Mental Health Impact of Massage and Massage Therapy for Survivors of Domestic and Family Violence and/or Sexual Abuse: A Scoping Review

Selina DiPronio, LMT,[1*] Sarah Fogarty, RMT, PhD[2]

[1]Pacific College of Health and Science, New York, USA, [2]School of Medicine, University of Western Sydney, Sydney, Australia

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Background: Sexual abuse (SA) and domestic and family violence (DFV) are a worldwide issue with high incidence rates. While massage therapists are not generally frontline responders, they may see individuals presenting with the lifelong sequelae of DFV/SA.

Purpose: The aim of this scoping review is to characterize the nature, scope, quality, and potential reach of publications within the massage therapy and research fields that focus on massage and massage therapy treatment for those who have or are currently experiencing DFV and/or SA. Additional objectives for this review are the intent to compile a summary of practice- and evidence-based recommendations and completion of an appraisal of included publications.

Methods: A scoping review was conducted following Arksey and O'Malley's six-step scoping review framework and the PRISMA-ScR guidelines. The electronic databases PubMed, ProQuest, CENTRAL, CINHAL, Web of Science, and MEDLINE as well as Google Scholar were searched to identify publications. Summaries of the publications were undertaken as the included publications did not yield enough rich qualitative data to undertake a thematic analysis.

Results: Twenty-six publications were included from five countries with the most papers coming from the United States. The review demonstrated multiple psychological benefits of massage with the majority of publications presenting mental health improvements as the predominant impact of massage therapy on individuals who had experienced DFV/SA; however, the majority of the interventional benefits came from SA research.

Conclusion: The review highlighted a void in the interventional research on massage and DFV with no interventional study focusing on DFV and massage solely despite anecdotal evidence of benefit. There was also a lack of evidence of impact of massage in clinical practice for individuals with any history of DFV/SA. There is potential that massage therapy may be a useful tool in aiding survivors' recovery, if administered by trained individuals.

KEYWORDS: Mental health; massage therapy; domestic and family violence; sexual abuse; sexual assault

INTRODUCTION

Massage is "a patterned and purposeful soft-tissue manipulation accomplished by use of digits, hands, forearms, elbows, knees, and/or feet, with or without the use of emollients, liniments, heat and cold, handheld tools, or other external apparatus, for the intent of therapeutic change."[1] Massage therapy consists of the application of massage and non-hands-on components, including health promotion and education messages, for self-care and health maintenance; therapy, as well as outcomes, can be influenced by therapeutic relationships and communication; the therapist's education, skill level, and experience; and the therapeutic setting.[1] Massage and massage therapy have been delineated separately based on the difference between massage provided from a trained individual both in terms of massage techniques and non-hands-on skills and massage provided with limited or no

training. While massage therapy is better known for its benefits on pain and muscular tension, research evidence has been increasing over the last 20 years on the beneficial effects of massage on mental health (mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community).[2]

Statistics show that “one in every eight people in the world live with a mental disorder or a mental health condition.”[3] These conditions include, but are not limited to, anxiety, depression, mood disorders, stress, and/or trauma. There is growing evidence that massage might be beneficial in assisting mental health in many populations including pregnant women,[4–8] cancer patients including adults and children,[9–12] laboring women,[13–15] preoperative surgical patients,[16,17] intensive care unit patients,[18] burn patients,[19] healthy women,[20] adults,[21] individuals with dementia,[22–24] individuals having surgery,[25,26] veterans,[27] individuals with human immunodeficiency virus (HIV) disease,[28] individuals with a brain tumor,[29,30] nursing students,[31] healthcare workers,[32] young adults,[33] and victims/survivors of sexual abuse (SA).[34,35]

SA (“any nonconsensual or exploitive sexual behavior or activity imposed on an individual without their consent”[36] or “the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions”[37]) and domestic and family violence (DFV) (behaviors in which one individual gains power over another through abusive methods, including physical violence, sexual violence, psychological aggression, emotional manipulation, and neglect that results in harm in an intimate or domestic setting[38]) are a worldwide issue with high incidence rates. In the United States alone there are 1500 deaths annually and a national economic cost of over $12 billion every year from DFV/SA.[38–40] Health-care professionals play an important role in supporting and empowering individuals experiencing DFV/SA[41,42] and while massage therapists are not generally frontline responders, they may see individuals presenting with the lifelong sequelae of DFV/SA[43] such as chronic pain, migraines,[43] anxiety, depression, substance abuse, post-traumatic stress disorder,[43,44] irritable bowel syndrome, asthma, diabetes, fibromyalgia, and other autoimmune diseases.[45] Given the incidence rates of DFV/SA, massage therapists are “likely, at some point, to come into contact with a client who either is or has been subjected to domestic violence” (p. 2)[46] with Sohnen-Moe and Benjamin (2021) estimating a massage therapy “practitioner could generally expect that approximately one in five clients will likely be a survivor of sexual abuse (p. 295)”.[47] A 2024 systematic review highlighted the emergent exploration of massage therapy as a potential means of helping survivors of rape SA, and the review evaluated the psychological support benefits of massage therapy.[48] The authors concluded that massage had a large number of positive effects on the care of people who have suffered sexual violence and that “massage therapy can serve as an important adjunct to traditional psychotherapeutic treatments, providing tangible benefits that extend beyond the psychological realm into the somatic experience of survivors.”[48] The review did not include DFV which can overlap with SA nor did it explore factors which might contribute to massage therapists’ and consumers’ safety and comfort in utilizing massage therapy in a clinical setting. For example, despite the frequency with which a massage therapist might encounter a victim/survivor of DFV/SA and the purported benefits of massage for individuals experiencing SA, some massage therapists believe that any discussion of DFV has no place in massage therapy[49] and some massage therapists exclude psychotherapeutic treatment of trauma related to rape and abuse.[50] Additionally, many of the included papers in the 2024 review provided massage care in research settings with additional psychological supports, and it is unclear if these benefits and effects translate into clinical practice. If individuals seek out massage therapy and other complementary therapies to manage the sequelae of DFV and/or SA, it is important to not only understand the benefits of massage but also the current research, education, and clinical practice around DFV and SA, and the experiences and beliefs of therapists and consumers. Doing so could enhance the care provided to DFV and/or SA survivors, improve the environment in which care is provided, and expand the quality of education provided to massage therapists

about DFV/SA and massage. Thus, the aim of this scoping review is to characterize the nature, scope, quality, and potential reach of publications within the massage therapy and research fields that focus on massage therapy treatment for those who have or are currently experiencing DFV and/or SA. The secondary objectives of this review are (i) a complete summary of recommendations related to massage therapy for SA and DFV from reviewed publications and (ii) complete quality appraisals for publications included in the review.

METHODOLOGY

This review used a scoping review methodology which provides an overview of and identifies the available evidence about a particular topic and specific populations.[51]

Design

The study design was informed by the PRISMA-ScR guidelines[52] and the five-stage process for a scoping review design as outlined by Arksey and O'Malley[51] and further developed by Levac, Colquhoun, and O'Brien[53] is as follows: (i) identifying the research question; (ii) identifying relevant publications; (iii) publication selection; (iv) charting the data; and (v) collating, summarizing, and reporting results. The authors used the Covidence software tool[54] for screening and data extraction.

Inclusion and Exclusion Criteria

Specific inclusion and exclusion criteria were used to inform the study selection.

Inclusion criteria

The included publications had to be focused exclusively on DFV and/or SA and refer to, examine, or include massage or massage therapy provided in a professional, health-focused environment/context. Massage or massage therapy discussion, examination, or intervention can be provided by anyone as long as the health context is present. Massage therapy could be administered at any timeframe along the spectrum of care such as concurrent to the DFV/SA or in the years after the DFV/SA had occurred. Publications were needed to include outcomes such as benefits, experiences, and perspectives with a particular focus on mental health. Publications included any mixed methods, qualitative and quantitative studies, as well as the following gray literature: dissertations/theses and trade publications.

Exclusion criteria

Self-massage interventions were excluded as the effectiveness of self-massage for mental health conditions is unknown. Publications about massage provided as part of a holistic multidisciplinary care program were not included unless the massage findings were able to be distinguished from other therapies. Publications about (i) massage delivered within the sex industry context and (ii) sexual or domestic violence within the sex industry context were excluded.

Search Strategy

The electronic databases PubMed, ProQuest, CENTRAL, CINHAL, Web of Science, and MEDLINE were searched to identify publications potentially eligible for inclusion based on the predetermined criteria. The database searches were from inception until October 31, 2024 and limited to those published in English. The reference lists of all publications that met the inclusion criteria were scanned to identify further relevant publications. Self-searching, such as through Google Scholar, was implemented as well.

The search strategy included the Boolean terms "OR"/"AND," Medical Subject Headings (MeSH), CINAHL headings, and truncation "*". Varied combinations of search terms and MeSH terms that were unique to each database were used in this search strategy. Keywords and their synonyms were combined (domestic violence* OR family violence OR intimate partner violence OR domestic and family violence OR sexual abuse*) AND (massage OR soft tissue therapy OR myotherapy OR myofascial release).

