

## **The Science of Body Psychotherapy: Part 2: The Current Situation.**

### **Abstract**

Part 1 essentially described the various definitions of body psychotherapy and a historical overview of Janet & Reich's scientific work up to the Second World War (Young, 2009). In the second part of this 4-part series, the post-war scene of psychotherapy and body psychotherapy is examined and there is a description of what is meant by 'science' in psychotherapy (especially in Europe) in this context. The differences between different sciences, political science, medical science, the current state of science in psychotherapy are examined, and also where there have been failings to use science in body psychotherapy, and what was focussed on instead. Some reviews of recent scientific research in body psychotherapy are examined.

### **Key Words**

Body Psychotherapy – Development – Political Science – Clinical – Medical Research – Reich – Modalities – Training

### **Post-War Scientific Developments**

Body psychotherapy, as a reaction to various rejections, first of Reich by Freud, then of Reich in Europe, and then later in post-war America, of Reich by the FDA, was – in the late 1950's – left in the hands of a very few people mostly trained by Reich, like Ola Raknes in Norway, and Elsworth Baker, Alexander Lowen, John Pierrakos, Myron Sharaf, Eva Reich, and a few others in the USA.

As a result of the various attacks against Reich, body psychotherapy, as a method, had generally began to focus on developing different themes, social theories, methods of practice, clinical skills, and other refinements, perhaps as a way of staying acceptable, and it did not, individually or collectively, try to challenge the 'rejection' from its peers and from society for many years. However, these post-war developments did not involve much 'science'.

The 'orgonomists,' a very small group of (largely) American psychiatric practitioners, mostly trained originally by Reich, then Elsworth Baker, a pupil of Reich's, continued to follow his clinical and scientific work, albeit fairly rigidly. *"They have kept Reich's central concepts clearly in focus and have developed many of them. Some orgonomists have done important original research which expands Reich's ideas."* (Sharaf, 1983, p. 481) The backlist of the Journal of Orgonomy is very comprehensive and constitutes, in itself, an impressive 'body' of science within the wider 'field' of body psychotherapy<sup>1</sup>: however they do keep themselves very much to themselves, and their publications are not widely listed. Many body psychotherapists have never really heard of them. Their development of the science of body psychotherapy has been mainly in the clinical application of many theoretical aspect (case histories, character studies, mental health, sexuality, and the application of therapy) and here they have interestingly paralleled developments in other psychotherapies. They have also done some research into other non-therapeutic aspects of Reich's work, including the 'bions', cosmology, and weather control.

In the aftermath of Reich's trial, imprisonment and death, body psychotherapy (though it was not called that then) went into a decline for a few years. Then in the 1960s, body psychotherapy – as a field – found itself, quite suddenly, mostly unforeseen, in a rather comfortable place, being largely accepted within the Human Potential Movement, in association with various body-therapies, and amongst the humanistic, phenomenological and

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<sup>1</sup> [http://www.orgonomy.org/Main\\_Publications.html](http://www.orgonomy.org/Main_Publications.html) (accessed 11/12/08)

existential psychotherapies (Goodrich-Dunn & Greene, 2002: p. 93-96), where it has largely stayed ever since. Part of this was due to Fritz Perls' acceptance of the body (Perls had known Reich in Europe) and part was due to a widening of perspective that included the body, along with the mind and even the spirit, as interconnecting aspects of the whole person. Not much 'science' was done in the early days of Humanistic Psychology, and the 'scientific' view was even denigrated as being impersonal. Unfortunately, the later development of the 'New Age' and the continuance of non-scientific methodologies hindered any proper development of the science of body psychotherapy. There was still a solid level of exterior background support from educationalists, psychiatrists and social thinkers like A.S. Neill, R.D. Laing, Arthur Koestler, and the anthropologist, Bronislaw Malinowski (Sharaf, 1983). Reich's work had also influenced people like Frank Zappa, John Lennon, Bob Dylan, Itzhak Perlman, Fritjov Capra, Saul Bellow, Alan Ginsberg, Norman Mailer and William Burroughs, (Mannion, 2002), as well as William Steig,<sup>2</sup> Orson Bean,<sup>3</sup> and even Kate Bush.<sup>4</sup> These people all helped, one way or another, to popularize Reich's work after his death.

However, this 'placement' within humanistic psychotherapy and amongst the *cognoscenti* also meant that body psychotherapy did not really have to 'prove' itself, particularly as the whole 'humanistic' field, especially in the 1960s & 1970s, seemed fundamentally against any form of 'scientific proof'. Ironically, "*Humanistic psychology developed as the response of a number of influential psychologists to perceived deficiencies in the psychological theory and research of this same time period*" (Moss, 1999).

John Rowan (2000), an eminent Humanistic Psychotherapist, complains about the nature of research ethics, in that the basic ethical paradigm is one where the researcher is 'in charge,' sets the 'rules,' remains 'objective' and keeps his 'distance,' and 'uses' the research 'subjects' to prove or disprove his 'hypotheses' at his 'convenience,' thus the 'researcher' meets the 'subject' in a very 'role-bound' way. The language is very pejorative and this affects the research, even though, in Britain nowadays, the people on whom the research is conducted are now called 'participants'. He goes on to identify several areas of research, in which the most objective – basic empirical – is also the most alienated. He points out that these fields of qualitative research have a number of embedded ethical problems. In wider forms of research – more quantitative one – that is (to say) more the field of human enquiry, the role of the researcher changes and the research is more done "with people, rather than on people". Maslow's work is important here, but the field also includes hermeneutics and phenomenology and it has been strongly influenced by social movements such as feminism. Rowan also looks at another less well-known field of research: that of critical social action inquiry, where the fundamental purpose of the research is questioned and where "the main aim of the scientist became the amelioration of the human condition." He includes 2 further fields, but they don't really impinge on where body psychotherapy is at the moment.

