Biodynamic Psychotherapy for Trauma Recovery: A Pilot Study

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Abstract

Body-oriented approaches for treating trauma survivors focus on automatic processing, and aim to address the physiological effects of trauma directly within the body itself, without primary reliance on conscious recall. This longitudinal pilot study used standardized pre and post-intervention measures to evaluate the feasibility, acceptability and impact of Biodynamic Interventions delivered six months apart on mind-body healing for eight women receiving domestic violence support services in Western Ireland. Findings revealed that women were willing to engage in treatment, and had sustained improvements in distress, quality of life, and use of social support over one year. More research on integrative approaches to trauma recovery is needed.

Keywords: Biodynamic psychotherapy, trauma recovery, domestic violence, women's mental health, integrative trauma therapy

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Violence against women is a serious and pervasive social problem, often resulting in severe mental health consequences for its victims. The experiences of domestic violence (DV) have severe deleterious effects on women's mental health (De Jong, 2002; Kilpatrick, 2003; Tjaden and Thoennes, 1998). A large percentage of traumatized individuals meet criteria for an array of mental and physical conditions, including mood and anxiety disorders, substance abuse and dependence disorders, eating disorders, somatoform disorders, and medically unexplained symptoms (Crowne et al., 2010; Pico-Alfonso et al., 2006). Most current research emphasizes that the goal of complex trauma therapy is to provide for the immediate needs of security, personal strength, and self-confidence (Courtois, 2004; Courtois & Ford, 2009; van der Kolk, McFarlane, and Weisaeth, 1996). In addition, from a feminist perspective, women need help feeling whole and well. Much recent research supports treatment that aims at support and empowerment (Hill and Ballou, 2005). This research examines a short-term, body-oriented intervention designed to help women in the recovery phase of DV.

Background and Significance

Mainstream psychological therapies for trauma rely on the patient's conscious thought processes in conjunction with remembering or therapeutic re-experiencing of the event to resolve the problematic emotions, behaviors, and physical symptoms of the patient (Courtois and Ford, 2009). While there is some evidence that working with conscious processes can promote improvement in some patients (Kubany, Hill and Owens, 2003), other research warns that when trauma narratives are retold, bodily processes related to the traumatic memory are also activated, leading to a re-experiencing of the bodily symptoms associated with the event (Ogden, Pain, and Fisher, 2006). This debilitating and repetitive cycle of mind-body triggering can thwart therapy and serve to actually keep the past trauma "alive" in the body (Ogden, Pain, and Fisher, 2006; Schore, 2002; van der Kolk, Pelcovitz, and Roth, 1996).

People who seek treatment for trauma-related problems often have had histories of multiple traumas; however, most PTSD treatment has been developed and tested with single trauma populations (Courtois, 2004; Courtois & Ford, 2009; van der Kolk, McFarlane, and Weisaeth, 1996). The research question that remains is whether people who have experienced complex trauma are able to utilize the treatment approaches developed for PTSD. These approaches may address only part of the multifaceted syndrome of complex trauma, which includes the interrelated emotional, physical, behavioral, and social difficulties, as well as dissociation (Kezelman and Stavropoulos, 2012).

Most traditional psychotherapies, including cognitive-behavioral therapy (CBT), depend on what researchers are now referring to as "top-down processing," in which clients use cognitive strategies to manage or inhibit problematic feelings, thoughts, and behaviors (Sarter, Givens and Bruno, 2001; Ogden, Pain and Fisher, 2006). CBT aims to help clients understand how the traumatic experiences have affected their beliefs, and how these beliefs may foster maladaptive ways of feeling and behaving (Kubany, Hill and Owens, 2003). Clients learn how to identify stimuli that trigger them, understand their responses, and possibly learn how to manage disturbing emotions and reactions (Courtois, 2004; Courtois & Ford, 2009; Ogden, Minton, and Pain, 2006; van der Kolk et al., 1996). Top-down approaches, however, may not resolve physiological hyper-arousal in the short-term, leaving clients reflexively triggered by stimuli that their neurobiological system perceives as dangerous, therefore continuing to respond to these stimuli in maladaptive ways (Ford, 2009; Putnam, 1997). This reflexive neurological responsiveness, which lies outside of consciousness, affects affect regulation (Wilson, 2008); may relate to dissociation (DePrince and Freyd, 2007; Price, 2007; Zelikovsky and Lynn, 2002); and may cause physical pain and hyper-vigilance (Nijenhuis, van der Hart, and Steele, 2010; Ogden et al., 2006). Research is beginning to explore how treatment for complex trauma can be directed towards integration of the mind and the body suggesting we need to "pay…attention to the experience and interpretation of physical sensations and preprogrammed physical action patterns" (van der Kolk, 2006, p. xxii forward to Ogden, et al 2006)(Kezelman and Stavropoulos, 2012).

Body-oriented approaches to treating trauma survivors (referred to as "bottom-up" treatments) focus on the physiological, automatic processing, and aim to address the physiological effects of trauma directly within the body itself, without the primary reliance on conscious recall of painful memories. By mitigating the physiological arousal processes, these therapies purport to foster the body's natural healing processes, which in turn affect

cognition, emotion and behavior (Solomon and Heide, 2005). Body psychotherapeutic approaches focus on the physiological arousal processes described above and use interventions aimed at interrupting reflexive responses to trigger stimuli. Bottom-up approaches may also foster the body's natural healing processes, which in turn affect cognition, emotion, and behavior (Allmer, Ventegodt, Kandel, and Merrick, 2009; Boyesen, 1980; Koemeda-Lutz et al., 2004; Koemeda-Lutz, Kaschke, Revenstorf, Scherrmann, Weiss, and Soeder, 2006; Ogden et al., 2006; Price, 2005; Solomon, Solomon, and Heide, 2009).