Publication Selection

After removing duplicates, both authors independently screened all titles and abstracts for inclusion into the review. Following this preliminary screening, the full-text publications were obtained and assessed independently by both the authors for eligibility. Both the

authors contributed to the discussion to resolve any disagreements regarding inclusion. All studies eligible for the review had data extracted by one of the authors and were checked by the other author. See Figure 1. Author SDP only screened and extracted data from the Fogarty et al. publications.

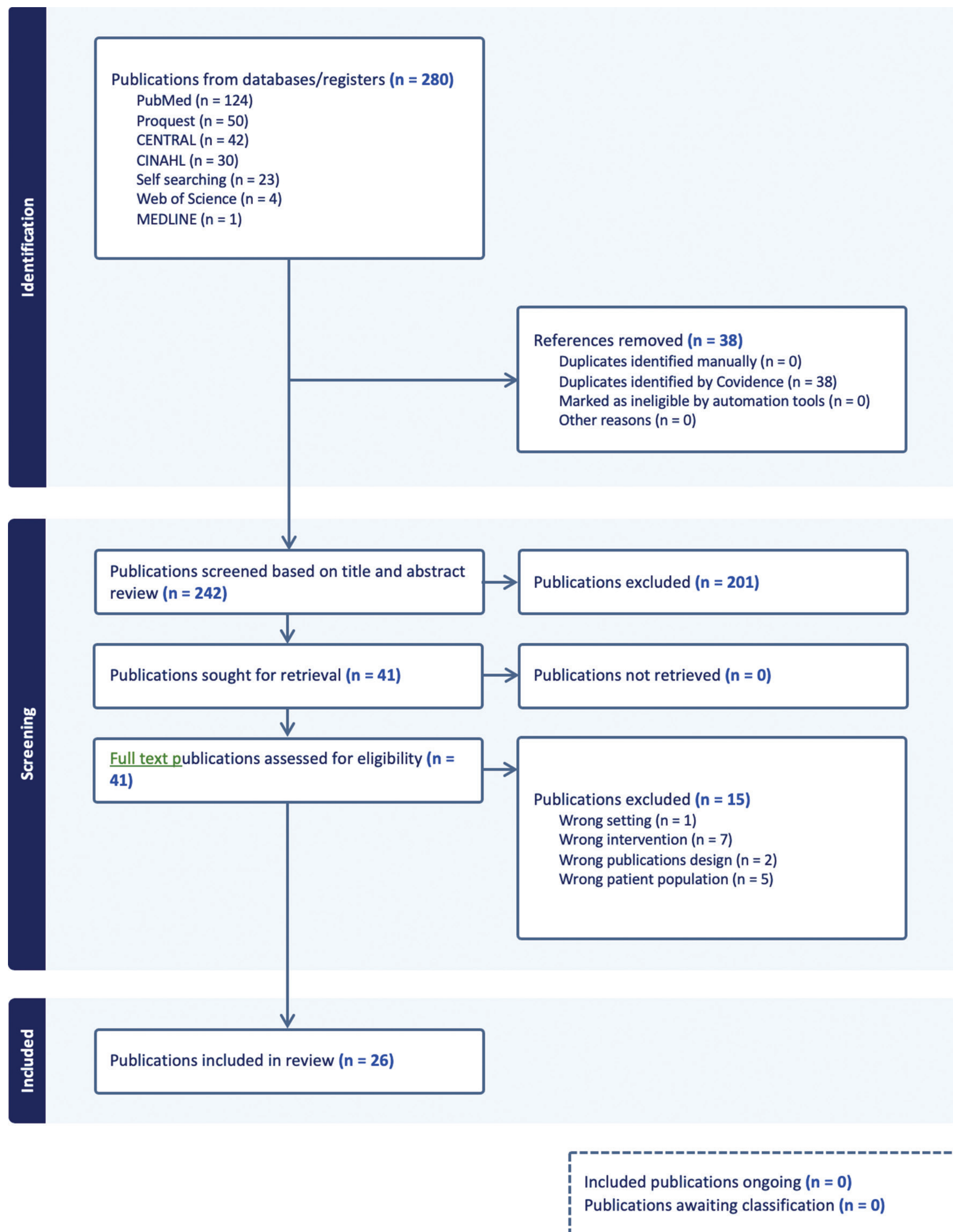

FIGURE 1. PRISMA flow chart. The benefits, knowledge, safety, and experience of massage therapy and massage therapists regarding domestic and family violence: a scoping review.

Data Extraction

Data were extracted using a descriptive analysis that included details of the publications such as authors, date of publication, any intervention provided, results, information about any theoretical underpinnings of DFV/SA in the massage space or how massage might work, and recommendations or advice about working with DFV/SA in massage spaces. The latter was specifically collected to undertake a synthesis of practice- and evidence-based recommendations. Both authors extracted the data and consensus was obtained. Data were also extracted on the reach of the publications including general public, industry, community, and academic reach.

Publication Appraisal

All included full-text publications were appraised using the appropriate Joanna Briggs Institute (JBI) critical appraisal checklist tools[55–61] or the Mixed Methods Appraisal Tool (MMAT).[62] The checklists appraise the publications' quality, reporting of, and risk of bias to assess the trustworthiness, relevance, and finding/results. The appraisal tools for research studies also appraise the methodological quality of the study. No publications will be excluded based on the checklist tools as "decisions on whether a study is considered weak, moderate, or strong are based on arbitrary cut-off scores."[63] Instead, a summary of the strengths and weaknesses of the publications will be provided, and data will be extracted, where possible, from the publications using quotes, thematic analysis, qualitative counts or scoring, and or experiential input. Both authors appraised the publications, and any deviations were resolved via discussion between the two authors. The papers by Fogarty et al.[49,64] were appraised only by SDP.

RESULTS

After removing duplicates and publications that did not meet the inclusion criteria, data from 26 publications were included in the review (see Figure 1). The characteristics of the included 26 publications are presented in Tables 1–4. The included publications did not yield enough rich qualitative data to undertake a thematic analysis.

Study Characteristics

Trade/educational publications

There were five trade articles published[46,66–69] from three trade magazines including *Massage & Bodywork* magazine, *Massage Magazine*, and *Massage Today*, and two educational pieces including one electronic resource[70] and one book.[65] The majority of these publications covered DFV (see Table 1). Two articles,[46,67] the online electronic resource,[70] and the book[65] were discovered in the Google Scholar search and three articles[66,68,69] were discovered through review of other references or using a Google search.

Non-interventional publications

There were six non-interventional publications[49,50,64,71–73] (see Table 2). There were three theses, two using qualitative methodologies[50,71] and one utilizing a mixed-methods approach.[73] Two prevalence studies[49,72] were conducted using the mixed-methods survey methodology with the Fogarty study resulting in two publications[49,64] (see Table 2).

Interventional publications

There were 9 interventional studies[34,35,74–79,82] and 2 theses[83,84] resulting in 13 publications[34,35,74–79,80–84] (see Tables 3 and 4). All but the Price 2002[78] case study covered SA, with the Price[78] case study covering childhood physical and sexual abuse. No interventional study or thesis investigated DFV solely.

Publications with no control arm/group

There were six interventional studies[74,76–79,82] and one thesis[83] that had no control group in their experimental design (see Table 3). Three of these studies did not provide massage as part of the study design but were investigating individuals in a community setting who had or were receiving massage and had a history of DFV/SA.[76,77,79] The methodologies included three case reports,[74,78,82] a thesis using a qualitative methodology,[83] an uncontrolled mixed-methods single-arm pilot study,[76] and a qualitative study.[77]

Publications with a control arm/group

There were three interventional studies[34,35,75] and one thesis[84] utilizing a control arm/group resulting in six publications[34,35,75,80,81,84] (see Table 4). The Price 2004[80] paper was a study conducted