Anyway, as a result of this association with humanistic psychology, body psychotherapy found itself frequently being 'lumped' with body therapy techniques, like Rolfing, and other (possibly) more radical 'psychotherapeutic' techniques, like Janov's Primal Therapy (Clare, 1981). And this trend continued into the 1970's and 1980's, with only a few books about body psychotherapy being considered as actually 'respectable' (Lowen, 1958; Boadella, 1976). However, none of these radical 'body therapy' or 'primal' techniques really has anything to do with body psychotherapy. As a reminder, the term 'body psychotherapy' still did not exist yet – so it is being applied retrospectively: the common terms of the time were the names of the various 'modalities' – Bioenergetics, Orgonomy, Radix, or the therapies

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<sup>2</sup> Popular cartoonist and artist for Wilhelm Reich's (1972) 'Listen, Little Man!' London: Souvenir.

<sup>3</sup> An actor who wrote about his experiences of Reichian therapy in 'Me and the Orgone' (1971) New York: St Martin's Press, and then helped to found the 15<sup>th</sup> Street School, along the lines of A.S. Neill's Summerhill School.

<sup>4</sup> In a song entitled "Cloudbusting" on "The Children of the Night" album.

were known by the name of their ‘founder,’ and the only generic term perhaps was ‘neo-Reichian’.

During this period, there were also very few genuine ‘scientific’ projects. Alice Ladas (2005) is perhaps one exception, as she did some research into women’s sexuality. This study tried to show if there were differences between the theory of Bioenergetic Analysis and the experiences of women within Bioenergetic Analysis. It was in the form of a mail questionnaire. Ladas comments in a footnote:

*“Bioenergetic Analysts have done a lot of education, developed many important therapeutic techniques and taught them to many people. But there is no published research apart from clinical observation.”* (Ladas & Ladas, 2005)

This is pretty much true for most methods within body psychotherapy and mind-body therapies in this period. In a large meta-analysis of research on the efficacy of mind-body therapies on cardio-vascular disease, one of the conclusions was:

*Reviewers found only a handful of randomized, controlled research studies conducted in the United States. As a result, there is a lack of replicated studies with which to determine appropriate treatment dosage and the mechanisms by which many of the practices work. Compelling anecdotal evidence, the presence of some controlled research, overall cost effectiveness, and the lack of side effects resulting from mind-body treatments make further investigation a high priority.* (Luskin et al, 1998, 2000)

The ‘field’ of body psychotherapy was growing steadily, becoming wider and more diverse, and with many different components and links, but it was not doing research – its energies were all going in these other directions. The exploration and diversification of techniques and methods continued apace throughout this period and into the early 1990s. Science was unfortunately sometimes somewhat conspicuous – by its absence – in these new and developing body-oriented psychotherapies: indeed, that type of thinking was sometimes even demonised. There was no real attempt (other than those specifically mentioned) at any form of rational analysis, nor of proper differentiation, nor of any systematic study. And that was also, as mentioned, a feature of the Humanistic Psychology and New Age movement: we were all into ‘holism’ rather than the so-called ‘abstractions,’ ‘objectivities’ and ‘reductionism’ of science.

Bioenergetics, one of the first ‘neo-Reichian’ body-psychotherapies, originally founded by Alexander Lowen and John Pierrakos, had developed quite a numerous list of publications (books and journal articles) with a reasonably healthy scientific basis, although there have only been a few ‘properly’ scientific research studies. Lowen’s very successful books (*The Language of the Body, Bioenergetics, Love & Orgasm, The Way to Vibrant Health*, etc.) had done a lot to popularise body psychotherapy, but the only real body of ‘science’ lies in the numerous journal articles, a few of them peer-reviewed (but many were not), and in unpublished collections of conference papers in Bioenergetic Analysis stretching over the last 40 years. Currently there is no comprehensive single listing of all the publications, research and scientific work for ‘Bioenergetics’ – nor for any of the other forms of body psychotherapy, but a single-word search in the most recent version of the EABP Bibliography of Body Psychotherapy (Young, 2006, 2009) brings up more than 250 different published references, whereas a similar search on the APA’s PsychNet<sup>5</sup> only brought up 4 references.

## **The Political Science of Psychotherapy**

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<sup>5</sup> <http://psycnet.apa.org/>

As mentioned in previous articles, I have explored some of the history of this development and diversification in America (Young, 2008), and in Europe (Young, 2010), where, in the 1990s, the ‘professionalisation’ of psychotherapy started. This was a determined attempt, still ongoing, to create a separate and distinct profession of psychotherapy, parallel to clinical psychology and psychiatry. Some European countries had already started to pass ‘laws’ – as yet not fully tested in the courts – to restrict the practice of psychotherapy only to psychiatrists and psychologists. This would effectively have prevented any of the multitudes of non-academic or non-medical ‘lay’ psychotherapists from practicing. And this was set within the context of a free labour market across Europe, established by the European Union, which means that someone able who is able to practice psychotherapy legally in one country could not be prevented from practicing legally in another. It was therefore necessary to create a common standard of training, and also to define what was meant by psychotherapy.

