychotherapy, while a therapy in and of itself can also be incorporated with other therapeutic models. The Focusing Institute provides Focusing training for clients and the general public through a worldwide network of certified teachers and maintains a Focusing partnership pool for people wanting to practice Focusing.

For more information see: http://www.focusing.org/index.html

❖ Formative Psychology (Stanley Keleman)

Keleman, S. (n.d.) *A new vision for somatic psychology: Stanley Keleman's formative approach*. Retrieved on June 1, 2005, from http://www.centerpress.com/html/new.html

The goal of Formative Psychology is to utilize daily life and voluntary muscular effort to learn how to form a personal somatic/emotional embodied adult to be present in the world and additionally, to have the tools to reorganize it as becomes essential in life situations. It is an evolutionary, developmental process that includes the "bodying practice," which is a five step system based on the ability to use voluntary muscular effort to influence the organism's basic expansion-contraction pulsatory organizing reflex. The first step is becoming aware of our present somatic-emotional stance. The next step is to intensify the muscular attitude or stance and in this way become aware of what our somatic reality is. Step three is to use voluntary muscular effort to disassemble the muscular pattern. Four is to pause to contain the pulsatory response, in other words to be able to reorganize the former muscular stance by differentiating it. And five is the practice of applying the reorganization to life situations over time. It is through this practice that the client regroups or shapes themselves from past somatic traumas. By finding solutions through the body, we begin to create a somatic identity.

For more information see http://www.centerpress.com/index.html

❖ Gentle Bio-Energetics (Dr. Eva Reich)

Overly, R. (2002). *Gentle bio-energetics theory for everyone*. Retrieved on June 1, 2005 from http://gentlebio-energetics.com/

To get to this article go to the website, choose "Teach Me," and then you will be led to an online tutorial system. There you will scroll down and click on "Life Energy: Module 1." There are eighteen different online programs each taking you through a learning on Gentle Bio-Energetics.
Gentle Bio-Energetics was created by Eva Reich, Wilhelm Reich's daughter and close co-worker. This body-psychotherapy is founded on the interaction of three essential components that structure our life patterns: life energy, trauma, and armor. Life energy is the animate, life-giving essence that pulsates, expands and contracts, charges and discharges, streams through the body, and flows beyond the surface of the skin. We experience this life energy when we experience emotions and sensations. Armor is reflected in all the conscious and unconscious patterns we bring into existence to guard ourselves from experiencing to the full extent the overwhelming emotions and sensations when trauma occurred. Trauma and armor are woven together; underneath all armor is the experience of trauma. According to Gentle Bio-Energetics armor is what interrupts the normal flow of energy. One of the goals of this therapy/healing is to get the life energy flowing freely and this is done by working with the whole being- physically, spiritually, emotionally, and mentally. This therapy is multi-functional in that it can be utilized as a first-aid immediately after experiencing a trauma, as a tool for uncovering and healing past trauma, and employed to prevent future trauma. Important to note is that this therapy is not done through forceful manipulation of the body but rather observation and gentle touch. By watching the way the life energy is currently flowing, the therapist can see where the armor is blocking the flow, and then discover the way the armor can be gently melted. Gentle Bio-Energetics is particularly effective in working with preverbal primal trauma.

For more information see: http://gentlebio-energetics.com/

❖ Gestalt Body Psychotherapy

Kepner, J. (2001). Gestalt approach to body oriented theory: An introduction. *Gestalt Review*, 4(4), 262-264.

Gestalt Therapy founded by Fritz Perls, Laura Perls, Ralph Hefferline, and Paul Goodman was not defined as a body psychotherapy although the body has always been included in Gestalt theory. Like most therapies, over the years this therapy has changed and some Gestalt practitioners have moved towards a more direct body emphasis. Kepner, who is on the professional staff at the Gestalt Institute of Cleveland, has been one of the contributors to this expansion. This article presents the work of three Gestalt Body Psychotherapists and includes the strengths and weaknesses regarding the Gestalt approach. Each practitioner has also established herself outside of the Gestalt framework: Ilana Rubenfeld, Ruella Frank, and Frances Baker. What the reader learns about Gestalt is that it is rooted in: an experimental and an experiential mode of working, an interest in experience, a syncretic capacity and holism, the integral nature of body, mind, and emotion, the validity of embodied modes of therapeutic contact, the importance of experience and awareness as opposed to the intellectual understanding in the change process, self-regulation and self-responsibility, and an understanding of the therapeutic encounter as a healing process. From Kepner's perspective the strength of Gestalt Body Psychotherapy is "its broad sweep and inclusiveness and that its methodology provides the practitioner with an inherently experimental mode in which every aspect of experience is fair game."

For more information see: http://www.gestaltreview.com/ The Gestalt Review
http://www.newyorkgestalt.org/index.html The Original New York Gestalt Institute
http://www.gestaltinstitute.com/ Gestalt Institute of San Francisco
http://www.aagt.org/ The Association for the Advancement of Gestalt Therapy

❖ Hakomi (Ron Kurtz)

Barstow, C. (1985). An overview of the hakomi method of psychotherapy. *The Hakomi Forum*, 2, Winter, 8-17.