TABLE 1 (Part 1 of 2). Trade and or Educational Publications

Author and Date	*Country Where the Article was Published*	*Type of Article*	*Suspected Audience of the Article*	*Title of the Article*	*Population or Program the Article Was Written For*	*Focus of the Article/Book/Educational Resource*
Publications involving DFV						
Clark and Mathiesen, 2017[65]	United States	Educational textbook/ teaching resource	Massage therapists	Working with domestic violence survivors as a massage therapist	Textbook written for massage therapists	Information on what DFV is, populations who experience DFV, DFV and mental health, why people experiencing DFV stay, signs of DFV, what therapists can do, benefits and contraindications of massage, emphasis on treating the symptoms associated with it not treating the DFV directly, information on scope of practice, and therapeutic alliance.
Finger, 2023[66]	United States	Trade publication in *Massage & Bodywork* magazine	Massage therapists	After domestic violence: Massage as a recovery companion	Domestic violence victims	Lists what massage can help to with; they state massage is to relax and reset the nervous system and to help client feel safe and in control, which empowers them.
Mines, 2001[67]	United States	Trade publication in *Massage & Bodywork* magazine	Massage therapists	Healing triumphs over domestic violence. Unlocking and responding to a client's trauma	Massage therapists	Information about boundaries, shock, and trauma and then links DFV survivors and victims to these concepts. Information on what DFV is and some suggestions about working with DFV in clinical practice.
Page, 2017[68]	United States	Trade publication in *Massage Magazine*	Massage therapists	The massage therapist with a healing touch for domestic violence survivors	Domestic violence victims in a shelter	The publication talks about massage at pop-up events at a DFV shelter. The president at the shelter said that the results [of the massage] have been uplifting and touching. "Women leaving a domestic violence situation usually feel scared, broken, worthless and lost," and "massages and pampering play a beautiful role in helping them know they are special, important and cared for."
Razo, 2009[46]	United States	Trade publication in *Massage Today*	Massage therapists	Understanding domestic violence: What massage therapists should know	Massage therapists	Information about DFV and the holiday period, signs of DFV and the role of the massage therapist, asking about DFV and providing examples and guidance on how to respond to a disclosure, and ways a massage therapist can help victims of abuse.
Schlossberg, 2016[69]	United States	Trade publication in *Massage Today*	Massage therapists	Massage eases recovery for domestic violence survivors	Massage therapists	Information about a complementary health-care service offered at a DFV shelter and resource center for women. Wellness days are hosted each month which includes free massage sessions for those who have experienced DFV. Massage is provided by massage practitioners who volunteer their time. Feedback includes that women love the massage part of the program as most of them have never had the opportunity to receive a massage. One woman said that *it was the best 10 minutes she's had to herself in years*. A similar program runs out of another shelter which offers a 20-min chair massage once a month at the shelter from an experienced volunteer massage practitioner. An advocate of the program said she sees "*the way the energy shifts in the room and people light up and are sort of transformed just by getting a little bit of personal loving attention*." The program also offers other complementary health services, so it is unclear if this is just massage related or all therapy related. The publication looks at trauma and the body and qualifications needed to work in the DFV shelter.

TABLE 1 (Part 2 of 2). Trade and or Educational Publications

Author and Date	*Country Where the Article was Published*	*Type of Article*	*Suspected Audience of the Article*	*Title of the Article*	*Population or Program the Article Was Written For*	*Focus of the Article/Book/Educational Resource*
Publications involving sexual abuse						
Benjamin, 1991[70]	United States	Educational resource article	Massage therapists wanting to work with survivors of abuse	Massage and bodywork with survivors of abuse	Teachers and massage students	The aim of the publication was to educate massage therapists working with survivors of sexual abuse. The article talked about creating professional boundaries for doing effective massage therapy with survivors of abuse. The article sought to educate massage therapists about the psychological underpinnings of abuse, basic concepts in the treatment of survivors, important prerequisites for working with survivors, how to create an appropriate therapeutic environment, ethical issues involved, verbal and physical techniques used in treatment (including how to deal with flashbacks), setting up an ongoing support system, finding an appropriate supervisor, and how to expand the therapist's education for working with survivors.

DFV = domestic and family violence.

within a trial looking at psychological and somatic profiles of women in the body-oriented arm of their randomized control study sample,[75] and the Price 2007[81] paper reported on an analysis of dissociation in their study sample.[34] The methodologies included a thesis utilizing a quasi-experimental pretest–posttest comparative design,[84] a randomized controlled trial (RCT),[35] and two mixed randomized control studies.[34,75]

Publication locations

Three RCTs,[34,35,75] one prevalence study,[72] a single-arm study,[76] two case studies,[78,82] and four theses (two qualitative,[50,71] one mixed methods,[73] and one quasi experimental[84]) were conducted/undertaken in the United States. One prevalence study was conducted in Australia,[49] one case report[74] and one qualitative study[77] were conducted in the United Kingdom, one qualitative study was conducted in Iceland,[79] and one qualitative thesis was undertaken in Canada.[83] All seven trade/educational articles were published in the United States.[46,65–70]

Population Characteristics

Abuse type

One prevalence study,[49] five trade articles,[46,66–69] and one educational book[65] investigated or discussed DFV. There were three RCTs,[34,35,75] one prevalence study,[72] two case reports,[74,78] a single-arm study,[76] two qualitative studies,[77,79] four theses,[50,71,83,84] and one online educational resource[70] that investigated or discussed massage and sexual assault survivors. One qualitative thesis[73] and one case report[82] combined DFV and SA in their study sample.

Abuse information

No publications investigated the use of massage for individuals currently experiencing DFV and/or SA. Two trade articles[68,69] shared details about massage being provided in a DFV shelter. There were two educational resources for massage therapists working with DFV/SA survivors: an electronic resource[70] and a book.[65] A prevalence study,[49] a single-arm study,[76] and a thesis project[50] did not specifically seek out participants with a DFV and/or SA history. In the two studies, massage therapists[49] and community mental health program participants[76] were the population

TABLE 2 (Part 1 of 4). Non-Interventional Publications

Author and Date	*Country the Study Was Conducted In*	*Publication Aim*	*Publication Design*	*Number of Participants*	*Population and Characteristics*	*Data Collected*	*Results*
Non-interventional DFV studies							
Fogarty et al., 2024[(49) a] and 2025[(64) a b]	Australia	*2024 paper:* To investigate massage therapists' attitudes, consultation processes, and confidence to respond to situations involving DFV in clinical practice *2025 paper:* To investigate massage therapists' knowledge, confidence, and awareness of DFV in clinical practice	Quantitative and qualitative survey methodology	217	Australian massage therapists aged 18 years and older who were currently practicing or had recently ceased practicing in Australia *Age:* Mean age of 48 years *Gender:* Majority identified as female *Abuse:* Female respondents were significantly more likely to have prior experience with DFV *Practice characteristics:* Mean time in active practice was over 10 years. The majority worked in urban location, were self-employed, and identified as sole practitioners	Quantitative and qualitative questions	*2024 paper:* There is a contrast of beliefs about the place of DFV in massage that is patterned by prior experience with DFV. Respondents with personal DFV experience were more knowledgeable about it, more comfortable asking clients about if they were experiencing it, routinely asked all clients about it, were more likely to have a client disclose it, felt better equipped to manage a disclosure, and were more likely to believe DFV has a place in massage therapy than those with no personal experience. Respondents with no personal experience of DFV were more likely to express the belief that DFV had no place in massage therapy. Respondents who expressed belief that DFV had no place in massage therapy cited irrelevance to clientele, inappropriateness to massage space, and detriment to themselves or clients as reasons for their belief. Respondents who expressed belief that DFV does have a place in massage therapy cited potential negative responses from clients, not knowing enough to help, or fear of making the situation worse as roadblocks to integrating the topic of DFV in their practices. *2025 paper:* 1. There was a void of training and knowledge regarding DFV within the context of clinical massage care. 2. There was a lack of resources and a deficiency in skills to recognize and respond appropriately to DFV. 3. Therapists felt under-resourced and limited in recognizing DFV and identifying the next steps when DFV was disclosed. 4. Respondents expressed a desire for training and resources. 5. Personal experience with DFV influenced therapists' confidence and ability to identify DFV.

TABLE 2 (Part 2 of 4). Non-Interventional Publications

Author and Date	*Country the Study Was Conducted In*	*Publication Aim*	*Publication Design*	*Number of Participants*	*Population and Characteristics*	*Data Collected*	*Results*
Non-interventional sexual abuse theses							
Klein, 2010[50]	United States	This was a section of the thesis and thus the aim is related to the whole thesis. The goal of this study is to describe a new embodied possibility for the relationships between touch, intimacy, love, and sexuality in US culture through the practice of massage and bodywork.	Qualitative research—thesis using an inductive grounded theory approach	130 h of participant observation in an introductory massage classroom and 22 in-depth semi-structured qualitative interviews with massage therapists and bodyworkers	*Observation:* Demographics of this group not provided *Interviews* *Age:* Range 18–65 years (five were 18–25, six 28–35, three in their 40s, eight over 50) *Gender:* 11 men and 11 women *Sexual orientation:* 13 heterosexual, 6 bisexual, 3 gay *Race/ethnicity:* 18 white, 4 not white 21 white/European American 1 Mexican/Mexican American *Abuse:* One man had been sexually abused as a child, seven women had been raped or sexually abused *Practice characteristics:* 20 were licensed therapists and 18 practicing. Years of experience ranged from less than 1 to greater than 30; nine had a career length of 3 years or less, eight, 5–12 years, and five, 15–30+ years	Semi-structured interviews and then analyzed using grounded theory and an ethnographic approach using a classroom of a 200-h introductory Swedish massage class and writing field notes	Some of the massage students were survivors of sexual abuse and they felt that massage during their training helped them with their recovery. It helped bring things to the surface and then they would get their talk therapist to help them with it. Many interviewees specifically delineated their scope of practice to exclude psychotherapeutic treatment of trauma related to rape and abuse, yet acknowledged that traumatic memories do come up for clients receiving bodywork. Many bodyworkers do not ask clients about the psycho emotional correlates of their bodily troubles. Interviewees' experience was that receiving bodywork frequently causes trauma to "surface" and "reassuring touch" can go a long way in helping clients through psycho emotional "shifts" without extensive verbal processing always being necessary. *Education space:* A number of students in the class had experienced sexual abuse and had reactions to the practical aspects of the course, in particular when they were receiving the massage.
Wusler, 2023[71]	United States	To better understand the experiences of women who have been sexually assaulted and how they make meaning of their relationship with their bodies after completing body-oriented therapy	Qualitative research—thesis	6	*Gender/sexual orientation:* Cisgender women with histories of sexual trauma/abuse *Age:* Age range between 26 and 52 years old *Race/ethnicity:* 3 White 2 Hispanic 1 Hispanic/American Indian *Abuse:* Repeated episodes of sexual abuse - Two in childhood and as an adult - Two in childhood Isolated incidence - One as an adult Not stated	*Qualitative:* Semi-structured interview using phenomenology with a feminist epistemology and somatic theory as an interpretive framework	The most salient themes that emerged from their interviews consisted of (i) disconnection due to sexual assault, (ii) reconnecting with others through bodywork, (iii) reconnection with self through bodywork, (iv) sharing wisdom, and (v) reverence through transformational resistance Disconnection due to sexual assault—avoiding physical sensations, prejudice toward feminine bodies, and disconnection from embodiment. Reconnection with others through bodywork—respect and mutual reverence, opening to connection through safe relationships, consent, and transparency. Reconnection with self through bodywork—feeling safe to be present, emotional release, reembodying life, and reclaiming presence and sovereignty.