The European Association of Psychotherapy (EAP) created the 1990 Strasbourg Declaration on Psychotherapy, which stated that:

1. Psychotherapy is an independent scientific discipline, the practice of which represents an independent and free profession.
2. Training in psychotherapy takes place at an advanced, qualified and scientific level.
3. The multiplicity of psychotherapeutic methods is assured and guaranteed.
4. A full psychotherapeutic training covers theory, self-experience, and practice under supervision. Adequate knowledge of various psychotherapeutic processes is acquired.
5. Access to training is through various preliminary qualifications, in particular human and social sciences.

The EAP currently represents about 128 organisations (28 national umbrella associations and 17 European-wide associations for methods of psychotherapy) from 41 European countries and, by that, more than 120,000 psychotherapists. More than 5,000 of these now have been awarded the European Certificate of Psychotherapy. All this necessitated putting psychotherapy – and particularly the various methods or modalities within psychotherapy – onto a more ‘scientific’ basis and thus the 15 Questions for Scientific Validity were established (see Appendix 1, in Part 1: (Young, 2009)).

So, in Europe, all the different methods of psychotherapy, including Body Psychotherapy (promoted by EABP) as a mainstream, and with Biosynthesis, Psycho-Organic Analysis, Concentrated Movement Therapy and ‘Bioenergetic-Analysis Psychotherapy have been accepted as ‘scientifically-valid’ by the submission of substantive answers to the 15 Questions and a peer-review process of these answers within the EAP. The ‘answers’ to the 15 Questions on the Scientific Validity of Body Psychotherapy are available on the EABP website ([www.eabp.org](http://www.eabp.org)). Additionally to this, by the same process, various modalities within body psychotherapy have also been accepted as ‘scientifically-valid,’ like: Hakomi, Bodydynamics, Unitive Psychology, Biodynamic Psychology, Emotional ReIntegration, Character-Analytic Vegetotherapy, Psychotherapeutic Postural Integration, etc. Some of these ‘answers’ are also posted. Biosynthesis, Bioenergetics and Concentrative Movement Therapy have also all been ‘scientifically validated’ independently by the EAP, though using the same protocols.

This is what I refer to as the ‘political’ science of psychotherapy: science, but not really science – and yet the considerable body of knowledge and information contained in these ‘scientific validation’ documents is quite astonishing.

## The Medical Science of Psychotherapy

However, all of these mainstreams and methods – and any other modalities of body psychotherapy (as well as many of the humanistic psychotherapies) – still do not meet, and perhaps nowadays need to meet, what is considered as the ‘gold standard’ of ‘science’: these are Randomised Control Trials (RCT). This is the only form of (medicalized) ‘science’ that seems to be accepted by governmental bodies like Health Ministries. The RCTs also have to have all the other criteria: significant numbers, proper statistical analysis, publication in peer-reviewed research journals, and evidence of significance greater than the normal ‘placebo’ effect; that form this ‘gold standard’ that is being demanded by these quasi-medical, quasi-political governmental bodies. Furthermore, any studies that cross into different diagnoses are also ignored, so a study that looks at both anxiety and depression is ignored both for the evidence-base for depression, and for the evidence-base for anxiety. This is known as the ‘science’ of ‘evidence-based’ practice: however it is also very ‘political’ in that it excludes a great number of methods that have value, yet have difficulty in proving it according to these criteria.

Of course, these Health Ministries and, in the UK, the departments that give guidelines to the medical profession as to what treatments should be prescribed for what conditions (UK NICE<sup>6</sup> & SIGN<sup>7</sup>, etc), do not supply any funding for such trials; they just set the ‘goalposts’ and they keep on upping these. So, they, *de facto*, effectively manage to ‘prove’ only what they want to prove, or what is proven already by such exclusively ‘managed’ criteria. This hegemony is only just beginning to get questioned (Nel, 2009).

What is also studiously being ignored in this context, for example, are the numerous meta-studies that ‘show’ that there is no significant difference between the various psychotherapeutic methods; all are basically better than a placebo effect; and that the most significant factor is actually the rapport between the therapist and the patient (a good working relationship) and the level of determination of the patient to get better.<sup>8</sup> What is also being ignored, especially by the Health Ministry in the UK, are the findings of a particular fairly widespread ‘tool,’ the Clinical Outcomes in Routine Evaluation (CORE) system<sup>9</sup>, that measures both the patient’s progress in therapy as well as being able to give a measure of comparative efficacy between different therapists. Again, this shows little difference between the various therapeutic methods, which is (of course) inconvenient and even (given the predominance of CBT) somewhat politically incorrect.<sup>10</sup> So, this is another application of the ‘politics’ of ‘science’ in psychotherapy. The case for the only currently widely accepted ‘evidence-based’ psychotherapy, CBT, thus looks somewhat weaker in this light and indeed is being shown up to be less effective with certain client groups: eg schizophrenics.