Ron Kurtz studied various forms on his way to formulating Hakomi and still this refined practice is very much its own modality. In this article we find a therapy session followed by notes of explanation that make it helpful for the beginner to understand what constitutes Hakomi therapy. Additionally at the end of the article is a visual display that further explains the therapy process. In this way we see different Hakomi techniques in action such as contact, tracking, crossing the mind/body interface, taking over, and supporting the body. We learn that there are 4 states of consciousness and that Hakomi therapy takes place within the state of mindfulness; that the 4 components of a "Sensitivity Cycle," outline the process of therapy and that the 8 major body types are a part of the character theory that assists the therapist in determining what the client's character strategy is and what it is they need in that moment. The therapist models and embodies attitudes of compassion, curiosity, openness, acceptance, trust, and patience and in this way encourages the client to feel safe and eventually learn how to embody these attitudes themselves. In Hakomi, therapy is not about repairing something broken. It is about studying the organization of one's experience, on the part of the therapist and the client. Transformation is said to occur in Hakomi when a client can organize in some aspect of life that their core organizing beliefs had previously organized out.

For more information see http://www.hakomiinstitute.com
All issues of Hakomi forum can be found in full text at the above address.

❖ The Hendricks Method of Relationship and Body-Centered Transformation (Gay & Kathlyn Hendricks)

Hendricks, G., Hendricks, K. Guiding principles of our work. Retreived on June 1, 2005, from
http://www.hendricks.com/store/guiding_principals.asp?dept_id=14

This section of their website outlines ten guiding principles of the Hendricks Method of Relationship and Body-Centered Transformation. This modality includes experiential exercises designed to change the state of consciousness within which problems occur and assist discovery of a new state of consciousness where problems can resolve themselves. This training is designed to provide spiritual shifts of consciousness which can be felt in the body. Spirituality in this sense is not about cosmology or religious belief systems rather it is about the universal spiritual experience that all humans share. An example of this might look like a heart-centered awakening of love and compassion. In addition, this modality's ideas and practices have practical application for relationship transformation and are founded on scrupulous honesty, creativity and commitment to the relationship. People are encouraged to put their energy into taking responsibility for their part in the relationship rather than defending their role as the victim. There is a focus on giving and receiving appreciation rather than attempting to get others to appreciate us. Also between partners it is encouraged to notice the similarities rather than noticing

the differences, whether this is between different genders or same gender. Within the Hendricks Method, relationship problems can be resolved with five questions: What am I not facing? What truths have I not spoken? What have I been blaming others for that I need to own responsibility for creating? What choices do I need to make? What actions do I need to take?

For more information see http://www.hendricks.com/store/default.asp

❖ Integrative Body Psychotherapy (IBP) (Jack Rosenburg, Marjorie Rand, Beverly Kitaen Morse)

Rand, M.L., & Fewster, G. (1997) Self, boundaires and containment: An integrative body psychotherapy viewpoint. Retrieved on June 1, 2005, from http://www.drrandbodymindtherapy.com/articles.html

Integrative Body Psychotherapy utilizes a developmental model and values relatedness and autonomy through direct somatic participation and observation and body awareness. This is a modality that views awareness as the key to change. As far as history, IBP has been influenced by Gestalt therapy, Reichian therapy, Yoga, Object Relations theory, and Transpersonal Psychology. Integration of different methodologies serves to address all aspects of the client; in other words, it provides a way of working with each client as a whole. In this article there is a thorough list of the 12 basic assumptions of IBP, which includes the premise that body, mind, and spirit are in a symbiotic relationship and so must be worked with collectively. A detailed explanation of boundaries, development of the self, and containment within IBP, as well as a comparison between the containment model and the cathartic model, gives the reader a further understanding of the work that is being done here. Additionally, a transcript of an individual therapy session demonstrating boundary work and an example of a group boundary exercise show the experiential and didactic nature of this work. The article ends with a review of the factors necessary for therapy.

For more information see
http://www.drrandbodymindtherapy.com/index.html
and http://www.ibponline.com/

❖ Life Energy Process (Stephano Sabetti)

Sabetti, S. (2004). Life energy process. Retrieved June 1, 2005, from http://instituteforlifeenergy.com/public/index1.html

Life Energy Process (L.E.P.) has evolved from what was originally called Life Energy Therapy (L.E.T.) which Sabetti developed by integrating elements of numerous Western and Eastern therapies and philosophies. L.E.P. utilizes psycho-physical forms and techniques in order to support and aid the physical, mental and spiritual development of individuals and groups. The core concept of L.E.P. is that life energy is the foundation and forms every living being, this energy can be felt as physical vibrations. These may be in harmony, or take the form of disorders, which can appear as physical or mental illness. Therefore, each difficulty is to be viewed as a disturbance of energy flow. This energy viewpoint results in clarity, simplification and the chance to reach beyond the level of symptoms to the root of any disorder. L.E.P. is process oriented and takes into consideration the natural phenomenon of continuous change as the basis of life. When a person resists this change energetic disturbances can result. Often people hold on to these disturbances and are attached to the problems of the past as part of their neurotic identities. Sabetti encourages the client to stay in the present, become conscious and let the energy movement vibrate through. As blockages and disorders gradually vanish, the aim of the work is to individually explore who we essentially are. Thus, in time it becomes possible to surpass the limitations of the past and to recognize oneself more and more as part of a greater wholeness.