TABLE 2 (Part 3 of 4). Non-Interventional Publications

Author and Date	*Country the Study Was Conducted In*	*Publication Aim*	*Publication Design*	*Number of Participants*	*Population and Characteristics*	*Data Collected*	*Results*
					- One where the abuse happened in childhood but not specified if repeated incidences *Body-oriented therapy history:* Must have had a history of completion of at least four sessions of body-oriented therapy that involves consensual touch such as massage or acupressure *Massage treatment history:* - Four with more than 10 massages - One multiple massage treatments but number not stated - One stated has had massage but not how many sessions Of note, three of the six participants are massage therapists		Sharing wisdom—generational healing, providing alternatives to Western medicine, and integrating mental health with bodywork. Reverence through transformational resistance—rejection of societal oppression and taking care of self despite lack of respect from society.
Non-interventional sexual abuse study							
Weingarten, Baker and Einolf, 2023[72]a	United States	To examine types of therapies utilized by survivors of sexual assault and rape and the timing of service utilization, treatment engagement such as the number of therapies used, order of therapy use, and patterns of therapy use, and to identify barriers to use for psychotherapy and complementary therapies	Mixed methods using a survey and qualitative interviews	*Quantitative:* 331 participants *Qualitative:* 24 participants selected from the above participants	Survivors of sexual violence and sexual assault *Quantitative:* *Gender/sexual orientation:* Female identifying *Age:* 18–73 years. Mean age 37.4 years *Race/ethnicity:* Predominantly Caucasian (76.9%), then Hispanic or Latino (10.9%) with less than 6% for other racial identities *Education:* A third had not completed college, just over a third had a bachelor's degree, and just under a third had schooling beyond a bachelor's degree. *Qualitative:* There was no significant difference in demographics between the quantitative and qualitative participants.	*Quantitative:* Online survey distributed through nonprofit organizations providing services for survivors and other survivor networks *Qualitative:* Interviews	*Quantitative:* 61% of participants had used some form of complementary therapy. All therapies had long periods of time between victimization and treatment. Yoga had the highest rate of use (50.2%), followed by massage (32.1%) and chiropractic medicine (31.9%). 32.1% of participants used massage. On average, it took 21.15 years from the time of initial victimization for survivors to seek this particular therapy. Of participants who did not use massage, 6% cited stigma, 25.4% cited financial reasons, 32.5% cited lack of awareness, and 39.6% cited disinterest as barriers to seeking out massage as therapy. *Qualitative:* Survivors noticed that specific forms of therapy were able to target different symptoms or difficulties—like psychotherapy for thoughts, yoga for reconnection to body, and massage for pain.

TABLE 2 (Part 4 of 4). Non-Interventional Publications

Author and Date	*Country the Study Was Conducted In*	*Publication Aim*	*Publication Design*	*Number of Participants*	*Population and Characteristics*	*Data Collected*	*Results*
Non-interventional combined sexual abuse and DFV thesis							
Hixson, 2006[73]	United States	To examine the experiences of women over the age of 21 years who have received massage therapy during their healing process from sexual or domestic violence	Mixed methods using a survey and qualitative interviews—thesis	10	*Gender/sexual orientation:* Women *Age:* Over the age of 21 years. Mean age 41.6 years *Abuse:* Not specified. Individuals had to identify as survivors of sexual or domestic violence *Time since abuse:* Average of 12.4 years since the last incidence of abuse. Seven women received massage therapy within the last 6 months *Massage treatment history:* Must have received massage therapy at least once as part of their healing	Self-report survey and semi-structured interview process in person or via the telephone	Therapist gender, trust building between client and practitioner, and communication with the client during massage therapy sessions were important clinical practice factors. There was apprehension on the part of some survivors of abuse about receiving massage therapy initially and most participants experienced some emotional distress while receiving massage therapy due to the effects of their own trauma and/or their interactions with the massage therapist. 70% of respondents had been triggered or reminded of abuse during a massage session and 70% felt safe and comfortable with their therapist during their massage session. *Qualitative:* Respondents had difficulty seeing the world as a safe place, had a fear of conflict, difficulty setting personal boundaries, and perceived any touch as invasive and unsafe. They experienced chronic muscle tension and pain, digestive disturbances, and headaches. Anxiety and depression were common for the participants (80% reported one or both). 70% reported that they had become emotional or uncomfortable during a massage session. Of these, two were visibly distressed and five tried to hide their discomfort from the therapist. The way in which the therapist responded when visually upset mattered. In the interview, 60% reported having some safety concerns during a massage session with 40% feeling generally safe. Having a female therapist was important for 70% and was a positive factor in perceived safety.

DFV = domestic and family violence.
[a]Peer-reviewed publication.
[b]Same study cohort (two papers published from the same dataset).

TABLE 3 (Part 1 of 4). Publications Involving Interventional Treatments (Massage) with No Control Group

Author and Date	*Country the Study/Project was Conducted In*	*Study/Project Aim*	*Study/Project Design*	*Number of Participants*	*Intervention*	*Population and Characteristics*	*Measures/ Outcomes*	*Results*
Interventional publications sexual abuse								
Ben-Shahar, 2002[74]a	Unspecified, but presumably England	Not stated	Case study about goal-oriented therapeutic interventions for sexual abuse	1	*Intervention:* Integrated massage therapy. This therapy has three aspects of therapeutic approach: cognitive, subconscious (or somatic), and bodywork. Therapy included psychotherapeutic and/or hypnotherapeutic processes, neuro-linguistic psychotherapy, shamanic processes, massage, breathing work, deep bodywork, and Reichian and neo-Reichian body-psychotherapeutic techniques *Duration and frequency:* 10 sessions over 4 months *Safety:* Safety in the treatment was important but not stated what this meant	*Gender:* Female *Age:* 30 years old *Abuse:* History of sexual abuse	A narrative approach was used in the case study from study observations and consultations	Subject no longer had invasive pictures; she began to dare be happier, "full'," and more alive. She started to reframe the relationship with her mom, and she began to understand and accept her mom. Her communication with her friends, family, and partner improved. Subject opened up, learning to tolerate higher levels of excitation, higher intensities of feelings, of sensations; she began exploring her sexuality and enjoying it. Her relationships became clearer and more open, her body less aching and more mobile, flexible, erect, and dynamic.
Campbell, 2015[75]	Canada	To explore how trauma-informed massage therapy might affect the long-term negative consequences of childhood sexual abuse on men	Qualitative study	Three men impacted by childhood sexual abuse	*Intervention:* Massage therapy varied for each participant (therapeutic and relaxation) *Duration and frequency:* Eight 1-h sessions. Time frame for the treatments varied between participants *Body areas treated:* Individual for each person in each session *Protocol:* Participants given a choice of a standardized massage or a customized massage, and all chose the customized massage *Therapist:* Qualified massage therapist with over 12 years of experience	*Gender:* Two men, one non-gendered *Age:* Ranging in age between 30 and 60 years *Ethnicity/race:* All white *Education:* Varied (some college education, college graduate, and postgraduate degree) *Employment:* Two full-time employed and one self-employed *Relationship status:* Two married and one single *Treatment history:* All had had some treatment for their abuse over time *Abuse history*: Varied for each participant. One experienced repeated physical and sexual abuse (female perpetrator), another experienced repeated childhood abuse (female perpetrator) and a one-time gang rape (male and female perpetrators) and the other one-time sexual abuse by a male perpetrator	*Qualitative:* Semi-structured interview and analyzed using narrative enquiry	Thematic analysis revealed the following themes: The positive impact trauma-informed therapy had on healing, dissociation and increased body awareness, exploring misconceptions around touch in the quest for rekindled trust, identity confusion, submissiveness, isolation, and blocked messages.