Recent research is beginning to measure the efficacy of a wide variety of body psychotherapy approaches. This review will focus only on peer-reviewed evidence about the usefulness of selected body psychotherapy techniques. However, we acknowledge that this is a rapidly expanding field and welcome much more research in this area. Probably the most widely known of these methods is *Eye Movement Desensitization and Reprocessing* (EMDR). EMDR is a combination of body-focused (bottom-up processing) and cognitive-behavioral (top-down processing) treatment primarily for PTSD (Kutz, Resnik, and Dekel, 2008; Servan-Schreiber, 2000; Shapiro, 2009). EMDR focuses on reprocessing the stored memories of the traumatic experience, enabling the client to use cognitive and affective mechanisms to reach an adaptive resolution. Another promising line of research involves *Somatic Experiencing,* which is a treatment technique developed to respond to the biological, reflexive, and defensive bodily responses to trauma, and to residual trauma-related fearfulness. The treatment aims to help the client complete the response that was interrupted at the time of the trauma, and teach self-regulation skills (Leitch, Vanslyke, and Allen, 2009; Levine, 1996). In a retrospective study of bioenergetic therapies, Ventling (2002) examined the recovery of 149 former patients who had terminated their therapies after a minimum of 20 sessions 6 months to six years earlier. She found significant positive changes in interpersonal and psychosomatic problems and the effect of body work on physical consciousness, cognitive insights and changes in quality of life, with 107 (75%) patients indicating a stable or even improved condition (Ventling, 2002). In a multinational study, Koemeda-Lutz et al. (2003) compared routine applications of body psychotherapy in outpatient settings to other outpatient psychotherapeutic patients after 6 months of therapy, and found that the body psychotherapy patients (N=78) had significantly improved with small to moderate intraclass effect sizes. After two years of treatment, large effect sizes were attained in all scales (N=21) (Koemeda-Lutz et al., 2003). Price (2007) found that dissociation can be significantly reduced with the addition of body-oriented therapy as an adjunct to traditional psychotherapy for women who were recovering from sexual abuse. In a sample of 24 women who received eight, one-hour body psychotherapy sessions, dissociation was reduced (Price, 2005; Price, 2007). This present pilot study, we hope to contribute to this growing body of research by examining the acceptability, feasibility, and initial estimates of the effect of Biodynamic Psychotherapy to promote trauma recovery for a sample of women receiving DV services in the West of Ireland.

Theoretical Rationale for Biodynamic Intervention for Trauma

Biodynamic Psychology and Psychotherapy is a very specific form of body psychotherapy that was developed by a Norwegian physiotherapist and psychologist Gerda Boyesen in the 1940s (Southwell, 1988). Several major institutes train students in Biodynamic psychotherapy in Europe, including centers in the Netherlands, Germany, Italy, France, England, and

Ireland. Biodynamic psychotherapy is a treatment approach that can help people recovering from trauma with the bodily and psychological processes of affective and sensory stimulation, promoting well-balanced and well-regulated physiological and emotional functioning (Boyesen, 1980; Saint Arnault, Molloy, and O'Halloran, 2012; Saint Arnault, Molloy, O'Halloran, and Bell, 2013; Southwell, 1988). Biodynamic psychology theorizes that painful emotions related to traumatic experiences become encapsulated in muscles. Emotional and physical trauma and shock are stored in rigid and chronically contracted muscles, referred to as armouring. Armouring keeps the psychic and physical energy static, and the body is held in a chronic, permanent startle reflex. This muscular contraction prevents tensions and emotions from being released. Armouring is understood to occur in layers, from superficial to deep. In addition to storing tension and emotional pain, armouring traps bodily fluids and restricts blood circulation that would remove biochemical deposits at the time of the trauma or shock. This is referred to as *tissue armour,* or a concentration of metabolic residues in the body, such as adrenaline and lactic acid. The storage of tension and fluid by the body may repeatedly engage the sympathetic nervous system, keeping the person in a chronic state of hypervigilence or shock. This chronic state of sympathetic nervous system excitement can exhaust adrenal glands and other feedback mechanisms that would normally engage to restore a state of neurological quiet and equilibrium (Boyesen, 1980; Saint Arnault, Molloy, O'Halloran, and Bell, 2013; Saint Arnault, Molloy, and O'Halloran, 2012; Southwell, 1988).

Boyesen hypothesized that emotions are spontaneous bodily processes that may be inhibited by muscular contraction (Boyesen, 1980). Conscious and unconscious processes trigger these biological and emotional imbalances, and these, in turn, prevent the flow of physical and emotional feelings in order to limit emotional pain. This biodynamic repression prevents spontaneity and disturbs normal physical, mental and spiritual homeostasis. The Biodynamic psychotherapist uses specialized touch techniques to locate areas of tension in the muscles, and the aim is to release tissue armouring and trapped energy to promote energy discharge and resolution (Saint Arnault et al., 2013; Saint Arnault, Molloy, and O'Halloran, 2012; Saint Arnault et al., 2012). Biodynamic therapists use stethoscopes to listen to peristaltic sounds (rumblings in the gut) that allow them to track the body's parasympathetic activity (which signifies relaxation) (Boyesen, 1980; Saint Arnault, Molloy, O'Halloran, and Bell, 2013; Saint Arnault, Molloy, and O'Halloran, 2012; Southwell, 1988).