For more information http://instituteforlifeenergy.com/public/index1.html

❖ Lomi School (Robert K. Hall, Richard Strozzi-Heckler, Alyssa Hall and Catherine Flaxman)

Pope, T. (1999). Vehicle of life. *Lomi Somatics Forum*, 4(1).

The Lomi School is thirty-five years old and is known in the USA and Europe for its training of psychotherapists interested in developing skills in body-based and meditation-related therapies. Lomi counselors practice a body based approach to psychotherapy by concentrating on the whole person – body, mind and spirit. This article is

driven by a case study. In it the author assists a client in being mindful of whom she is in the therapeutic moment, and to inquire into the nature of her being and of her life. The Lomi techniques have developed over the years through an integration of ancient practices and modern techniques of focusing attention on the entire scope of being alive. This case study concentrates on guiding the client to witness (through mindfulness) and unravel her past conditioning. In this way she can then discover her essential self and move forward into her experience of who she really is.

For more information see http://www.lomi.org/

❖ The Moving cycle (Christine Caldwell)

Caldwell, C. (2004) Caring for the caregiver. *Psychotherapy Networker*, July/ August, 34-35.

The Moving Cycle has its influences in dance, bodywork, and contemplative psychology. As a modality, it is a natural healing process that has four stages: awareness, owning, appreciation, and action. This article describes an important aspect of the therapy, therapist self-care. There is "freestanding self-care", which involves the renewal process that we tend to outside of the therapy session. Then there is "embedded self-care" and this calls for action within the session, for example, being attentive to the client and to ourselves at the same time. This "oscillation of attention" is the central way to take care of ourselves, which is to say our body, our mind, our spirit, our psyche, our selves. Caldwell utilizes an actual session to exemplify this essential part of good body psychotherapy.

For more information see http://www.naropa.edu/ where Caldwell is the founder and director of the Somatic Psychology Department.

❖ Organismic Psychotherapy (Katherine Ennis Brown and Malcolm Brown)

Goodrich-Dunn, B. & Greene, E. (2001). Voices: A history of body psychotherapy. *USA Body Psychotherapy Journal*, 1(1), 53-117.

While this article is a history of body psychotherapy it was chosen because, while the Browns are an important part of the body psychotherapy field, their work is mostly published in book form. My annotation is not of the entire article but rather covers the section on Malcolm Brown which briefly shares with us the path of Brown and how he came to develop Organismic Psychotherapy. Brown was primarily influenced by C.G. Jung, Abraham Maslow, Erich Neumann, Carl Rogers, D.H. Lawrence, neurologist Kurt Goldstein, and Wilhelm Reich and he went on to develop a modality that functions to re-activate the natural mental/spiritual polarities of the psyche and soul. His work includes techniques to rouse the energy flow and integrate with the main dynamic Being Centers of the embodied soul: (1) the Agape-Eros Being Center consists of the upper frontal portion of the body and mediates feelings of openness toward others, (2) the Hara Being Center, the abdominal portion of the body, permits self-love, (3) the Logos Being Center, the upper dorsal portion of the body, holds intuitive faculties, and (4) the Phallic-Spiritual Warrior Being Center, which consists of the lower back and the limbs, enables resoluteness (perseverance). Two other significant aspects of the Brown's work is the wide use of motionless, direct touch for the purpose of undermining armor and mobilizing exercises designed to challenge the armor.

For more information see http://www.bodypsychotherapy.org/ and
"Healing Touch: An Introduction to Organismic Psychotherapy" by Malcolm Brown.

❖ Orgonomy (Wilhelm Reich, M.D.)

Baker, E.F. (1977). Medical Orgonomy. *Journal of Orgonomy*, 11(2), 188-194.

Orgonomy was developed by Wilhelm Reich, M.D., as the scientific study of orgone energy (life energy). This article gives a clear history of how Reich's theories developed, including the central observation that if a person is capable or becomes capable of complete sexual release at the moment of orgasm they naturally regulate their energy metabolism and will remain free of neurosis. From this and other observations Reich arrived at a theory of

"sex economy" which rests upon the natural functions of charge and discharge of energy. Almost all people, because of the culture they grow up in, have energy blocks in various areas of the body and these are largely manifested as chronic muscle contractions. Medical orgone therapy, the mind-body treatment developed by Reich, is practiced only by physicians that are board certified in the specialty of psychiatry. It focuses both on removing physical armoring and addressing the individual's specific character attitudes. This article gives a thorough and approachable explanation of the theory and method of treatment. It includes how armor is formed in infancy and childhood, how it becomes layered and distributed in the individual, and how the therapist proceeds in treatment. The ultimate goal is orgastic potency and, while this is not always attained, many lasting benefits come about as armor is dissolved.

For more information see http://orgonomy.org/index.html
This article and others can be found at the above site.