TABLE 3 (Part 2 of 4). Publications Involving Interventional Treatments (Massage) with No Control Group

Author and Date	*Country the Study/Project was Conducted In*	*Study/Project Aim*	*Study/Project Design*	*Number of Participants*	*Intervention*	*Population and Characteristics*	*Measures/ Outcomes*	*Results*
Collinge, Wentworth & Sabo, 2005[(76) a]	United States	1. To describe the integration of massage and energy-based therapies with psychotherapy in a community mental health center 2. To present qualitative feedback on the service 3. To present pilot data from a sample of long-term clients with persistent mental health concerns	Uncontrolled mixed-methods single-arm pilot study	25 individuals who completed at least two complementary therapy sessions	*Intervention:* Massage (type not specified), healing touch, or Reiki or acupuncture with psychotherapy in a community mental health center *Duration and frequency:* Up to 10 sessions for all therapies except acupuncture, which was five sessions *Body areas treated:* Not stated *Protocol:* Unclear *Therapist:* Massage therapists were licensed therapists	Patients with histories of trauma (PTSD, depression, anxiety, dual diagnosis) currently receiving psychotherapy treatment from Counselling Services, Inc. *Gender:* 20 women, 5 men *Age:* Mean 42.1 years (range 26–60 years) *Education:* Mean of 12.1 years (range 8–18 years) *Income:* The clinic serves a primarily low-income population *Treatment history:* Psychotherapy—Mean 7.4 years (range 1–20 years) Massage - 19 of the 25 individuals received a massage. *Abuse history:* 10 of the 25 individuals reported a history of sexual abuse	*Quantitative:* Likert-scale ratings for satisfaction and changes in perceived interpersonal safety, interpersonal boundary setting, bodily satisfaction (not dissociation), and bodily shame *Qualitative:* Observations of therapist and clinicians	*Quantitative:* *Helpfulness*—mean rating of 8.6/10 10 clients provided supplemental data perceiving significant positive change in sense of interpersonal safety ($p = 0.004$), bodily sensation ($p = 0.001$), interpersonal boundary setting ($p = 0.005$), and sense of bodily shame ($p = 0.012$). *Qualitative*—sense of interpersonal safety in the presence of the therapy provider, bodily sensations (as opposed to dissociation) during the treatments, interpersonal boundary setting relative to comfort in telling therapist what areas of the body to be treated, and sense of bodily shame during the treatment
Powell, 2010[(77) a]	United Kingdom	The aim of this study was to conduct a pilot evaluation of the Mosac Massage Program (MMP), a novel program that uses massage to address some of the difficulties faced by children, who have been sexually abused, and their non-abusing parents. The program instructs non-abusing mothers of children who have been sexually abused basic massage skills.	Qualitative research	Three non-abusing "mothers" (three mothers and a grandmother) of children who had been sexually abused. There were five children involved (one mother had two children)	*Intervention:* Massage (type not specified) performed by "mothers" *Duration and frequency:* Nine sessions of teaching. Sessions 1–3 were 3 h long and were with mothers only. A safe framework and ground rules were established. Theoretical skills and practical skills were introduced and learned, including massage skills to use with their child. Mothers had the opportunity to practice on one another. Sessions 4–8 were 60-min one-on-one sessions attended by individual parent–child pairs and the therapist. The therapist taught and guided the mother in their massage skills. These sessions were optional. Session 9 was a 3-h group session for all mothers who evaluated and assessed the sessions. *Safety:* Massage was conducted fully clothed *Body areas treated:* The hands, feet, head, and face. *Protocol:* Simple sequences taught *Therapist teacher:* Qualifications not stated	N/A *Gender:* "Mothers"—women Children—four females and one male *Age:* "Mothers"—from 39 to 56 years. Children—5–18 years old *Ethnicity/race:* "Mothers"—three were white and one was Afro-Caribbean *Abuse history:* Children—time since disclosure of the abuse ranged from 6 months to 5 years.	*Qualitative:* Semi-structured interview and analyzed using thematic content analysis	*Qualitative*: Benefits included improved bonding and communication between mother and child and a relaxing and enjoyable therapy for both mother and child. The program appeared to be a useful complement to talking therapies. Mothers wanted to participate to improve their relationship with their child (bonding) and safe touch. The MMP was something that had the potential to be fun and relaxing and it did not necessarily involve talking about the abuse. They considered it a complement to talking therapies (such as counseling) and hoped that it could help where talking had not.

TABLE 3 (Part 3 of 4). Publications Involving Interventional Treatments (Massage) with No Control Group

Author and Date	*Country the Study/Project was Conducted In*	*Study/Project Aim*	*Study/Project Design*	*Number of Participants*	*Intervention*	*Population and Characteristics*	*Measures/ Outcomes*	*Results*
Price, 2002[78] a	United States	The purpose of this study was to examine quantitative and qualitative effects of body-oriented therapy as an adjunct to psychotherapy for a woman with a childhood history of physical and sexual abuse	A descriptive, single case study utilizing pre- and post-self-report measures; methods are multi-modal including interview, written questionnaire, and standardized psychological questionnaires	1	*Intervention:* massage as part of bodywork (type of massage not specified) *Duration and frequency:* Weekly 75-min session of which 25 min of massage followed by 25 min of body awareness education *Body areas treated:* Most sessions began with massage to the upper chest, shoulders, and neck because these areas were found to be particularly tense *Therapist:* Licensed massage therapist *Protocol:* Semi-rigid massage protocol. The study participant wore loose-fitting clothes. Massage was used to facilitate relaxation and body awareness. All sessions began with massage to attend to areas of muscular tension and physical discomfort and/or anxiety	*Gender:* Women *Age:* Mid 40s *Ethnicity/race:* Caucasian *Education:* Graduate degree *Employment:* Worked full time *Relationship status:* Divorced and living with her two children *Treatment history:* Seeing current psychotherapist weekly for 3 years *Medication:* Low dose of Prozac during the first week of the current study *Mental health:* No history of suicide attempts	*Quantitative:* *Psychological well-being:* - General psychological health (SCL-90) - Mood (POMS) - Post-traumatic stress (CR-PTSD) *Physical well-being:* - Discomfort via the Physical Symptom Checklist *Qualitative:* The meaning and impact of body-oriented therapy via a written questionnaire	*Quantitative:* *Psychological well-being:* Significant improvement in PTSD status, improvement on all psychological indicators. Mood states improved steadily across the intervention. *Physical well-being:* Improvement on all endorsed physical symptoms except fatigue. *Qualitative*: A positive impact of body-oriented therapy on feelings of safety, emotional connection, and psychotherapeutic progress.
Sigurdardottir, 2015[79] a	Iceland	The aim of this paper was to present a description of the wellness program for female childhood sexual abuse (CCSA) survivors, the participating women's evaluation of the different therapies in the program, as well as a qualitative study on their experience of the program's effects on their life, health, and well-being.	Qualitative research	Twelve female CSA survivors	*Intervention:* The wellness program is a person-centered, holistic, traditional, and complementary therapy for female CSA survivors. Group and individual sessions were available. *Duration and frequency:* 5 days a week for 10 weeks (20 h). The opportunity for massage occurred once per week in a 1-h block and was offered as part of body-oriented therapy. The massage was not described. *Therapist qualifications:* A nurse/reflexologist provided the massage treatments *Protocol:* Not stated	*Gender:* Women *Age:* Between 22 and 25 years *Education:* Seven had attended secondary school, two all or part of high school, and one university degree *Employment:* All were unable to work/study *Relationship status:* Seven were married or cohabiting, three were single *Children:* All had 2–4 children *Previous health care:* All had sought help within the health-care system at different stages	*Quantitative:* An evaluation of the different therapies *Qualitative:* In-depth interview and analyzed using phenomenology	*Quantitative:* 90% (n = 9) found the body-oriented therapy with massage was very good, 10% (n = 1) was neutral. *Qualitative:* *Main theme*: Personal resurrection *Subthemes:* 1. Feeling totally lost 2. Releasing experiences 3. Developing trusting relationships 4. Gaining control 5. Experiencing positive change in physical and mental health 6. Finally feeling empowered The in-depth interviews showed that their health and well-being, personal life, and relationship with partners, family, and friends improved. They felt empowered, more in control, and had developed increased trust toward others.