Furthermore, it seems as if there is considerable resistance from within the profession of psychotherapy in general to accept, or even understand, almost any type of research. Boisvert & Faust (2006) examined practitioners’ knowledge of general psychotherapy research findings and found that, whilst some psychotherapists showed excellent familiarity with outcome research, many did not, and furthermore many believed that the findings were less positive than reality, and thus discounted them. This is probably as true for Body-Psychotherapists as for the other psychotherapists. So, we need – at some point – to look at

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<sup>6</sup> NICE: UK National Institute for Health and Clinical Excellence: a governmental body that checks out the ‘science’ – and cost – of medicines and treatments and recommends which can be used by the National Health Service in England & Wales.

<sup>7</sup> SIGN: Scottish Intercollegiate Guidelines Network: develops evidence based clinical practice guidelines for the National Health Service (NHS) in Scotland

<sup>8</sup> “The Efficacy of Psychotherapy”: retrieved 5/12/09 from APA website: [www.apa.org/practice/peff.html](http://www.apa.org/practice/peff.html)

<sup>9</sup> CORE: [www.coreims.co.uk/index.php](http://www.coreims.co.uk/index.php)

<sup>10</sup> Barkham, M. et al. (2006) Dose-effect relations and responsive regulation of treatment duration: The good enough level. *Journal of Consulting and Clinical Psychology*. Vol 74(1), Feb 2006, 160-167.

Stiles, W.B. et al (2008) Responsive regulation of treatment duration in routine practice in United Kingdom primary care settings: Replication in a larger sample. *Journal of Consulting and Clinical Psychology*. Vol 76(2), Apr 2008, 298-305.

what lies behind our resistance to ‘science’ and ‘research’: are we scared that it will take us away from our bodies? Some ‘science’ certainly does. But, whilst we need to meet the parameters of the outside world, we also need to do it in a way that does not compromise our integrity as ‘natural scientists’.

What body psychotherapy therefore probably needs to do, **in this context**, is to produce (say) 4-5 substantive research studies, possibly from different countries, dealing with a particular condition (like depression), with each study having sufficient numbers (say 50-100), with a properly randomised ‘control group, with sufficient follow-up studies, with a degree of ‘scientific’ rigour, with a statistical analysis, published in a reasonably prestigious, ‘scientific’ peer-reviewed journal, showing a significant degree of efficacy that cannot be explained by the placebo effect. These sorts of studies then need to be repeated for anxiety, for OCD, for trauma, for phobias, etc (see later).

So we will have then ‘proved’ body psychotherapy to be ‘evidence-based’ to *their* satisfaction. One of the next sets of questions are: who, how, where, and with what funding, do we do this? I believe this is the role of the National Association for body psychotherapy in each country, possibly working together, and translating any findings of projects within their country into English: or from English into their own language. These translations will help people in other countries access the research, and so it can be used in that country. It is a task that cannot and should not be confined to one modality or another within body psychotherapy. It is a task that will take about 15 years. And this is, again, another form of ‘science’.

### **The Present Science of Body Psychotherapy**

There are thankfully several other ways of looking at the ‘science’ of body psychotherapy.

The latest version of the EABP Bibliography for Body Psychotherapy (Young, 2006, 2009) lists about 500 results for the single-word search “Research” (206 entries from Books or Chapters; 277 Journal articles; 7 Papers; 6 Tapes; 1 Thesis; 1 Video; and 9 websites); whereas there are only 132 results for the single-word search “Science” and only 22 results with the single-word search “Efficacy”. This is out of just over 4,000 entries, most of these with abstracts. This Bibliography is now being published on the Internet, via the EABP website: [www.eabp.org/bibliography](http://www.eabp.org/bibliography). It is a comprehensive searchable database, thus similar to PsychLit or PsychIndex (the APA databases). This means that people can now check what is ‘out there,’ and there is also a facility to enable people to add new material to it. Non-English entries have an entry in their language, as well as an entry in English. There are also categories for student theses, conference papers, tapes & films, websites and website-based articles. We want to encourage body psychotherapy training schools to adopt this database, and, it is hoped, that – with a little encouragement – the number of entries will soon grow to about 10,000. This then becomes a very powerful ‘scientific’ research tool in body psychotherapy.

Other than this, there have been 2 substantive English-language articles on the topic of the present science of body psychotherapy published fairly recently in the last few years (May, 2005; Röhrich, 2009) and there are some other foreign-language articles, but these are less accessible. There was also a chapter on empirical research in the Handbook of Body Psychotherapy in the German edition (Loew & Tritt, 2006), which was rather limited, and is hopefully going to be improved in the forthcoming English-American edition.

John May, a Clinical Psychologist and respected Body-Psychotherapist in St Louis, MO, USA, attempted to survey all empirical studies in peer-reviewed journals on the outcome of Body Psychotherapy in the English language. He located 6 retrospective studies; 9 efficacy studies and 18 effectiveness studies (with 55 references). *“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.”* (May, 2005, p. 98)

More significantly, May nicely highlights some of the basic dilemmas with respect to 'science' in the field of body psychotherapy:

*"Psychotherapeutic knowing is derived from three sources, which I have described as a three-legged stool. One leg represents knowledge that comes from one's own inner exploration and work. Direct experiential knowing, sometimes called primordial knowing, plays an important role in this sort 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."* (Ibid, p. 98)

This is essentially the state of body psychotherapy today: a stool without the third leg ... something more akin to religious dogma ... And we really have only ourselves to blame. No-one can, or will, do this sort of work for us. We have got to become more objective – of ourselves, about ourselves and that does not necessarily mean de-humanisation. We have got to find ways (resources with which) to do the research, which probably means the current Somatic Psychology PhD programs and students initially. We have also got to change our somewhat blinkered attitudes towards science and research.