- **Pesso Boyden System Psychomotor (PBSP) (Albert Pesso and Diane Boyden-Pesso)**

Pesso, A. (2000). Memory and consciousness: In the mind's eye, in the mind's body. Retrieved June 1, 2005, from
http://www.pbsp.com/dutchcon.htm

This article scientifically explains the connection between memory and consciousness and how they intrinsically involve the body localizing this concept as central within body psychotherapy theory, while also giving a clear and condensed overview of the Pesso Boyden System Psychomotor modality. Our past experiences and the memories associated with them can lead to a body filled with emotion, these "charged body states" come before emotional expression but this emotionality is often unconsciously suppressed and so remains stuck in the body. The result of this can manifest anywhere along the continuum of disease. This modality creates a venue, an environment where the client can safely express these "body-bound emotions." Everything we experience or have experienced in our lives is registered and stored in our brain and in our body. Brain research shows that our consciousness, our idea of who we are and what is going on around us, is for the most part based on and driven by memory. This explains why people who have grown up in an unsupportive environment tend to have a negative adult experience as well. In PBSP, clients reenact and then recreate a more positive, symbolic "as-if-past" conditioning. Thus clients are provided a way to reinterpret their consciousness, allowing them to create new, positive experiences and therefore a new way of viewing the world.

For more information see http://www.pbsp.com/

- **Prenatal and Perinatal Body Psychotherapy (Thomas Verny and David Chamberlain)**

Glenn, M. (2002). *The use of body-centered psychotherapy in working with prenatal and perinatal imprints within a group context*. Retrieved June 1, 2005 from
http://www.sbgi.edu/cont_edu/glenn/SBGICEUGroupTherapy.pdf

Within Prenatal and Perinatal Psychology there is a large theoretical substratum that includes the developmental period before birth, birth, birth trauma and its healing. This particular article focuses on healing early imprints including attachment and birth trauma. All areas of Prenatal and Perinatal Psychology have aspects that incorporate somatic experience. In addition, some of the modalities in this bibliography utilize Prenatal and Perinatal Psychology theory and use their modality to work with birth trauma.
The theory and research behind birth trauma work demonstrates that early somatic experience produces the foundation upon which people live their lives. Problems with interpersonal and intrapersonal relations can be traced back to conception, gestation, birth and bonding. Prenatal and Perinatal Psychology utilizes dynamic and body-oriented interventions that can heal and re-pattern early trauma.
This article gives a brief history of Prenatal and Perinatal group process work along with a review of the different types of group modalities that do this work. The redeemable qualities of group work for birth trauma verses individual work and when this may not be the mode of choice is explained. The article then focuses on the structure of Prenatal and Perinatal group therapy and individual therapy creating a protocol for the work. This article reviews one of several ways of working with birth trauma based on Prenatal and Perinatal Psychological theory.

For more information see: http://birthpsychology.com/ and http://www.sbgi.edu/

❖ Process Oriented Psychology (Dreambody) (Arnold and Amy Mindell)

Mindell, A. (n.d.) Some history, theory and practice: Beginning with the dreambody and including the quantum mind and healing. Retrieved June 1, 2005, from http://www.aamindell.net/processwork_frame.htm

POP or Process Work has its roots in physics, Jungian Psychology, and Taoism. This is a non-pathological, relational approach to learning about our selves and our experiences. Observation is a foundational aspect of this work; the therapist tracks the process of the client and supports the process as it unfolds. The dreambody is another essential piece of this work. There are several books by Mindell that describe this concept. One explanation is the dreambody is the "psychophysical process which is trying to dream itself, so to speak, into being." The article also briefly explains the concept of quantum mind and gives an example of Process work that is experiential. The focus of this modality is on awareness, because it is through awareness that one can observe the path of psychological and physical processes that make clear the issues that people deal with personally and socially. Rather than having a fixed way of working with each individual, or an ideal image of what it is to be healthy, this modality is interested in assisting individuals in following their own process, the process that their dreambody is urging them toward.

For more information see http://www.aamindell.net/index.htm

❖ Psycho Organic Analysis (Paul Boyesen)*

Blamauer, R. (2003). Psycho-Organic Analysis. International Journal of Psychotherapy, 8(3), 223-226.

This method was originally an expansion of Biodynamic Psychology (Gerda Boyesen) that went on to become its own modality. As such Psycho Organic Analysis has roots in Reichian and Neoreichian body psychotherapies. Paul Boyesen also based his approach on the work of Freud and Jung. This article reviews the basic concepts of Psycho Organic Analysis. The modality is client-centered in the sense that there is a respect for the client's process. Psycho Organic Analysis works with the unconscious through dreams, imaginations, movements, actions, and spoken words; this exploration and what comes forward through the unconscious is to be inspiration for daily life. The transference and countertransference that arises is an indispensable part of the analysis. During the Psycho Organic Analysis there are two types of energy brought forth by the unconscious: when a client is dealing with the past there is *residual energy* and the other refers to the not yet lived potential of the person, the *consequential energy*. To invite the consequential energy is the primary goal of Psycho Organic Analysis. There is also the Psycho organic cycle, a phenomenological model, which is a differentiation of the Reichian formula, describing nine stages of a need that are advanced through on the way from its emergence to its fulfillment: need, accumulation, identity, force, capacity, concept, expression, feeling, and orgonomy. In this way the practitioner can view the client's process on the level of psyche, organism and energy. Two other aspects of this theory that are significant are words and thoughts, and sense and sensation. Words and thoughts are important as they are embodied and so reflect the state of each persons being. Sense is related to the choices people make while sensation is the result of these choices; the unconscious is acknowledged when the client begins to examine the relation between sense and sensation. This modality is more commonly found within Europe, as a result most of the training centers are located there.