Biodynamic Psychology also uses group methods to facilitate healing. One important technique is a Biodynamic version of *psychodrama*, including techniques such as role-playing, role reversal, mirroring and doubling (Saint Arnault, Molloy, O'Halloran, and Bell, 2013). Biodynamic psychology theorizes that by completing the reaction or response that was already activated *but not expressed* in the original situation (referred to as *therapeutic ab-reaction*), the autonomy, dignity, strength and spontaneity of the 'primary personality' is restored (Klopstech, 2005; Saint Arnault, Molloy, and O'Halloran, 2012; Saint Arnault et al., 2013).

Methods

Design

This paper reports a longitudinal pilot study that used Biodynamic methods to foster healing for eight women who were receiving DV support services in Western Ireland. The aim of this research was to examine the feasibility and acceptability of three 2 ½ day Biodynamic Interventions, complemented by a three-hour individual bodywork session.

The data reported here are part of a larger study that uses mixed biological, qualitative, quantitative, clinical ethnographic and experience sampling methods to examine the healing experience for eight women receiving DV services in Western Ireland.

An Institutional Review board approved all procedures. The lead author, a master's prepared Psychiatric Mental health nurse, attended all group sessions, and at least two members of the research team attended all of the individual sessions. The Gerda Boyesen International Institute (GBII) provided all of the treatment. Mary Molloy, the principle of GBII, has been providing biodynamic education and treatment internationally for over 30 years, delivered all of the interventions. She was assisted by two senior therapists who hold director positions in GBII, and the director of the SAFE Ireland (herself a qualified Biodynamic therapist).

Sampling, Recruitment, and Retention

We recruited a convenience sample of women receiving DV services who were in the recovery phase of their survivorship, were at risk of somatic and psychological symptoms and disorders related to their trauma, and expressed a desire for healing from the effects of that trauma. We sampled women in Ireland because they were proximate to an established Biodynamic therapy clinic and training center (GBII). Inclusion criteria were women over 21 who were receiving services and had a case manager, spoke and read English, and who agreed to the treatment. We used the Kessler 6 (K6) to screen for distress. The K6 is a six-item distress inventory designed to screen for the likelihood of significant psychological symptomology (Kessler, et al, 2002). Because we knew that the distress for women who have experienced DV is generally high, we set our exclusion criteria quite high, allowing women with K6 scores under 20 to enter (Kessler, Andrews, et al, 2002). However, women who were actively psychotic were excluded.

Women receiving DV services were notified of the opportunity to participate in the study by their case manager, or through seeing the poster at the DV shelter. Those expressing interest to their case manager, and who were deemed by their case manager as appropriate for this trial were given the contact information of the Project Coordinator at SAFE Ireland to arrange an intake screening. If the woman met criteria, potential participants were informed of the BP protocol, the research instruments, and the incentive payment. Women who agreed received the informed consent, the survey packet, directions to the pre-treatment qualitative interview, as well as directions and details about the workshop itself. Participants received written information and reminder phone calls before the scheduled interviews. In case of adverse events, women were instructed to call their case manager or the SAFE Ireland office. The SAFE Ireland director coordinated any followup needed. Case managers monitored women regularly and coordinated closely with the SAFE Ireland staff to create what we termed "wrap-around" services.

Instruments and Measures

Demographic data included age, education, and employment. The survey measures were assessed at baseline, six weeks pre and post each intervention. Psychological distress data included depression, anxiety, and psychosocial symptoms. Physical distress measures included physical symptoms. Overall quality of life was measured with the Vitality, Social, Role-Emotional and Role functioning subscales of the SF-36 to gain a full understanding of women's wellbeing. Social support and Social conflict was measured with Social Conflict Scale (SCS), a subscale of the Quality of Relationship Inventory (Pierce, Sarason and Sarason, 1991).

All CESD, anxiety and physical and emotional symptoms were measured using the same Likert scale with "0" indicating little or no times per week to "3" indicating most or all of the time. *Depression* was measured with the Center for Epidemiologic Studies-Depression scale (CES-D), developed at a division of the National Institutes of Mental Health, in 1971 (Radloff, 1977). The CES-D is a self-report scale that is an amalgamation of previously devised depressive inventories. Cronbach's alpha reliability for the CESD with this sample ranged from .95-.96. *Anxiety* was assessed using the Zung Anxiety Self Report (Zung, 1971), which is a 20-item instrument. Cronbach's alpha reliability for this sample was .84 (Zung, 1971). *Physical and emotional symptoms* were measured with the 45-item Composite Symptom Checklist (CSC), which included 22 physical items and 23 emotional items (Saint Arnault & Fetters, 2011). Quality of Life was examined with the Medical Outcomes Study Short Form-36 Health Survey (SF-36). The SF-36 was developed in the USA and has been used in a number of countries (Ware et al., 1998; Ware, Kosinski, & Keller, 1994; Ware & Sherbourne, 1992). We selected the sub-scales representing Bodily Pain, Vitality, Social Functioning and Role Functioning. *Social Support Satisfaction* was measured with the Social Support Questionnaire for Transactions (SSQT)(Suurmeijer et al., 1995) that measures satisfaction with social support in five domains: Emotional Support, Problem Oriented Emotional Support, Social Companionship, Instrumental Support and Problem Oriented Instrumental Support. Cronbach's alpha reliability ranged from .92-.95 (Suurmeijer et al., 1995). *Social conflict* was measured with Social Conflict Scale (SCS), a subscale of the Quality of Relationship Inventory (Pierce, Sarason and Sarason, 1991).