TABLE 3 (Part 4 of 4). Publications Involving Interventional Treatments (Massage) with No Control Group

Author and Date	*Country the Study/Project was Conducted In*	*Study/Project Aim*	*Study/Project Design*	*Number of Participants*	*Intervention*	*Population and Characteristics*	*Measures/ Outcomes*	*Results*
Interventional publication combined sexual abuse and DFV								
Field, 1995[74][a]	United States	To reduce grandparents' and infants touch deprivation as well as reduce any touch aversions infants might have from being sexually or physically abused	Case study	Not stated	*Intervention:* Massage *Duration and frequency:* 15 min every day for 1 month *Therapist qualifications:* No formal qualifications, trained by the program. Massage provided by grandparents (not biological grandparents—retired volunteers) *Protocol:* Unclear whether the massage provided had a regimented protocol or was individualized	Neglected and abused infants in a shelter *Age:* From 3 to 18 months. *Gender/sex:* Not stated	Not stated	Preliminary data analyses suggested the following were the significant effects for the infants: 1. Drowsiness and quiet sleep increased, and activity decreased after the massage 2. After 1 month of massage therapy, alertness and tracking behaviors increased 3. Behavior observations suggested increased activity, sociability, and soothability

CR-PTSD = Crime-Related PTSD Scale; DFV = domestic and family violence; POMS = Profile of Mood States Scale; PTSD = post-traumatic stress disorder; SCL-90-R = Symptoms Check List Revised.
[a]Peer-reviewed publication.

of interest. In the thesis project, massage therapy students[50] were the population of interest and just over 36% of the massage students disclosed a history of SA.[50] In the Fogarty et al., 2024[49] prevalence study 49.5% of massage therapists disclosed a personal experience of DFV, and in the Collinge et al. 2005[76] study 40% of the community mental health program participants disclosed a history of SA.

Three RCTs,[34,35,75] one prevalence study,[72] three case reports,[74,78,82] two qualitative studies,[77,79] and four theses (two qualitative,[50,71] one mixed methods,[73] and one quasi experimental[84]) specifically sought participants with an experience of DFV and/or SA. In the 1997 RCT,[35] 2002 case report,[74] 2023 prevalence study,[72] and 2006 thesis,[73] it was unclear or not stated if the abuse occurred in childhood, adulthood, or both. The 1995 case study,[82] the 2010 qualitative study,[77] and the 1984 quasi experimental thesis[84] focused exclusively on treating children who had experienced childhood abuse. The 2005[34] and 2006[75] RCTs, the 2002 case study,[78] the 2015 qualitative study,[79] and the 2015[83] qualitative thesis focused exclusively on treating adults who had experienced childhood abuse. The 2023[71] qualitative thesis included participants who experienced SA both as a child and as an adult (50%) and SA only as a child (50%).

Three trade articles did not present information on specific clients or abuse types.[46,66,67]

Age

All the study and/or thesis populations[34,35,49,50,71–76,78,79,83,84] except Powell and Cheshire, 2010[77] and Field, 1995[82] sought the experience of and/or provided treatment to adult populations. The Field, 1995[82] case report recruited infants (3–18 months) and the Powell and Cheshire, 2010[77] qualitative study recruited children 5–18 years of age.

Gender/sex

Two case reports involved women only.[74,78] A prevalence study,[49] a single-arm study,[76] and a thesis project[50] recruited men, women, and those who chose to self-describe. Two qualitative studies,[77,79] three RCT studies,[34,35,75] one prevalence study,[72] and three theses (one qualitative,[71] one mixed methods,[73] and one quasi experimental[84])[71,73,84] included women only, one qualitative

TABLE 4 (Part 1 of 3). Interventional Publications with a Control Group

Author and Date	*Country the Study/ Project Was Conducted In*	*Study/Project Aim*	*Study/ Project Design*	*Number of Participants*	*Intervention*	*Control Group*	*Population and Characteristics*	*Measures/Outcomes*	*Results*
Interventional publications sexual abuse									
Field, Hernandez-Reif, Hart, Quintino, Drose, Field, Kuhn and Schanberg, 1997[35] [a]	United States	To investigate the effects of massage therapy on women who had experienced sexual abuse	Randomized control trial	Twenty women who had reported having experienced sexual abuse were recruited from local psychotherapy clinics	*Intervention:* Massage (type not specified) *Duration and frequency:* 30 min twice a week for 1 month *Body areas treated:* Face, legs, arms, and back *Protocol:* Rigid massage protocol *Therapist:* Several licensed massage therapists provided the treatments	*Intervention:* Relaxation therapy (active control) *Duration and frequency:* 30 min twice a week for 1 month *Protocol:* Not stated *Therapist:* Several different therapists	*Gender:* Women *Age:* Mean age 35.0 years *Ethnicity/race:* 55% Hispanic, 35% Caucasian, and 10% black *Education:* 15% had some college education and 50% had high-school education *Employment:* 80% were not working *Income:* Primarily of low to middle socioeconomic status *Relationship status:* 50% were single *Number of children:* 75% had at least one child	*Quantitative:* Mood (POMS) Tactile defensiveness (ATTS) Anxiety (STAI) Depression (CES-D) Self-esteem (RSES) Life event stress and assays of stress hormones (saliva cortisol)	*Quantitative:* *Pre/post session:* Massage participants were significantly less depressed ($p < 0.05$) and anxious ($p < 0.005$), and their salivary cortisol levels decreased ($p < 0.05$). The control group had a significant decrease in anxiety ($p < 0.005$). *1-month treatment period:* The massage therapy group experienced a significant decrease in depression ($p < 0.05$) and life event stress ($p < 0.001$). The relaxation therapy control group reported a significant decrease in depression ($p < 0.05$) and they reported a significantly increased negative attitude toward touch ($p < 0.05$). There were no significant changes in self-esteem for either group.
Price, 2004[80] [a] and Price, 2006[75] [a,b]	United States	*2004 paper*—To examine the psychological and somatic profile of women who seek bodywork as an adjunct to psychotherapy in recovery from childhood sexual abuse *2006 paper*—The purpose of this study was to examine the effects of body-oriented therapy, as an adjunct to psychotherapy, for women in recovery from childhood sexual abuse	*2004 paper*—Mixed-methods analysis of psychological profile, physical abuse, and semi-structured qualitative interviews *2006 paper*—A two-group randomized design	Eight women were recruited from a community sample	*Intervention:* Body-oriented therapy (combination of bodywork (Swedish massage) and body awareness education and body/mind integration) *Duration and frequency:* Eight 60-min sessions *Body areas treated:* Not stated *Protocol:* Flexible protocol *Therapist:* Licensed massage therapists provided the treatments	Waitlist group waited 8 weeks prior to receiving the intervention	*Gender:* Women *Age:* 28–52 years *Ethnicity/race:* Caucasian × majority African American × 1 *Education:* All highly educated—bachelor's degree or higher *Employment:* All employed *Relationship status:* Committed relationships × 5 *Abuse history:* Four experienced abuse in early childhood (10 years or younger) Four experienced abuse during adolescence (13–16 years) Five had threat of violence accompanying the SA and four reported physical abuse by a parent(s) in childhood. Six participants experienced subsequent date rape(s) in early adulthood	*Qualitative:* Psychological symptoms (SCL-90-R) Dissociation (DES) Post- traumatic stress (CR-PTSD) Physical symptoms (PSC) *Mixed methods:* Semi-structured interview, written questionnaire	*2004 paper*—Characteristics included being highly motivated regarding their health and healing, awareness of the chronicity of their physical difficulties, and that their problems were not easily remedied. Most found sexual intimacy problematic. Participants articulated a relationship between their physical symptoms and their abuse pointing to the importance placed on somatic healing in recovery. *2006 paper*— *Quantitative*: Pre-post comparisons of the outcome's measures indicated significant improvements in psychological and physical well-being for the body-oriented therapy group. The body-oriented therapy group demonstrated significant improvements on psychological symptoms, PTSD, total number of physical symptoms, and physical discomfort. There were no significant improvements on any outcomes for the control group. As might be expected with such