For more information see http://www.eapoa.com/ and http://www.iipoa.org/

❖ Psycho-Physical Therapy (Bill Bowen)

Bowen, B. (n.d.) What is psycho-physical therapy? Retrieved on June 1, 2005 from http://psychophysicaltherapy.com/what_is_PPT.html

The founder of this modality had training in Hakomi, Bodynamic Analysis, Somatic Experiencing, and many other modalities, and worked with numerous people in the field before creating Psycho-Physical Therapy. As an integrative system, PPT considers awareness to be the ground that transformation is built upon. This article has a list of principles that gives a well defined understanding of what makes up this modality. The therapist holds: that each part of the person (spirit, psyche, thinking mind, etc) are never separate from the whole being; that the body is the primary vehicle through which the therapeutic work is done; and that a balance must be maintained between

analysis and process. The container for the therapy is the therapeutic relationship itself and so the therapist must model wholeness and integration. As far as therapeutic goals, the work is centered on the clients clarifying their goals throughout the process and building their inner resources to meet these goals. PPT is a therapeutic method that actively integrates approaches of both psychotherapy and body therapy in one simultaneous process.

For more information see http://psychophysicaltherapy.com/

❖ Radix (Charles R. Kelley)

McKenzie, N. (1999) Our eyes: Windows of the soul, shields from the world, integrators of life. *Radix Reader*, 2.

Like many body psychotherapy modalities, Charles Kelly founded Radix upon the humanistic psychology model. In this way, Radix views each person as being on a continuing spectrum of personal growth, rather than using the illness model of diagnosis. Radix also assumes mind-body unity and utilizes an integrated process-oriented approach that includes working with the body (somatic), feelings (affective), and thought (cognitive). Radix is a process that releases one's capacity for feeling and vitalness both intra- and inter-personally and it is especially useful for disengaging emotional blocks. Kelley was influenced by Reich and Bates vision work; the life force and muscular armoring are two theories that were articulated by Reich and have a place in Radix work though with significant shifts in emphasis. The word Radix refers to the life force, which is the foundation of all thinking, feeling, and behavior. Radix practitioners are taught to observe, track and work with the flow of this life force in cases where it results in muscular armor (the traditional Reichian perspective) and also in softer structures where often there is an absence of armor or in severe cases of trauma, embodiment. Bates influence is evident in the special importance placed on the functioning of the ocular segment. The main goal of Radix Education is to facilitate the clients in becoming fully in contact with themselves and be in connection with others and the world around them while having the choice of experiencing their feelings and aliveness. The basic theoretical concept of Radix is pulsation, the rhythmic contraction and expansion of all living things. Two experiential examples of pulsation are the beating of our heart and the ebb and flow of our respiration. Often people have acquired pulsating patterns that restrict the full expression of their life force whether this being in quiet contemplative activities or more rigorous expression. This article gives a thorough description of how a practitioner may work with a client to determine their pulsation and other concepts of Radix Education. An important facet of Radix is that their trainings do not teach techniques, rather they teach concepts and process. From there the practitioner can invent all kinds of techniques to support and develop the client's process.

For more information see: http://www.radix.org/

❖ Rubenfeld Synergy Method (Ilana Rubenfeld)*

Rubenfeld, I. (1990-1991). Ushering in a century of integration. *Somatics,* 8(1), 59-63.

In this article Rubenfeld stresses the importance and relevance of integrated work (as opposed to the trend of specialized focus). Then she succinctly takes the reader through her own process of learning and working with different modalities and why and how she created her own paradigm. With a background in Feldenkrais, Alexander Technique, and Gestalt, Rubenfeld went on to create a system that is among other things: process oriented, holistic, respectful of the uniqueness of the individual, a communication between the therapist and client through touch, about self-care of the therapist as a part of the client-care, and one that includes humor. She views the body as an interconnected part of the human whole. Rubenfeld's article also contains a case study/ example session that shows the four-stage metaprocess intrinsic to the method: awareness, experimentation, integration, and reentry. This composition is an effective explanation of the Rubenfeld Synergy method as well as a vision for the future.