Intervention

Participants in the BP intervention were treated over a 12-month period between May 2011 and May 2012. Our intervention consisted of both a group intervention and an individual bodywork session six months apart. In the group portion of the intervention, we focused on a biodynamic version of psychodrama, for which examples are published elsewhere (Saint Arnault, Molloy, O'Halloran, and Bell, 2013). Within this group, other members of the group might become part of the psychodrama; however, most of the time the most of the therapeutic work was done with the therapist in a one-on-one and the participant, witnessed by the group. The other component of our intervention was a bodywork session aimed at releasing tissue armoring and trapped energy, and the specific technique depended on the location of the trapped energy, but included well-known Biodynamic massage techniques. During both the group and the individual sessions, the therapist worked with the body and the psychological content that comes to the surface to promote energy discharge and resolution (Saint Arnault et al., 2013; Saint Arnault, Molloy, and O'Halloran, 2012; Saint Arnault et al., 2012).

The philosophy that guided the interventions provided in this study have been reported elsewhere (Saint Arnault, Molloy, & O'Halloran, 2012). In summary, the therapeutic team employed a *biodynamic environment*, which was understood as a space that affirmed the integrity of each person, and supported honest self-expression without judgment. This was a conscious creation of a safe and structured environment that aimed to allow self-discovery, release of trapped energy, and promote the re-integration of the mind and body. In addition, the treatment team used a system of *holding*, which involved supporting the participant to take time, with focused support and encouragement, to express feelings or thoughts arising from the intervention. Holding attention allowed the participant to complete their thoughts, feelings, and the interrupted impulses without judgment or interruption. In the bodywork sessions, holding the muscle or part of the body that had been weakened aimed to allow the complete circulation of energy. An important focus of our Biodynamic psychotherapy intervention was *listening to the body*, whereby

the therapist assists the participant to gain awareness of habitual movements and discover their source through observation and mirroring, or encourages the participant to consciously alter or exaggerate these movements or bodily sensations to facilitate self-discovery and the discharge of trapped energy. Consistent with the Biodynamic psychotherapy goal of completing emotional cycles and facilitating vegetative discharge of trapped energy, the therapist assisted the participant in the discovery of the psychological and bodily places where energy had been stored, and held attention there while the participant completed the action, spoke the unspoken, or gave expression to the energy that needed to be discharged.

Analysis

We evaluated the impact of this treatment on the psychosocial health and wellbeing using baseline assessments and 6-week post-intervention standardized psychological, and quality of life measures for all workshops. According to recent research, paired t-test can be used with small sample sizes (De Winter, 2013). Therefore, we used t-test to compare pre and post-intervention scores for all time points (see Table 1). We also used means and standard deviations to calculate Cohen's d effect sizes. Cohen (1988) reports the following interpretation guideline for interpretation of effect sizes: 0.1 to 0.3 is a small effect; 0.3 to 0.5 is an intermediate effect and 0.5 and higher is a strong effect.

Findings

Sample Characteristics

Eight women volunteered for this study, attended all workshops and the individual sessions, and completed all instruments. The average age of the women was 44 years. The range of time the women were with their abuser was 5-20 years. Four of the women had experienced and/or witnessed abuse as children, and several had experienced sexual abuse or rape either as children or in the abusive relationship. All of the women had been out of the violence for over four years, and two of the women were in new relationships. All of the women were in DV support services at the time of the study, and all but one had been in these services for years. Most of the women had vocational training and one had a graduate degree. All of the women were residing in rural areas of Ireland.

One of the findings from this study is a detailed picture of how trauma devastates the quality of life for women, even after years away from the abuse. The mean Kessler score of the women was 13.4 (SD=4.9), with a range from seven to 20 at baseline. The CESD scores ranged from 18-56 and the mean was 36.2 (SD=13.8) (cut-off, for indicating clinically significant depression, is 16)(Radloff, 1977). While the mean is still in the moderate range, Zung Anxiety Scale scores ranged from 18-46 with a mean of 31.3 (SD=10.7)(cut-off for moderate to severe anxiety is 45-59)(Zung, 1971). Physical and emotional symptoms were also high. On the CSC, women's sum of symptom scores ranged from 19-54 with a mean of 34.4 (SD=10.9). On the emotional symptom checklist (23 physical symptoms including depression, sadness, anxiety, fear, anger, loneliness, and out of body feelings), women's sum of symptom scores ranged from 27-68 with a mean of 47.2 (SD=15.5). There are no cutoffs for these scales, however Escobar reports that even three somatic symptoms predicts psychopathology (Escobar, Cook, Chen, Bara, Alegria, et al, 2010). Four of the eight women were on antidepressant medication, sleep aids, or both. The Kessler, CESD, Zung Anxiety scale, or symptom scores did not correlate with age, employment status, or education.