TABLE 4 (Part 2 of 3). Interventional Publications with a Control Group

Author and Date	*Country the Study/ Project Was Conducted In*	*Study/Project Aim*	*Study/ Project Design*	*Number of Participants*	*Intervention*	*Control Group*	*Population and Characteristics*	*Measures/Outcomes*	*Results*
							Treatment history: All were in psychotherapy and have been seeing their current therapist for at least 1 year *Massage history:* Seven had at least minimal experience with massage therapy		a small sample, the results indicated no significant between-group (body-oriented therapy versus control) differences. *Qualitative:* *Main theme:* A positive impact of body-oriented therapy on sense of inner security and psychotherapeutic progress *Subthemes:* 1. The most important thing learned/experienced was the experience of a more secure sense of self. 2. The positive influence of body-oriented therapy on psychotherapeutic work through deepening and accelerating psychotherapeutic progress.
Price, 2005[34]a and Price, 2007[81]a,b	United States	*2005 study:* To examine the efficacy and the perceived influence on abuse recovery of body-oriented therapy. *2007 study:* To describe dissociation with respect to body therapy in sexual abuse recovery, specifically a study of non-pathological dissociation	A two-group, repeated measures randomized controlled mixed-methods trial	Twenty-four adult females in psychotherapy for child sexual abuse	*Intervention:* Body-oriented therapy (combination of massage and body awareness exercises, and inner-body-focusing process) *Duration and frequency:* Eight 60-min sessions *Body areas treated:* Not stated *Protocol:* Flexible protocol *Therapist:* The body-oriented therapists were licensed massage therapists and had graduate-level education in psychology	*Intervention:* Standardized massage, like one might receive at a spa with the goal of improving the client's health and well-being *Duration and frequency:* Eight sessions 60-minute sessions *Body areas treated:* Not stated *Protocol:* Standardized with no verbal therapeutic elements or educational components but a focus on sense of safety. *Therapist:* Licensed therapists	*Age:* Age ranged from 26 to 56 years, with a median age of 41 years *Ethnicity/race:* Native American × 1 Hispanic × 1, Black × 2, White × 20 *Education:* Overall, they were highly educated *Income:* The household incomes varied widely *Abuse history:* The majority had endured extensive childhood abuse. Eleven were abused by parents and others experienced childhood sexual abuse (not stated by whom)	*Quantitative:* *Psychological well-being* - Brief Symptom Inventory - Post-traumatic stress (CR-PTSD) - Dissociation (DES) - Bowerman Touch Empathy Scale *Physical well-being* - Medical Symptoms Checklist *Body connection* - The Scale of Body Connection *Qualitative:* Questionnaire at end of study	*2005 study:* Body-oriented therapy did not demonstrate greater improvements in outcomes across time than the massage group. Both groups showed equally significant improvements/changes across time for psychological well-being, physical well-being, body connection, and body investment. Improvements were maintained on all outcomes from post-intervention through 3-month follow-up for both groups. *2007 study:* The greatest change was the reduction of dissociation; there was an incremental effect across time and a strong association between change in dissociation and health outcomes. High dissociation at baseline (moderate levels) predicted positive outcomes. The results demonstrated the importance of moderate dissociation as an indicator of distress, and the central role of dissociation reduction in health and healing. Dissociation decreased significantly for both the massage and body-oriented therapy interventions (F = 33, p < 001).

TABLE 4 (Part 3 of 3). Interventional Publications with a Control Group

Author and Date	*Country the Study/ Project Was Conducted In*	*Study/Project Aim*	*Study/ Project Design*	*Number of Participants*	*Intervention*	*Control Group*	*Population and Characteristics*	*Measures/Outcomes*	*Results*
Interventional thesis combined sexual abuse and DFV									
Denman, 1984[79]	United States	The ultimate purpose of this study was to increase the efficacy of treatment programs for victims of sexual abuse.	Quasi-experimental, pretest–posttest, comparative research	16 women from two incest therapy groups (experienced incest as a child)	*Intervention:* Group work as per control group plus Swedish massage. Oil was used in the treatment and participants could be nude or partially clad. *Participants:* 10 *Duration and frequency:* Group work as per control group plus four individuals, 60-min massage sessions. The frequency of the massage was not stated *Therapist training:* Qualified masseuses	*Intervention:* Group work based on a particular format of incest therapy *Participants:* 6 *Duration and frequency:* Four months in length. The number of sessions and duration of group work was not stated	*Gender:* Women *Age:* 24–40 years	*Quantitative:* Body-Related Self-Image Questionnaire The Profile of Mood States The Index of Human Affection. Additional data were generated with observation forms completed by the masseuses	*Quantitative:* The results of an analysis of covariance of the major test scores showed no statistically significant difference between the two groups. Means and additional data indicated slight trend toward greater improvement among the experimental group. The masseuse's observation was that their clients changed positively during the massage treatments.

[a]Peer-reviewed publication.
[b]Same study cohort (two papers published from the same dataset).
ATTS = Attitude Towards Touch Scale; CES-D = Centre for Epidemiologic Studies–depression; CR-PTSD = Crime-Related PTSD Scale; DES = Dissociative Experiences Scale; POMS = Profile of Mood States Scale; PSC = Physical Symptom Checklist; RSES = Rosenberg Self-Esteem Scale; SCL-90-R = Symptoms Check List Revised; STAI = State Anxiety Inventory.

thesis recruited men only,[83] and gender/sex was not reported for one case report study.[82]

Intervention Characteristics

There was diversity across all aspects of reporting on the massage intervention including type of massage, duration, frequency, areas treated, protocols applied, and therapist details. The Powell and Cheshire, 2010[77] qualitative study reported on a teaching program for non-abusing mothers/grandmothers of children who had been sexually abused but did not report on the style of massage taught or the massage techniques taught.

Massage type/intervention

One case report study[82] and two theses projects[83,84] utilized massage only as the treatment intervention. One single-arm pilot study,[76] one case study,[74] and one qualitative study[79] had massage as part of a multimodality intervention or wellness program. One RCT study had massage with relaxation therapy as an active control.[35] Two RCT studies[34,75] and one case report[78] had massage as part of a body-oriented intervention which combined massage with body awareness and/or mind–body integration. The Price, 2005[34] RCT study had the control intervention as massage only, compared to massage and body-oriented therapy in the intervention arm.

The type of massage provided was stated in two RCT studies[34,75] and two theses projects.[83,84] Swedish massage was provided in one RCT study[75] and one quasi-experimental thesis project,[84] "massage like you get in a spa" was provided in one RCT study,[34] and relaxation or therapeutic massage was provided in one qualitative thesis project cohort.[83]

Duration of the treatment

Duration of the treatments varied with one single-arm pilot study,[76] one qualitative study,[79] and two theses[83,84] providing 60-min sessions; one case report study providing 15-min treatments[82]; and one RCT study providing 30-min treatments.[35] The Price studies provided 25 min of massage plus 25 min of body awareness and then body–mind integration with additional time for consultation and check-in.[34,75,78] One case report did not report on the duration of the treatment.[74]

Frequency of the treatment and intervals between the treatments

Frequency and time between treatments varied with one RCT study providing eight sessions in a month (twice a week),[35] another RCT providing eight treatments weekly,[75] and one case report providing daily treatments for a month.[82] One RCT provided 8 treatments[34] and one single-arm pilot study provided 10 treatments,[76] but neither stated the timeframe within which the treatments were provided. One case report provided 10 treatments over 4 months but did not state what the treatment intervals were.[74] One thesis project provided eight sessions and stated that the timeframe for these sessions varied for participants.[83] One qualitative study did not report on the frequency of the treatments.[79] One quasi-experimental thesis project provided treatment for 8 months but did not report on the total number of treatments nor the frequency of the treatment thesis.[84]

Body areas treated

Two case reports,[74,82] one single-arm pilot study,[76] one qualitative study,[79] two RCT studies,[34,75] and one quasi-experimental thesis[84] did not report on the areas of the body they treated with massage. The 2015 qualitative thesis project[83] provided individualized treatments but did not report the areas of the body treated. The chest, shoulders, and neck were treated in the Price, 2002[78] case report, and the face, legs, arms, and back were treated in the Field, 1997[35] RCT study.

Intervention study protocols used and type of protocols

Two case reports,[74,82] one single-arm pilot study,[76] one qualitative study,[79] and one quasi-experimental thesis[84] did not state if there was a massage protocol as part of their study/project. The qualitative 2015 thesis project[83] provided individualized treatments, but no protocol was mentioned. One case report[78] and three RCT studies utilized massage study protocols.[34,35,75]

Therapist qualifications

One case report,[78] one single-arm pilot study,[76] three RCT studies,[34,35,75] and two theses projects[83,84] had licensed/qualified massage therapists providing the massage treatment. One qualitative study had a nurse/reflexologist provide the treatment,

but their massage qualifications were not stated,[79] and one case report did not report on the therapists' qualifications.[74] The mothers and "grandparents" (volunteers) in the Field, 1995[82] case report were trained (not stated by whom) but were not licensed or qualified massage therapists.

Summary of Results

Three case reports,[74,78,82] one single-arm pilot study,[76] three RCT studies,[34,35,75] two qualitative studies,[77,79] one prevalence study,[72] and four theses projects[71,73,83,84] provided findings or results that massage therapy had a positive effect on the health of people who have experienced DFV/SA. In the Hixon mixed-methods thesis project,[73] the massage was not used as part of a healing process from their DFV/SA; however, for the 2010[77] qualitative study it was used as an adjunct or complement to talking therapies where the abuse was not talked about in the massage sessions. For the 2005 RCT,[34] the 2006 RCT,[75] the 2002 Price[78] case report, the 2005 single-arm pilot study,[76] and the 2002 Ben-Shanhar[74] case report, massage was part of the therapy alongside psychological care for the impact of their DFV/SA experience.

Quantitative results

Three RCT studies,[34,35,75] one single-arm pilot study,[76] two case reports,[78,82] one qualitative study,[79] and two theses projects[73,84] quantitatively assessed the benefits of massage after massage-based interventions or massage use. The majority found that massage therapy led to positive psychological and/or physical beneficial effects for participants.

Massage was rated very highly for helpfulness in one single-arm pilot study (86%)[76] and one qualitative study (90%), and reasonably helpful in a thesis project (66%)[73]). Participants in the Hixson, 2006[73] mixed-methods thesis project rated massage as helpful for coping with the impact of SA.