For more information see http://www.rubenfeldsynergy.com/

❖ Self Regulation Therapy (Edward Josephs and Lynne Zettl)

Josephs, E. (2003). *Self regulation therapy.* Retrieved on June 1, 2005 from http://www.cftre.com/srt.php

Both Josephs and Zettl are trained as clinical psychologists. Josephs has also practiced as a neuropsychologist with training in EMDR, Somatic Experiencing, and CBT. He began developing Self Regulation Therapy while

working with brain injured clients and noticing the similarity between their symptoms and PTSD and after obtaining remarkable results working from a psychophysiological perspective. Zettl specializes in the treatment of Posttraumatic Stress Disorder (PTSD) and developmental dysregulation from a psychophysiological perspective; she has conducted research on the efficacy of this approach on police, paramedics and firefighters with PTSD and found it to be a highly effectively treatment.
Self Regulation Therapy is a non-cathartic mind/body modality focused on decreasing excess activation in the nervous system. It is grounded in neurobiology and gives evidence of the quality of our innate ability to flexibly respond to new or threatening stimuli. Trauma can result in a shift in the nervous system that negatively affects one's capacity to be in relationship. Self Regulation Therapy alters the nervous system so it can integrate the trauma and bring balance back into the system. This is done in part by providing a safe, supportive environment for the client to complete the thwarted flight, fight, or freeze responses. Once balance is restored, clients can experience their lives more fully in all aspects. Self Regulation Therapy Practitioner trainings are conducted worldwide. Check out the website for information. The website also provides articles on current research regarding Self Regulation Therapy.

For more information see http://www.cftre.com/index.php

❖ Sensorimotor Psychotherapy (Pat Ogden)

Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. *Traumatology*, 6(3) article 3.

Sensorimotor Psychotherapy has been influenced by neuroscience, attachment theory, psychological theory, and Hakomi. This article explains that there are three levels of information processing, dependent upon one another for the maintenance of human functioning that can be worked with individually. SP is a comprehensive method that integrates these three levels, sensorimotor (body), cognitive, and emotional processing. It is up to the therapist, who uses mindful tracking to determine the most productive route during the therapy moment, although initially in SP the body is the primary entry point in processing trauma. This article provides a detailed neurological discussion that among other things explains “top down” and “bottom up” processing and how science supports working with the sensorimotor in the treatment of trauma. When a person experiences trauma the result is unassimilated sensorimotor reactions. Sensorimotor Psychotherapy is a way of facilitating the processing of these reactions, which in turn resolves the destructive effect these reactions had on cognitive and emotional experiences. The goal of SP is to nurture holistic processing by integrating the three levels of our being: cognitive, emotional, and sensorimotor. This article goes over the essentials of SP and gives a case example for further clarification.

For more information see
http://www.sensorimotorpsychotherapy.org/index.html
The above article can also be found at this website.

❖ Somatic Experiencing (Peter A. Levine)

Levine, P.A. (2003) What is somatic experiencing? Retrieved on June 1, 2004 from http://www.traumahealing.com/intro.html

Somatic Experiencing is a brief, realistic and natural approach to the resolution and healing of trauma. The concept behind this therapy came from the realization that animals in the wild rarely suffer trauma even though they more regularly face life-threatening situations. Humans as animals are equipped with the ability to deal with trauma but the cognitive part of our brains will often interfere, shutting down the natural bodily process of discharging this “survival energy.” Symptoms of trauma are the result. SE encourages clients toward awareness of body sensation. In this way a person can “renegotiate” and heal the experience of trauma. Trauma is more often associated with extremely dangerous situations or close calls but humans can experience the symptoms of trauma after a commonplace incident that they somatically interpret as terrifying or inescapable. By reacquainting clients with their own natural ability to recover, they can then use their experiences with trauma and healing as a transformational journey.

For more information see http://www.traumahealing.com/index.html

❖ Somatic Reclaiming (Judyth O. Weaver)

Weaver, J.O. (1994). An explanation of the development of my somatic psychotherapeutic work. Retrieved June 1, 2005, from http://www.judythweaver.com/explain.html

Judyth O. Weaver is certified in Reichian therapy, Somatic Experiencing, massage, and pre- and perinatal therapy and is a teacher of T'ai Chi Ch'uan, Rosen Method and Sensory Awareness. This article takes the reader through her learning and working process, including her work and studies with Eva Reich, to the evolution of her own body psychotherapy. The reader witnesses the power and subtly of her work through sessions with a particular client. There is also an example of a small piece of work that she did in a classroom. The point is made that it is paramount to meet clients where they are, to support them in they way they need support, rather than force a technique onto them. During a session a client may focus on their breath, touch is likely to be involved, and awareness is cultivated. Awareness leads to choice and this opens the possibility of change. Somatic Reclaiming is a natural, gentle process of resolving and releasing past conditioning and then reclaiming our innate goodness that was always there deep within.

For more information see http://www.judythweaver.com/index.html

❖ Somatic Trauma Therapy (Babette Rothschild)

Rothschild, B. *What is somatic trauma therapy*. Retrieved June 1, 2005 from http://www.trauma.cc

Babette Rothschild is a member of the International and European Societies for Traumatic Stress Studies, the Association of Traumatic Stress Specialists and the National Association of Social Workers. She has trained extensively in Transactional Analysis, Gestalt Therapy, Psychodrama, EMDR and Somatic Experiencing, and is a certified Bodynamic Analyst and certified Radix Teacher. Somatic Trauma Therapy is an integration of these systems and it draws from a range of current theory and techniques for the understanding and treatment of trauma, including PTSD. Somatic Trauma Therapy covers all aspects of trauma's consequence on the mind, body and psyche, and its integrated structure allows the therapist to cater to each client's special needs. Although it is not essential to remember a traumatic event in full, or even at all, what is important is to gain mastery over and shrink symptoms, improve quality of life and to reestablish a good relationship to the self. To begin, Somatic Trauma Therapy guides one through the process of gaining control over symptoms and reestablishing a sense of safety. Later steps call for a restoration of emotional resources, physical reflexes and nervous system balance. If the traumatic event is remembered, there will be additional steps to assist one in making sense of what happened and to recognize it is over. Duration of Somatic Trauma Therapy can range from a few sessions to several years depending on: the nature of the trauma(s), age at the time of the trauma(s), if the trauma(s) is isolated, intertwined with other trauma(s) or continuous, and current resources and strengths.