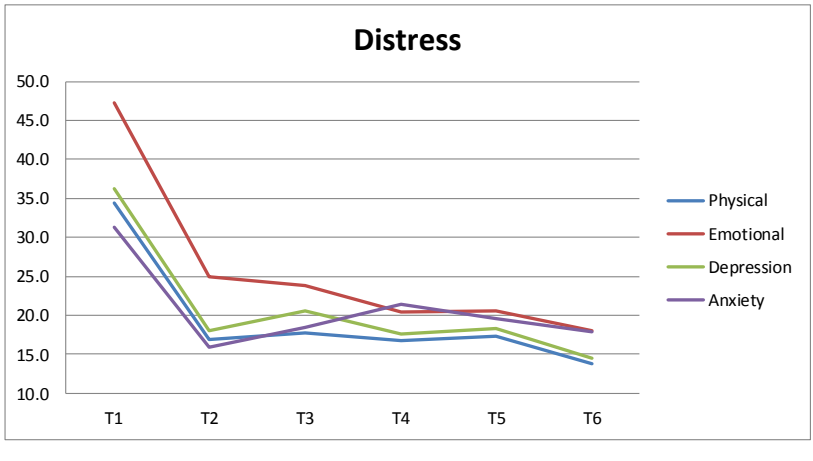
*Table 1: Health indicators changes over time (*p <05)*

Health Measure	T1 M (SD)	T2 M (SD)sig.	*d*	T3 M (SD)sig.	T4 M (SD)sig.	*d*	T5 M (SD)sig.	T6 M (SD)sig.	*d*
Emotional	47.3 (15.6)	24.9 (17.2)*	-1.4	23.9 (18.8)*	20.4 (21.1)*	-0.12	20.5 (21.0)*	18.0 (19.2)*	-0.12
Physical	34.4 (11.0)	16.9 (9.8)*	-1.7	17.8 (9.9)*	16.8 (10.1)*	-0.1	17.3 (9.7)*	13.8 (9.9)*	-0.36
Depression	36.3 (13.8)	18.0 (14.5)*	-1.3	20.5 (13.3)*	17.6 (15.2)*	-0.2	18.3 (14.5)*	14.5 (14.6)*	-0.3
Anxiety	31.3 (10.8)	15.9 (8.6)*	-1.6	18.4 (10.6)*	21.4 (7.8)*	0.3	19.6 (9.9)*	17.9 (11.7)*	-0.2
Support	47.8 (11.3)	53.4 (14.4)	0.4	57.0 (13.0)*	59.6 (14.9)*	0.2	59.9 (15.2)*	61.3 (16.2)*	0.1
Conflict	17.8 (3.4)	13.1 (6.0)	-1.0	13.4 (3.2)*	14.6 (2.9)	0.4	14.8 (2.8)	13.1 (2.9)*	-0.6
Vitality	25.0 (18.9)	46.9 (16.7)*	1.2	42.5 (19.6)*	35.0 (26.3)	-0.3	35.0 (26.3)	43.8 (17.7)*	0.4
Bodily Pain	42.8 (29.7)	55.9 (31.0)	0.4	59.1 (22.6)*	55.9 (22.5)	-0.1	57.5 (24.6)	59.1 (58.7)	0.04
Social	48.4 (30.9)	62.5 (30.6)	0.5	59.4 (18.6)	53.1 (19.8)	-0.3	56.3 (24.1)	56.3 (20.0)	--
Role	25.0 (38.8)	45.9 (39.6)	0.6	46.1 (32.2)	45.8 (35.4)	--	50.0 (39.8)	45.8 (46.9)	-0.1

Distress

The distress indicators in this study were emotional symptoms, physical symptoms, depression scores and anxiety scores (see Chart 1). The women in the cohort study had statistically significant and sustained improvements in all of their distress indicators. There was a large effect on emotional symptoms after the first workshop (baseline M=47.3, SD=15.6) compared with six-week findings, M=24.9, SD=17.2 (t=3.7, df=7, p=.01; d=-1.4). These means remained low, with statistically significant mean differences across all time points (mean range was from 18-23.9, p.> .01) compared with the baseline. Physical symptoms declined after the first workshop (baseline M=34.4, SD=11.0) compared with six-week findings, M=16.9, SD=9.8 (t=8.8, df=7, p=.00; d=-1.7). These means remained lowered, with statistically significant mean differences across all time points (mean range was from 13.8-17.8, p.> .01) compared with the baseline. Depression symptoms reduced after the first workshop (baseline M=36.3, SD=13.8) compared with 6 week M=18.0, SD=14.5)(t=5.8, df=7, p=.00; d=-1.3). These means remained low with statistically significant mean differences across all time points (mean range was from 14.5-20.5, p.> .01) compared with the baseline. Finally, Anxiety symptoms declined after the first workshop (baseline M=31.3, SD=10.8) compared with six-week findings, M=15.9, SD=8.6, (t=5.4, df=7, p=.01; d=-1.6). These means remained low with statistically significant mean differences across all time points (mean range was from 17.9-21.4, p.> .03) compared with the baseline.