With respect to the different 'modalities,' out of the 34 studies, John May states that Bioenergetics has the most outcomes studies (with 8), and three of these are particularly supportive and strong. Additionally, "*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.*" (May, 2005, p. 115) This tends to put the weight also on the modalities within body psychotherapy to prove themselves considerably better.

There are three main types of study:

- **Retrospective outcome studies** are the easiest to perform, 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.*" (Ibid, p. 115) Any clinic or training institute, or professional associations that encourage their members to send in such data, have the potential to perform such retrospective studies.
- **Effectiveness studies** measure, using standardized assessment procedures (usually a simple multiple-choice form), the changes between the client when entering therapy and at termination of the therapy. A little bit of rigour in the clinic or the training institute, or from the practitioner, helps to ensure that most clients actually complete a 'before' and 'after' therapy form.

The Clinical Outcomes for Routine Evaluation (CORE)<sup>11</sup> system is a quite good one to use in this respect. The professional association can help to create an expectation that their practitioners will encourage their clients to fill in such forms and to return them for analysis. Follow-up studies involve sending the same ‘end of therapy’ form to the client about 3 or 6 months later, to see whether any reported benefits have lasted. Again, they are useful, but – by themselves – they are not sufficient.

- **Efficacy studies** are the most complicated (and expensive) and require a high degree of planning and control. They require access to a large source of subjects, with prior information about these subjects, so that homogenous groups (same age, gender, class, etc.) can be ‘recruited’ and then randomly assigned to the different forms of treatment that are being studied. In respect to body psychotherapy, good ‘comparisons’ might be people with the same condition being assigned to Yoga classes, to a ‘talking’ therapy, or to a discussion group. Ideally some people would receive no ‘treatment’ by either opting out and later would be asked to complete the same outcome forms. Another comparison would be to differentiate between those on medication, and those not on medication. It is therefore probably necessary to locate such a study in a large clinic, with (definitely) an experienced researcher, to have the study ethically checked out beforehand, to check carefully how the clients are randomized, and then to have the results processed and analyzed. *“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.”* (Ibid, p. 116)

But, again, please note that we are moving away somewhat from the concept of ‘therapy’ to that of ‘treatment’. This sometimes starts to grate on the sensitivities of practitioners who see themselves becoming somewhat less significant during such a study. Furthermore, as I have said, governmental bodies are only really interested in the treatment of one particular condition: i.e. depression, or anxiety, or chronic pain, or whatever. It is therefore sometimes easier to perform these studies in specialist clinics, i.e. for ‘depression,’ ‘eating disorders’, pain clinics, or voluntary organizations for people with ‘phobias’.

The other wide review of body psychotherapy research (Röhrich, 2009) concludes something quite similar. Frank Röhrich is a consultant psychiatrist, a body psychotherapist, and professor at the University of Hertfordshire, UK. His literature review (80 references) is impressive. He writes:

*The heterogeneous field of body oriented psychological [BOP] therapies provides a range of unique contributions for the treatment of mental disorders. Practice based clinical evidence and a few empirical studies point towards good efficacy of so called non-verbal intervention strategies (although this is somehow misleading as all these therapies naturally work with both verbal and non-verbal interventions), particularly relevant for those disorders with body image aberration and other body-related psychopathology. Furthermore, BOP appears to offer promising additional psychotherapeutic tools in areas, where traditional psychotherapies seem to fail so far, i.e. somatoform disorders, eating disorders, psychotic disorders and chronic schizophrenia.* (Ibid, p. 20)

However, Röhrich is also appreciative of the German-Swiss study:

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<sup>11</sup> CORE: [www.coreims.co.uk](http://www.coreims.co.uk)

*Arguably, the most important study concerning the effectiveness of BOP in routine care (outpatient-setting) was conducted from 2002 to 2005 and published recently (Koemeda-Lutz et al. 2006). In this multicentre, naturalistic evaluation study of BOP (eight different schools including: Hakomi, Unitive Body Psychotherapy, Biodynamic Therapy, Bioenergetic Analysis, Client-Centred Verbal and Body Psychotherapy, Integrative Body Psychotherapy, Body-Oriented Psychotherapy and Biosynthesis), the researchers aimed to investigate the effectiveness of routine therapy in outpatient settings. Patients seeking BOP (n=342 participated) were compared to other outpatients (not in RCT fashion). The assessments were carried out at baseline, after 6 months and at the end of therapy (over a maximum of two years). The instrument used to estimate treatment responses was the symptom checklist SCL-90-R. This instrument measures subjectively felt impairment by means of a 90-item self-report inventory of physical and mental symptoms occurring the preceding week. Overall, the results suggest good efficacy of BOP for a variety of symptoms or problem areas. However, the study design does not allow for more substantive statements/conclusions. (Ibid: p. 16)*

He concludes:

*“The current evidence base can therefore be summarized as follows: BOP seems to have generally good effects on subjectively experienced depressive and anxiety symptoms, somatization and social insecurity. Patients undergoing BOP appear to benefit in terms of improved general well-being, reduced motor tension and enhanced activity levels. There is evidence from one RCT, that bioenergetic analysis may be specifically effective for somatoform disorder patients and there is substantial evidence for the efficacy of functional relaxation on psychosomatic disorders (asthma, tension headache, irritable bowel syndrome). Patients suffering from severe physical conditions (e.g. cancer) seem to be responding well to Dance Movement Psychotherapy with regard to enhanced self-esteem, changes in body perception and improved coping mechanism. At least three RCTs have demonstrated that schizophrenia patients with predominant negative symptoms respond to manualised body oriented psychological intervention strategies, improving their psychomotor behaviour, social and emotional interaction. ... The best example for the importance of research efforts in the field is the recent publication of [draft update of the] NICE guidelines for schizophrenia in the UK. Through a robust meta-analytic process, all the available evidence base has been reviewed and body oriented psychotherapy is now recommended amongst other non-verbal/arts therapies as treatment of choice for chronic schizophrenia patients with predominant negative symptoms.”*

Still, this is also a great start and it has already opened the door to body-oriented therapies being considered as significantly useful by the NICE Guidelines, where one of these studies is already referenced. Röhricht also points to a possible solution to this dilemma of who actually does the research:

*“One way forward could come from collaboration between the professional associations (e.g. ADMP, USABP, EABP) and the university (Masters & Ph.D.) programs: one providing the source material, through the practitioners’ case loads, and the other providing the time and energy from research students with the analytic facilities and desire to publish.” (Röhricht, 2010, p. 22)*

This makes a lot of sense.

The ‘scientific committees’ of the professional associations could, and probably should, commission research projects, or help design them, with perhaps a little bit of funding as an incentive (as happened in the Koemeda-Lutz study), and the university programs could, and probably should, do the collection and number crunching. The field of body psychotherapy is small enough, and skilled enough, to make this sort of collaboration eminently possible – if it were not also so parochial still. However, this brings me to the next major obstacle.

### **The Lack of Science in Body Psychotherapy**

In Europe, most of the current body psychotherapy practitioners have had absolutely no training whatsoever in scientific research from within their modalities: it is mostly excluded from their curriculum because of the (now outmoded) emphasis on technique. They may have got some grounding in research, if they have done a Masters degree or PhD in psychology, but this is not necessarily appropriate for psychotherapy or body psychotherapy. Many do not have this academic training. This deficit is becoming quite glaring and this leads to the paucity of any proper research, or thinking or writing about research, or encouraging others to do research. As a result, body psychotherapy itself is showing and feeling that deficit.

In America, some of this deficit is carried by the ‘requirement’ that most psychotherapists have to have a Masters or PhD academic degree in order to practice. However, few do any research. Much of the body psychotherapy training is still carried on in small private schools, and the few colleges (like CIIS, JFK (Berkeley), SBGI and Naropa.)<sup>12</sup> are also focussed on training and technique, more than on doing and publishing research projects.

Much more familiar is a ‘scientific’ version of case study type of research (Kaplan & Schwartz, 2005). The various body psychotherapy trainings have generally been excellent on the theoretical and the experiential sides, but woefully deficient on the academic and scientific sides. Maybe there is some fear of ‘dilution’ of their methodology here: Koemeda-Lutz et al. (2005) are unequivocal about the way forward:

*For body psychotherapy 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. (Ibid, p. 28)*

The changes needed here are really to be undertaken by the training schools in the various modalities and the methods of body psychotherapy, and by the professional associations behind them, like the EABP & USABP, who help coordinate and regulate them. The professional associations need to consider amending the training standards to ensure that science and research modules are included, so as to ensure that all future body psychotherapy practitioners at least have a basic understanding and some experience in research methodology and academic writing. The training schools need to recognise and promote the value of research to their trainees. There is really no other way.

Links also have to be formed with university programmes and some of the actual research can be undertaken there, in cooperation with the clinical aspects of the training schools and with clinics and groups of Body-Psychotherapists under the auspices of the

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<sup>12</sup> CIIS: California Institute of Integral Studies, San Francisco, CA; JFK: John F Kennedy University, Berkeley, CA; SBGI = Santa Barbara Graduate Institute, Santa Barbara, CA; Naropa University, Boulder, CO: currently the four universities in USA that run MA & PhD programs in Somatic Psychology or Body Psychotherapy.

professional associations. However, I am getting ahead of myself as this moves the argument into the third part in this series.

As a conclusion therefore, applying these principles to some of the English-language studies over the last 10 years<sup>13</sup>:

- There have been a couple of examples of the classic gold standard randomized controlled trials: one is the recent study done by Berg et al. (2009), and another is by Röhricht & Priebe (2006) (for abstracts: see Appendix 2), though, on deeper reflection, these are quite limited in their numbers and their applications to people with either a general anxiety disorder, or the negative effects in schizophrenia. Furthermore, the latter trial seems to have been using more of a movement-based therapy without much verbal process, so whether this can be considered as a proper body psychotherapy, or not, might be a slightly pedantic, though pertinent, criticism. [We have to be careful how we represent ourselves to the world.<sup>14</sup>]
- There was also a controlled outcome study on the effectiveness of psychodynamic body psychotherapy on chronic pain (Monson & Monson, 2000), and a small, randomized proto-study on the effectiveness of functional relaxation with asthmatics (Loew et al, 2001) (also see Appendix 2). However, again, on deeper reflection, the controlled outcome study is perhaps only ‘silver’ standard, and functional relaxation is also only considered by some to be an example of a proper body psychotherapy, and it was a very small proto-study.
- There have been a couple of other effectiveness studies, but they do not reach the ‘gold standard’ of Randomised Controlled Trials (RCT); the numbers were not really sufficient; nor were they published in a ‘scientific’ journal (Pettinati, 2002) (Sullens, 2002).
- An as-yet unpublished study from Israel (Peleg et al., 2009) is on the effectiveness of Mind Body Therapy (a combination of soft supportive touch, meditation, relaxation, conscious breathing, listening, empathy and positive thinking) on cancer patients receiving medical treatment. Again, whilst this is interesting, is it body psychotherapy? Is it useful? Yet it comes from a body psychotherapy school.