For more information see http://www.trauma.cc/

❖ Somatotherapies (Richard Meyer)

Meyer, R. (n.d.) Somato-psychotherapy: A history and a concept. Retrieved September 1, 2004 from http://www.eepssa.org/an/index.html

This article gives a thorough history of the development of the somatotherapies, which include the three relational frameworks of somatanalysis: socio-somatanalysis, psycho-somatanalysis, and auto-somatanalysis. By observing these three systems or "positions in life" the therapist can more accurately determine psychopathology and how humans function. Within the history, we learn of how Dr. Richard Meyer, with some colleagues, founded the European School of Socio- and Somato- Analytical Psychotherapy. They provide training in their modality that is holanthropic, which is to say it includes the whole human being. They have developed this word because it simultaneously reflects scientific and traditional medicines, human sciences, cultures and the many facets of psychotherapy. While the article goes in depth to explain the specifics of their theory and work, and in this way shows how the somatotherapies are in contrast to other modalities in the field, it also is clear that there are niches in their holanthropic model for these other contributions.

For more information see http://www.eepssa.org/an/index.html

❖ Strozzi Institute (Richard Strozzi-Heckler)

Strozzi-Heckler, R. *The power of somatics*. Retrieved June 1, 2005 from http://www.strozziinstitute.com/writings.htm

Richard Strozzi-Heckler, Ph.D. is the co-founder and President of Strozzi Institute. Drawing from his studies in a body-oriented philosophy, martial arts, contemplative disciplines, somatics, and linguistics, Richard developed a discourse that is based in the unity of being and action. The practices at Strozzi Institute produce individuals and teams that are self-generating, self-healing, and self-educating. Strozzi Institute has individual and corporate programs for those who seek to embody their leadership potential. They also have a somatic coaching programs and leadership programs for teens.
This article focuses on Somatic Coaching™ and Embodied Learning™ and explains that learning is not simply about changing the way we think about something; to truly sustain change in our behavior we must "embody" new distinctions. One of the keys to embodiment is recurrent practice. Just as one would recurrently practice to improve a golf game or play the piano, the same is true in the cultivation of the Self. At Strozzi Institute a learning environment is created in which somatic practices are used to produce the embodiment of new skills and behaviors.

For more information see http://www.strozziinstitute.com/

❖ Unergi (Ute Arnold)

Arnold,U. (1999). What is a healer? *New Vision Magazine*, March.

The essence of Unergi work is to transmit through words, touch, and movement, a memory of "wholeness, of universal mind, of unlimited potential." It is not based on a power structure or an attitude whereby the therapist has a plan to transform the client. Rather it is a mutual exploration that involves a metacommunication between the whole beings of both the healer and the client. With no agenda, the client is invited to change while the healer's own presence, informed by her own personal healing journey, serves as a model both consciously and unconsciously. The client re-records her own history as she is supported, encouraged, and witnessed by the healer.
The name Unergi is an amalgam of the words unity and energy. Arnold developed this body psychotherapy by integrating the Alexander Technique, Feldenkrais Method, Gestalt Therapy, Art Therapy, and the healing forces of nature. This article also illustrates the modality by providing a case study.

For more information see: http://www.unergi.com/intro.html

Conclusion

It is important to keep in mind that one or two articles could never describe a life work, could never encapsulate all aspects of a body psychotherapy modality. My hope is that this article will inspire the reader to investigate further into these worthwhile healing modalities.
I began this project with the personal goal of creating an overview of the field of body psychotherapy which turned into the intention of this project, to build a resource for others who desire a sense of where this field has gone and what it has become. From start to finish this project took me a year and within that year I have had contact with an amazing variety of competent and vital healers. It is hard to imagine what this dynamic field will do in another sixty years.

Biography

Colleen Campbell Barshop, BA, is currently pursuing her doctorate in Clinical Psychology at the Institute of Transpersonal Psychology. Her interests include body psychotherapy, studying under Virginia Dennehy, PhD., meditation, dreamwork, and integration. She has worked with adults and adolescents with Autism, within Hospice, and currently is focusing on the geriatric community.

USA BODY PSYCHOTHERAPY JOURNAL

The Official Publication of
United States Association for Body Psychotherapy
Jacqueline A. Carleton, Ph.D., Editor (jacarletonphd@gmail.com)

USABP Mission Statement:
The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, it's 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.
USA Body Psychotherapy Journal 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 interdisciplinary exchange with related fields of clinical practice and inquiry.