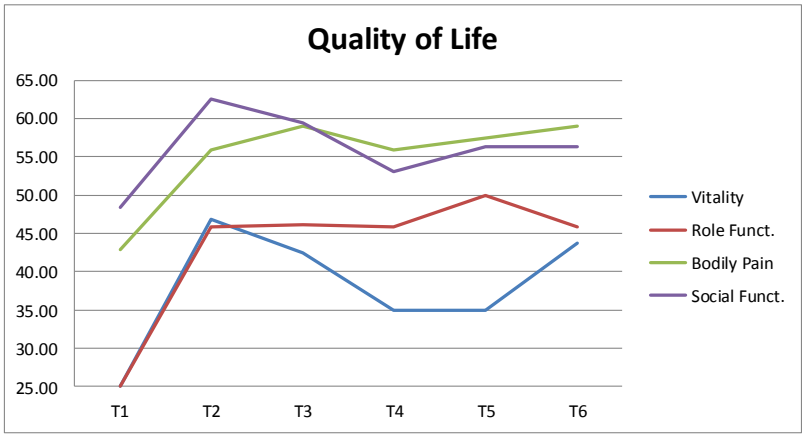
Chart 1: Distress Changes



Quality of Life

The Quality of Life indicators used in this study were vitality, bodily pain, social functioning and role functioning (see Chart 2). The women in the cohort study had some statistically significant changes in vitality. There were no statistically significant changes in social functioning or at any time point. Vitality means were statistically increased from baseline (baseline M=25.0, SD=18.9) compared with six-month time point mean of 42.5, SD=19.6 (t=-2.6, df=7, p=.04; d=1.2); and at the one-year time point (M=43.8, SD=17.7)(t=-2.5, df=7, p=.04; d=0.4).

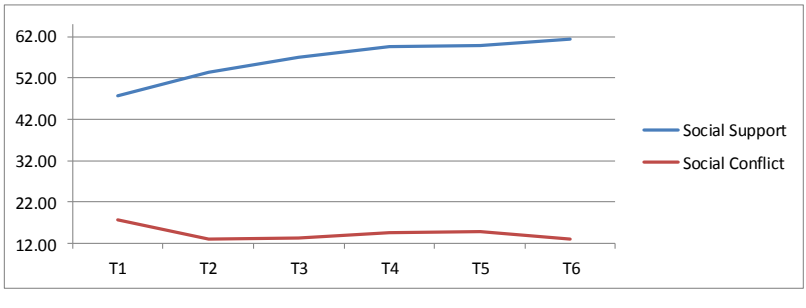
Chart 2: Quality of Life Changes



Social Support and Social Conflict

The social indicators in this study were use of social support and social conflict (see Chart 3). The women in the cohort study had statistically significant and sustained improvements in their use of social support at 6 months and for the rest of the time points. Social conflict scores were statistically reduced at the six-month point and after the year out intervention. There was an improvement in use of social support (baseline M=47.8, SD=11.3) at the 6 months (M=57.0, SD=13.0, (t=-4.1, df=7, p=.01; d=0.4). These mean improvements remained with statistically significant mean differences across all remaining time points (mean range was from 59.6-61.3 p.> .01) compared with the baseline. Social Conflict scores declined (baseline M=17.8, SD=3.4) at the six-month point (M=13.4, SD=3.2)(t=4.6, df=7, p=.00; d=-1.0). These means were statistically lowered again after the year out intervention (M=13.1, SD=2.9, (t=3.2, df=7, p=.01; d=-0.6).

Chart 3: Social Changes



Discussion

Having endured psychological, physical and sexual violence significantly increases the incidence of mental health problems, including depression, posttraumatic stress disorder, anxiety, suicidal behavior, sleep and eating disorders, social dysfunction, and an increased likelihood of substance abuse (Pico-Alfonso et al., 2006). This was true for the women in our sample, for whom the level of distress was extremely high. What was surprising, however, was that in the early conceptualization of this study, we met with DV service providers from our recruitment site, and decided to offer this research study only to recipients who they considered to be stable and ready for healing. The women who joined our study were stable: raising children, working or going to school, and generally getting on with their lives. These data underscore the amazing resilience of women who move on with their lives and families despite carrying a significant symptom burden. It also suggests that the symptom burden carries on for many years after leaving a relationship. The field of women's mental health could benefit from more studies about the readiness of women to avail themselves of services, and the types of services needed at critical junctures extending well beyond the first year after leaving an abusive relationship.

This study suggests that Biodynamic therapy can be rapid, which is consistent with the limited theoretical literature (Boyesen, 1980; Southwell, 1988). From a neurological standpoint, the person can move from a chronically hypervigilant state (experienced by the person as anxiety, depression, and physical pain) to normal and self-regulating states of arousal dictated by present circumstances. Indeed, we saw instabilities in some symptoms over the course of the year that may be related to these neuro-fluctuations, even though the women were on their way to healing and stable change. Theoretically, the principle of neuroplasticity can be seen as a building block effect, such that trauma exposure can result in incremental enlargement of a fear network in the brain (Kolassa and Elbert, 2007). However, we believe that this same neuroplasticity can allow people to begin to rehearse and relearn life patterns that can restore wellbeing. Feeling a renewed sense of coherence and feeling able to use available social supports (or beginning to form relationships that are fulfilling) can enable the person to re-build a life of health. The benefits of the value of positive emotions is theoretically explicated by Frederickson (Fredrickson, 2001; Fredrickson and Cohn, 2008). Her Broaden and Build theory suggests that positive emotions broaden people's moment to moment thoughts and actions, allowing them to recognize and respond to situations that promote life, happiness, satisfaction and peace. Making these moment-to-moment cognitive, affective, and behavioral choices allows people to bring in resources that further promote their health and wellbeing, including everything from activities, to creative pursuits, to social relationships. When people are trapped in reflexive and habitual responses formed during times of trauma, and reactivated and reenacted repeatedly after the threat has passed, their ability to identify and use potentially positive situations is diminished. When these reflexive pathways are interrupted, a person's natural inclination to identify and use situations to their advantage is enabled.