In these ways, we do seem to limit ourselves.

## End of Part Two

### APPENDIX 2: Abstracts of Research Projects

**Title:** Chronic pain and psychodynamic body therapy: A controlled outcome study.

**Authors:** Monsen, Kirsti, & Monsen, Jon T.

**Journal:** Psychotherapy: Theory, Research, Practice, Training. Vol. 37, No. 3, Fall 2000, pp. 257-269.

**Abstract:** Forty patients (aged 29–57 yrs) with pain disorders participated in a controlled study. Half of the patients were treated with psychodynamic body therapy (PBT) for 33 sessions, and the other half received treatment as usual or no treatment. All patients were evaluated before therapy (T1), at the end of therapy (T2), and at 1-year follow-up (T3) with a visual-analogue-pain scale (subjective experience of pain), symptom checklist, inventory of

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<sup>13</sup> [My apologies to the researchers of projects that have only been published in a non-English language. Whilst I would hope to be able to appreciate the valuable work you may have done, it cannot be known about, appreciated and spread more widely if you do not take the time and effort to translate \(at least\) the title, abstract and key-words into English. The EABP website will always publish these.](#)

<sup>14</sup> [I am grateful to Laura Steckler for her comments in a private e-mail for the basis of this critique.](#)

interpersonal problems, Minnesota Multiphasic Personality Inventory, and the affect-consciousness interview. The study demonstrated that at T2 the pain was significantly reduced in the PBT group compared to the controls, and 50% of the PBT patients reported no pain. The findings further showed a significant and substantial change on level of somatization, depression, anxiety, denial, assertiveness, and social withdrawal, and increased affect consciousness. The results remained stable at T3, and the PBT patients even continued their improvement on some scales during follow-up. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

**Title:** Efficacy of 'functional relaxation' in comparison to terbutaline and a 'placebo relaxation' method in patients with acute asthma. A randomized, prospective, placebo-controlled, crossover experimental investigation.

**Authors:** Loew, T. H., Tritt, K., Siegfried, W., Bohmann, H., Martus P. & Hahn, E. G.

**Journal:** Psychotherapy and Psychosomatics, Vol. 70, No. 3, pp 151-157.

**Abstract:** Background: 'Functional relaxation' (FR) according to Marianne Fuchs is a body-oriented psychotherapy that involves teaching the patient a type of relaxation techniques aimed at maintaining equilibrium of the nervous system. Methods: In order to determine whether the practice of elementary parts of this therapy has an immediate beneficial effect on pulmonary function, a randomized, single-blind, prospective crossover study was done with 21 asthmatics with acute bronchoconstriction. On 3 consecutive days they were given either (1) a 5-min verbal standard instruction in elementary exercises of FR (eFR), which they were to practice during subsequent bodyplethysmographic measurement or (2) inhalative terbutaline (IT), a  $\beta_2$ -sympathomimetic drug, or (3) an unspecific 'placebo relaxation' technique (PRT), so that all subjects tried all 3 treatments in random order. Spirometric variables were assessed. Results: There was a significant decrease in specific airway resistance with eFR, which, though not as pronounced as with IT, was significantly greater than with PRT. This study shows that clinically relevant effects can be achieved for patients with asthma through mind-body interaction, which can be triggered by reproducible procedures. Conclusion: Further development of the FR approach could lead to a non-pharmacological and effective supplementary treatment for asthma, which is in high demand by many patients.

**Key Words:** Asthma; Disease; Symptomatology; Bronchoconstriction; Acute; Treatment; Body psychotherapy' Relaxation; Comparative study; Chemotherapy; Terbutaline; Bronchodilator; Agonist;  $\beta_2$ -Adrenergic receptor;  $\beta$ -Adrenergic receptor agonist; Inhalation; Treatment efficiency; Prospective; Follow-up study; Human; Somatic disease; Respiratory disease; Obstructive pulmonary disease; 30 refs.

**Title:** Affect-focused Body Psychotherapy in patients with generalised anxiety disorder: Evaluation of an integrative method

**Authors:** Berg, Adrienne Levy; Sandell, Rolf & Sandahi, Christer: Karolinska Institutet, Stockholm, Sweden. Contact: adrienne.levy-berg@karolinska.se

**Journal:** Journal of Psychotherapy Integration, 19(1), March 2009, p. 67-85

**Abstract:** The aim of this study was to explore the long-term effects of affect-focused body psychotherapy (ABP) for patients with generalized anxiety disorder (GAD). A group of 61 consecutive patients, 21-55 years old, were randomized to ABP and psychiatric treatment as usual (TAU). The patients were assessed before treatment and followed up 1 and 2 years after inclusion. The ABP patients received one session of treatment per week during 1 year. Three self-report questionnaires were administered; Symptom Checklist-90; Beck Anxiety Inventory; and the WHO (Ten) Well-Being Index. In both groups, there was a significant

improvement. On termination, the ABP group had improved significantly more on the SCL-90 Global Symptom Index than the TAU group, whereas the differences were short of significance on the other two scales. The integration of bodily techniques with a focus on affects in a psychodynamically informed treatment seems to be a viable treatment alternative for patients with GAD.