SUBSCRIPTION & BACK ISSUES

(all funds USD)
_____$65 (USD) Two year subscription
_____$35 (USD) One year subscription
_____$20 (USD) Single issue
_____$25 (USD) Keleman issue

2002 ____Vol. 1, No. 1 ____Vol. 5, No. 2
2003 ____Vol. 2, No. 1 ____Vol. 5, No. 2
2004 ____Vol. 3, No. 1 ____Vol. 5, No. 2
(Selver Issue)
2005 ____Vol. 4, No. 1 ____Vol. 5, No. 2
(Research Issue)
2006 ____Vol. 5, No. 1 ____Vol. 5, No. 2
(Boadella Issue)
2007 ____Vol. 6, No. 1 ____Vol. 6, No. 2
(Keleman Issue)
2008 ____Vol. 7, No. 1 ____Vol. 7, No. 2
(Lowen Issue) (Research Issue II)
2009 _____Vol. 8, No. 1 _____Vol. 8, No. 2
2010 _____Vol. 9, No. 1 _____Vol. 9, No. 2
(Research Issue III)

POSTAGE
Shipping to U.S. and Canada included
International Orders need to include the following postage fees.

SUBSCRIPTIONS
The following postage rates apply *per year*.
_____$18 Mexico, Western Europe
_____$27 Eastern Europe
_____$40 China, Japan, Australia, Cent/South America

SINGLE ISSUE
The following postage rates apply to the first copy.
Additional copies are $3 shipping each.
_____ $9 Mexico, Western Europe
_____$14 Eastern. Europe
_____$20 China, Japan, Australia, Cent/South America

SUBSCRIBER INFORMATION

Name_____

Address_____

City_____State_____Zip_____Country_____

E-Mail_____Telephone (daytime)_____

An email address is required for electronic notification. A non-AOL address is preferred.

Amount Enclosed_____ Check □ Discovery □ Visa □ MasterCard □

Card Number_____ Exp. Date_____ Security Code_____

Signature_____

□ I would like information about becoming a member of USABP

Abstracts and Indexes available at www.usabp.org

The United States Association for
BODY PSYCHOTHERAPY

8639 B 16th St. Ste. 119
Silver Spring, MD 20910
Phone: 202-466-1619
E-Mail: usabp@usabp.org
Web: www.usabp.org

The USA Body Psychotherapy Journal
The Official Publication of the USABP

Editor
JACQUELINE A. CARLETON, PH.D.

ADVERTISING INFORMATION

The USABP Journal accepts advertisements for books, conferences, training programs, etc. of possible interest to our members. Please contact usabp@usabp.org for more information.

VOLUME 4, NO. 2, 2005 Printed in the USA

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.

To ensure the confidentiality of any individuals who may be mentioned in case material, names and identifying information have been changed. It must be understood, however, that although articles must meet academic publishing guidelines, the accuracy or premises of articles printed does not necessarily represent the official beliefs of the USABP or its Board of Directors.

Subscription inquires & changes of address should be sent to *USA Body Psychotherapy Journal*, 7831 Woodmont, PMB 294, Bethesda, MD, 20814. For customer service, call 202-466-1619.

Subscription Rates: Single current issue $20; $35 yearly. Postage outside the US and Canada please inquire at usapb@usapb.org.

Postmaster: Send address change to *USA Body Psychotherapy Journal*, 7831 Woodmont, PMB 294, Bethesda, MD, 20814.

SUBMISSION GUIDELINES AND SPECIFICATIONS
First consideration will be given to articles of original theory, qualitative and quantitative research, experiential data, case studies, as well as comparative analyses and literature reviews. Submission of an article to the *USA Body Psychotherapy Journal* represents certification on the part of the author that it has not been published or submitted for publication elsewhere.

Initial submission should be e-mailed to jacarletonphd@gmail.com as an attachment in Microsoft Word.

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.

Authors are responsible for preparing clearly written manuscripts free of errors in spelling, grammar, or punctuation. We recognize that the majority of contributors are not profes-sional writers, nor do they function in a publish or perish mode. Furthermore, we are aware that the work of our profession is sometimes pragmatic, associative, intuitive, and difficult to structure. However, a professional journal such as we envision normally accepts only pieces that are fully edited. Therefore, we may occasionally suggest that writers find a reviewer to edit their work before it can be accepted. We will suggest names of possible editors if requested.

References: References within the text should include author's surname, publication date and page number.

Full attribution should be included in bibliography at end. *For books*: surname, first name, book title, place, publisher, date of publication. *For periodicals*: Surname, first name, title of article in quotes, name of publication, year, volume, and page numbers. Or, consult the latest edition of the Publication Manual of the American Psychological Association.

LETTERS TO THE EDITOR
The editors are eager to receive letters, particularly communications commenting on and debating works already published in the journal, but also suggestions and requests for additional features or departments. They may be sent to the email address below. A selection of those received will be published in the next volume of the journal.

CORRESPONDANCE ADDRESS

Jacqueline A. Carleton, Ph.D.
Editor
USA Body Psychotherapy Journal
115 East 92nd. Street #2A
New York, NY 10128
212.987.4969
jacarletonphd@gmail.com