From a Biodynamic point of view, the discharge of energy that prompts habitual patterns may have enabled the women to recognize and use the positive circumstances and relationships they had put into place in their lives, and to learn new patterns of thinking, acting and relating such that they were able to maintain health and build from there. We believe that 12 months is a short time for such broaden and build changes to achieve their full effect. However, these data do suggest that the reduction in symptoms and

the restoration of wellbeing was sustained over that time, providing the women with the opportunity to begin to find and/or practice new healthful patterns of thinking, feeling, and relating. Further research is necessary to learn what resources and support women may need to make the best use of this critical time in their recovery.

We saw stages of recovery in the women that are somewhat different from those reported in the literature (Herman, 1997; B. A. van der Kolk et al., 1996; B. A. van der Kolk, D. Pelcovitz, & S. Roth, 1996). Herman recognized the establishment of safety, remembrance and mourning, and finally reconnection with ordinary life. The women in this study had been out of their relationships for over four years and had established relative physical safety. However, we found that feelings of safety, security and emotional safety remained an on-going struggle. In light of the number of symptoms and our earlier discussion of the nature of chronic activation of the sympathetic or immobilization systems, women were often not *feeling* safe. Our findings also indicate that reconnection with ordinary life involves numerous processes, and that this was often difficult for participants in our study. For example, since women were grappling with numerous physical and emotional symptoms, meeting the challenges of day-to-day life was a struggle. In general, women learned that the Biodynamic view of trauma could help them understand that even after so many years away from the abuse, trapped energy and incomplete cycles could explain why they had difficulty achieving the zest, vigour, vitality and social engagement that they had been searching for.

We defined healing broadly and theorized that earlier interventions would "unfreeze" the women's neurophysiological system. However, we gave two more interventions aimed at not only reducing symptoms but also improving functioning. While there are dramatic changes in symptoms that were sustained over time, the changes in other aspects of health such as quality of life or meaning were slower to change. For example, while social functioning (as measured by the SF-36) didn't improve, social conflict reduced and use of social support increased. When we understand healing as moving beyond symptom reduction to moving back into the social world after social isolation, this finding is an important one. In addition, since symptom burden, functioning and social engagement are interrelated, we can expect that over the course of a year, people healing from trauma might experience uneven changes or times when their problems return temporarily. Therefore, we recommend future research that maintains a broad-based conception of what healing is expected when, and why these may be so.

The limitations of this pilot study include the very small sample. In addition, we did not use a control or treatment as usual group. Our aim was to determine the feasibility of this approach to healing for women from this population, and we discovered that women would not only engage in the healing, but also engage in research related to the value of this approach for their mental and physical health. The data reported here are promising and support larger and more complex trials and comparison research studies with other types of more standard intervention methods such as cognitive behavioral therapy. While we did not collect all of the data from our sample about past history with the mental health system, women reported diagnoses and medication usage, suggesting at least some encounters with the medical system.

Additional research is needed to learn what services women access and the benefits and limitations of those services to assist with the healing women need to fully thrive after leaving an abusive relationship. This was an important longitudinal study of a cohort of

DV women and demonstrated that these women were able to gain significant reductions in their symptom burden. In addition, the measures of quality of life showed that these reductions in symptoms may have translated into an improvement in their quality of life, especially in the areas of bodily pain and vitality. The clinical foci were working with the feelings of being stuck or frozen, and opening up to life and relationships. The aim seemed to be to help the women get re-activated, and re-engaged in their lives, to complete actions they needed to complete, and to release the trapped energy so that it was available for other important uses.

BIOGRAPHIES

Denise Saint Arnault, PhD, RN is an Associate Professor of Nursing at the University of Michigan. In clinical practice as a psychiatric nurse, she provided psychotherapy for women who were recovering from trauma. Her recent research has focused on the use of integrative interventions to aid in trauma recovery, including Biodynamic Psychotherapy and narrative approaches to promote help seeking for distress. Other research includes federally funded studies that examine personal, cultural and social influences on illness experiences and help-seeking for mental health distress and trauma.
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Sharon O'Halloran, BD, Dip. Mediation, MGBII, has been the Director of SAFE Ireland, the national representative body for domestic violence services in Ireland for the past 13 years. She has worked in the community for over 20 years with expertise in organisational change, leadership, social change and violence against women. As part of her work with SAFE Ireland she explores new ways of healing from trauma and ending intergenerational cycles of domestic violence. As a fully qualified biodynamic psychotherapist, she is also interested in the intersection between organisational development, social change and healing.
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WRITING ABOUT BODY PSYCHOTHERAPY

An invitation to write for us, with us, with support along the way. Your writing can contribute to and enrich the 'body' of critical and reflective content, as well as to the clinical expertise, in the 'field' of body psychotherapy.