**Keywords:** Affects - Body Psychotherapy - Outcome - Physiotherapy - Randomized Trial  
66 refs, Appendix

**Title:** Effect of body-oriented psychological therapy on negative symptoms in schizophrenia: a randomized controlled trial

**Authors:** Rohricht, Frank & Priebe, Stefan

**Contact:** Dr Frank Röhricht, Academic Unit, Newham Centre for Mental Health, London E13 8SP, UK. [Frank.Rohricht@elcmht.nhs.uk](mailto:Frank.Rohricht@elcmht.nhs.uk))

**Journal:** Psychological Medicine, Volume 36 (5) May 2006, pp. 669-678.

**Abstract:**

**Background:** In order to improve the treatment of medication-resistant negative symptoms in schizophrenia, new interventions are needed. Neuropsychological considerations and older reports in the literature point towards a potential benefit of body-oriented psychological therapy (BPT). This is the first randomized controlled trial specifically designed to test the effectiveness of manualized BPT on negative symptoms in chronic schizophrenia.

**Method:** Out-patients with DSM-IV continuous schizophrenia were randomly allocated to either BPT (n = 24) or supportive counseling (SC, n = 21). Both therapies were administered in small groups in addition to treatment as usual (20 sessions over 10 weeks). Changes in negative symptom scores on the Positive and Negative Symptom Scale (PANSS) between baseline, post-treatment and 4-month follow-up were taken as primary outcome criteria in an intention-to-treat analysis.

**Results:** Patients receiving BPT attended more sessions and had significantly lower negative symptom scores after treatment (PANSS negative, blunted affect, motor retardation). The differences held true at 4-month follow-up. Other aspects of psychopathology and subjective quality of life did not change significantly in either group. Treatment satisfaction and ratings of the therapeutic relationship were similar in both groups.

**Conclusions:** BPT may be an effective treatment for negative symptoms in patients with chronic schizophrenia. The findings should merit further trials with larger sample sizes and detailed studies to explore the therapeutic mechanisms involved.

42 refs.

**Title:** Effectiveness of Body Mind Therapy of Cancer Patients receiving chemical treatment.

**Authors:** Dr. Irit Peleg, Dr. Joseph Brenner, Dr. Moti Shimonov, Ofra Ravinda, Dafna Karata Shwartz.

**Contact:** Dr Irit Peleg, Reidman International College, 26 HAim levaon St., Tel Aviv, 63507 Israel. [pelegirit@gmail.com](mailto:pelegirit@gmail.com)

**Abstract:**

The difficulties of coping with the crisis caused by the discovery and treatment of cancer and its implications induce a sense of mental and physical distress that influences the patient's quality of life. Body mind therapies in the framework of integrative medicine have, in recent years, become an inseparable part of the physical and mental treatments used by patients. There is considerable research evidence of the effectiveness of these treatments for cancer patients.

The research objective is to examine the effectiveness of body-mind therapy on cancer patients who are receiving chemical treatment. The research method: 24 cancer patients were

sampled, some of whom received body-mind therapies and some who constituted the control group. The research process: the research data were collected using a structured independently completed questionnaire that was validated. The results: four interactions were found according to group and timing, in which an improvement was found after the therapy among the experiment subjects as opposed to the control group.

In the area of psychological variables, in the experimental group before the therapy there were more physiological changes (M=4.65) than after the therapy (M=3.97). This measure examined the degree of tiredness, appetite, pains, sleep changes, constipation, nausea, changes in monthly menstruation, general state of health, and changes in the outer appearance.

In the area of variables in the economic situation and family situation, before the intervention there were more changes for the worse among the subjects in the experimental group (M=4.92) than among the subjects of the control group (M=2.55), while after the intervention there were no differences between the groups. This index examined the extent to which the disease bothered the family members, whether the support is adequate, and the extent to which the disease disrupted the employment and caused an economic burden.

In the area of changes for the worse in behavior, before the intervention there were more changes for the worse among the subjects in the experimental group (M=4.81) than among the subjects in the control group (M=3.36), while after the intervention there were no differences between the groups. This index examined the extent to which the patient is troubled by the first diagnosis, how the disease influences anxiety and depression, and concerns and fears of future diagnoses, fear of additional cancer, metastasis, and fear of the future.

In the area of negative changes following the disease, before the intervention there were more changes for the worse among the subjects of the experimental group (M=4.91) than among the subjects of the control group (M=3.98), while after the intervention there were no differences between the groups. This index is comprised of a mean of five indices: psychological changes related to the disease, changes in the economic situation and situations in the family, changes for the worse in the sexuality and social relations, changes for the worse in behavior, and changes and concerns related to the disease.

As the cancer patient receives more body-mind therapies, his physical and emotional immune system is strengthened (2.3), his ability to cope with crisis increases (4), his tension and anxiety are reduced (5.6), his level of tiredness is lowered (6.7), he acquires knowledge to relax the body and enable it to strengthen itself, and the ability to recover vitality, essentialness, and general quality of life increase (8). As the patient adopts positive thinking on life in general and on his personal situation in particular, the changes of his recovery will increase (9) and his relations with his significant other and his friends will improve (10).

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