Whom can you write for?
We suggest that – for a professional article – you consider:

The EABP/USABP peer-reviewed **International Body Psychotherapy Journal** (for original work only): www.ibpj.org
The peer-reviewed journal of Body, Movement and Dance in Psychotherapy (for original work only): www.tandfonline.com/toc/ tbmd20/current#.VBfpFS6wJRU
Or: (for German language authors) **körper – tanz – bewegung:** Zeitschrift für Körperpsychotherapie und Kreativtherapie: www.reinhardt-verlag.de/de/zeitschrift/51830
(You will find the necessary "instructions for authors" on their various websites.)
Or: for something a bit more conversational: **Somatic Psychotherapy Today:** https://www.SomaticPsychotherapyToday.com
Or: Something for a newsletter of your particular professional association, modality association, or national association in psychotherapy;
Or: A comment or a thread in one of the **Somatic Perspectives LinkedIn** group discussions, facilitated by Serge Prengel: www.linkedin.somaticperspectives.com
Or: Possibly, a chapter for an edited book, on a particular theme, possibly like one of the series being published by Body Psychotherapy Publications **(BPP)**: www.bodypsychotherapypublications.com.
Or: Something to be published somewhere else, at some other time, in a different medium; or for a personal internet blog; or . . . maybe just for your personal journal.

What can you write about?
You can write about attending a recent Congress, or seminar, or about attending a different event; - or about your student thesis; - or your experience of writing your student thesis; - or a special or particularly interesting case history; - or an aspect of your personal therapy; - or about working with a particular client group; - or about a development of theory or practice; or - even about your reflections on the field of Body Psychotherapy.

How to get started writing professionally?
There is an article in the journal of Body, Movement & Dance in Psychotherapy www.tandfonline.com/doi/ full/10.1080/17432979.2010.530060#.VBfsNC6wJRU (You can also find a free copy here.)
And there are some recent guidelines about how to write a professional Body Psychotherapy Case Study: www.eabp.org/researchcase-study-guidelines.php. There are also many articles on the Internet (in different languages) about how to write.
If you want any further assistance with where to publish, or with the process of editing, or re-editing, or with the complications of the publication process, the following people may be able to offer you some help. They are all professional body psychotherapists, editors and writers:
Nancy Eichhorn: Nancy@NancyEichhorn.com
Jacqueline Carleton: jacarletonphd@gmail.com
Gill Westland: gillwestland@cbpc.org.uk
Jennifer Tantia: JFTantia@gmail.com
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Sincerely,
EABP Publications Committee
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Squaring the Circle:
Bridging the Gap Between Research and Practice
About the EABP Collaborative Practice Research Network (CPRN)

The awareness of the importance of fostering different models of research, particularly those linked more closely to the actual practice of body psychotherapy and those encouraging a two-way communication between researchers and practitioners, has led to the creation of the EABP Collaborative Practice Research Network.

This is an exciting new initiative to provide a forum for dialogue, debate and the development of innovative and creative research methods and projects that assist clinical practice and help body psychotherapy (and/or somatic psychology) to develop an empirical underpinning of its professional practice.

The aim is to broaden knowledge of the field of body psychotherapy through communities of practice and clinical research. It explores how a CPRN can transform perceptions of psychotherapy research and practice, strengthen connections between members, and encourage continuous development and co-creation among participants. This important initiative is an opportunity to make a significant difference within our profession and to develop – together – the foundations of both scientific and clinical practice research.

Specifically, we are planning to explore and develop, at local and international levels, a variety of strategies to support practitioners' research and look at what types of research potentially provide a broadening of our understanding and practice of psychotherapy, and how various types of research advance, improve and extend our knowledge of body psychotherapy. We will do this by bringing together practitioners and researchers from around the world, both online and face-to-face, to discuss ways of bridging the gap between clinical practice and research.

The committee has organized two symposiums in conjunction with the 2012 and 2014 EABP Congresses. The next symposium will be held during the 15th European Congress of Body Psychotherapy in Athens Greece, 13-16th October 2016.

We would like to invite you to join us and become part of this exciting and innovative initiative. If you are interested please contact Sheila Butler and Herbert Grassmann - cprn@eabp.org

EABP Science and Research Committee - Sheila Butler, Herbert Grassmann (chairperson), Frank Röhricht, Maurizio Stupiggia, Joop Valstar, Courtenay Young and Jennifer Tantia www.eabp.org/research-scientific- committee.php

Strengthening links between practitioners and researchers at every stage of the process

News:
The Society for Psychotherapy Research (SPR), an association devoted to the development and dissemination of research on psychotherapy has some exciting upcoming SPR events:

- *The International Annual Meeting in Philadelphia,* USA in June 2015 from 24th to 27th June.
- *The European Conference on Psychotherapy Research* in Klagenfurt, Austria, September 24th to 27th, 2015, and the planned 2016 International Meeting in Jerusalem, Israel in June 2016.

You might also like to browse the Psychotherapy Research Journal pages, especially the Special Issues and the online resources; there is a lot of information on the integration of theoretical, empirical and clinical knowledge in psychotherapy. See http://www.psychotherapyresearch.org

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Connecting professionals, exchanging expertise, enabling collaboration

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