- Psychological: Significant improvements in general psychological health/well-being plus significant reductions in PTSD scores and dissociation were found in the Price, 2002[78] case report and the Price, 2005[34] and 2006[75] RCT studies. In the Price, 2005[34] RCT study, reductions in PTSD scores were maintained in the follow-up period. Improvements in mood were found in the Price, 2002[78] case report. The massage group were significantly less depressed and less anxious immediately post massage and less depressed and less stressed after 1 month of massage therapy in the Field, 1997[35] RCT study. Participants in the Collinge et al., 2005[76] single-arm pilot study experienced significant improvements in sense of interpersonal safety with massage, significant increases in interpersonal boundary setting, and a decrease in sense of bodily shame. One quasi-experimental thesis found no significant difference in body-related self-image, mood, or human affection with massage and group work compared to group work alone, although observation ratings completed by the massage therapists indicated their clients changed positively during the massage treatments.[84]
- Physical: Two RCTs,[34,75] one single-arm pilot study,[76] and one case report[78] reported significant improvements of physical symptoms/physical well-being and one RCT study[34] reported significant improvements in body connection. In the case report[82] on infants, there was a significant increase for drowsiness and quiet sleep and decreased activity after the massage, and alertness and tracking behaviors increased significantly after 1 month of massage.
- Reactions to massage: One mixed-methods thesis[73] reported that there was apprehension about receiving massage for some survivors of abuse, 70% of respondents had been triggered or reminded of their abuse during a massage session, and 70% became emotional or uncomfortable during a massage session.

Qualitative results

Two RCTs,[34,75] one single-arm pilot study,[76] two case reports,[74,78] one prevalence study,[72] two qualitative studies,[77,79] and three theses projects[71,73,83] contained qualitative findings following massage-based interventions or massage use, of which the majority implied that massage therapy led to beneficial effects for participants.

- Enhancing recovery: Two RCTs[34,75] and one qualitative thesis project[83] noted

that participants felt the intervention had enhanced their recovery. The Price, 2006[75] RCT participants reported that body-oriented therapy positively influenced the psychotherapeutic work through deepening and accelerating psychotherapeutic progress.

- Psychological: Numerous psychological benefits were listed—a better sense of self-efficacy,[34] experiencing a sense of inner security,[71,75,78,83] better self-awareness, self-sovereignty, and confidence to live authentically,[71,74,75,79] less body dissociation,[34,71,73,76,78,83] less bodily shame,[76] improved boundary setting,[70,76] self-empowerment,[71,79] improved trust,[73,79,83] and improved self-confidence.[76]
- Physical: A number of physical benefits were documented—better body awareness and perception,[34,72,78,83] better listening to one's body and its needs,[34,78] reduced pain, aching, and/or muscle tension,[72–74] and better relaxation.[77]
- Social: A number of social benefits were described including the capacity to experience safe touch,[70,71,73,76,83] improved relationships and communication,[74,77,79] improved connection,[71,78,82] and reduced isolation.[79,83]
- Reactions to massage: One qualitative thesis[50] reported that a number of massage students in the class who had experienced SA had reactions to the practical aspects of the course, in particular when they were receiving the massage.

Recommendations from Included Publications

A number of publications provided recommendations or observations about working with individuals who had experienced DFV/SA in a number of areas such as therapist traits, resources, safety (both overall and during the massage), training, boundaries, and the massage itself (see Table 5). Establishing trust and having the additional training to work with DFV/SA clients was important as was setting appropriate boundaries. Many recommendations/observations to enhance the clients' feeling of safety during the massage consultation were presented. While the need for additional training was mentioned, this was often vague. Trauma training was mentioned most frequently as needed for working with DFV/SA. Two trade articles provided comments on the experience of being a massage therapist working with DFV clients.[66,68] Page[68] felt that working with DFV clients had given them more overall compassion toward all their massage clients, and Finger[66] disclosed their DFV history to clients to build rapport. Both therapists have resources that they provide their clients about DFV and DFV services.[66,68]

Reach

The publications demonstrated moderate reach among both the general public and the massage industry, including massage therapists, educators, and policy makers. A total of 19 out of 26 publications (73.1%) were discoverable via Google Scholar, though only 11 (42.3%) were freely accessible. Ten publications (38.5%) appeared in massage- or bodywork-specific outlets, evenly split between trade articles (n = 5) and peer-reviewed journals (n = 5). Publications in non–massage-specific peer-reviewed journals tended to receive higher citation counts, indicating broader academic impact. Community reach was evident through the accessibility of trade publications and publicly available articles, which facilitated engagement beyond academic audiences (see Table 6).

Critical Appraisals

All publications except the 2006 thesis[73] and the 2005 uncontrolled mixed-methods single-arm pilot study[76] were appraised using the JBI critical appraisal tools[55–61] (see Tables 7–13). The 2006 thesis[73] and the 2005 uncontrolled mixed-methods single-arm pilot study[76] were appraised using the MMAT[62] (see Table 14).

Overall, the critical appraisal of publications exploring massage therapy in the context of DFV/SA revealed a variable standard of methodological quality and reporting. Qualitative studies and thesis projects, case series, and prevalence studies generally demonstrated greater rigor, with clear study aims, data collection methods, and outcome reporting indicating confidence in the reported methods and findings/results/observations and addressing of any biases. However, limitations were more common in quantitative and opinion-based publications. For instance, RCTs did not consistently report on allocation

TABLE 5. Recommendations from Included Publications

Recommendations or Advice About Working with DFV or SA in Clinical Practice Provided in the Studies/Papers						
Therapist Traits	*Resources*	*Safety*	*Training*	*Boundaries*	*Safety for the Treatment*	*The Massage*
A sensitive therapist is needed[50] The capacity to build trust is important[50,70,79] Capacity to build a therapeutic relationship[69] Ability to listen[69] The power of the therapist believing and respecting the DFV/SA client[46] Reconnection of genuine caring relationships[70]	Have phone numbers for safe houses and information and guidance resources for clients[67]	Massage "*is not advisable with extremes of trauma or unstable clients*"[50] Massage should not be the primary treatment[50]	Training is needed to work safely with SA clients[70,74,75] Trauma training is needed to work with SA survivors[71,75] Having education in communication, sexuality, ethics, and trauma[70] Getting additional education in counseling and psychology[70]	It is not the job of the massage therapist to rescue/fix any client experiencing DFV and/or SA[50,65,67] Setting appropriate boundaries around the support therapists can provide is important[50,65,67] Suggestions for boundary setting included: -treating the symptoms associated with DFV rather than treating the DFV directly[65] - massage therapists are not qualified to give advice but they can listen and witness[50]	Therapist to use informed consent, explain specifically what they are going to do, and ask questions/check in throughout the session[73] Allow the survivor to be in charge of the session (autonomy)[70] Being able to choose the gender of their therapist[70,73] with the option of a female health-care provider[3] Autonomy to keep clothing on if desired during the massage[73,75] Having a chance to spend time with the therapist talking before the first session about issues that might come up if history of DFV and SA[73] Pressure being too deep, the pace of the massage strokes being too rapid or too rough, being positioned lying on the stomach, and repositioning of the client using their ankles and spreading the legs apart slightly with no communication all impacted clients feeling of safety during treatment[73] Shock and trauma are locked in the body and that therapists need to honor this and not go too deep if there is no support[67] (unclear if deep was in reference to the massage pressure or about talking with the client) Draping during stomach work made some clients feel unsafe (although not stated if it was the procedure of draping or inadequate draping that lead to feelings of being unsafe)[73]	Not feeling rushed in the treatment session is integral to building trust[79] Creating a trusting relationship between the health-care provider and the survivor is important[79] Giving control/autonomy to the client[50]

DFV = domestic and family violence; SA = sexual abuse.

TABLE 6 (Part 1 of 3). The Reach of the Included Publications

	General Public and Industry Reach		*Industry Reach*	*Academic Audience and Reach*	*Community Reach*
	Findable on Google Scholar[a]	*Full text available online for free*	*1. Publication in a massage-specific journal or magazine 2. Audience of the journal/magazine*	*1. Peer-reviewed journal published in 2. Number of times cited*	*Community-based program*
Benjamin, 1991[70]	Yes	Yes	- Published online as a document for teachers of massage - Audience is massage therapy teachers	- Not published in a peer-reviewed journal - Cited by 9[b]	N/A
Ben-Shahar, 2002[74] c	Yes	No	- Published in a non–massage-specific journal - Journal audience is for leading-edge thinking within the therapeutic professions and within psychology more generally (self and society)	- Published in a peer-reviewed journal - Cited by 0[b]	
Campbell, 2015[83]	Yes	Yes	- Published as a thesis - Audience is people searching the library of theses/archives	- Not published in a peer-reviewed journal - Cited by 1[b]	
Clark and Mathiesen, 2017[65]	Yes	No	- Published as a book - Audience is commercial (hardcover/softcover book)	- Not published in a peer-reviewed journal - Cited by 1[b]	N/A
Collinge, 2005[76] c	No	Link to free version via Google Scholar if you know to search for the article	- Published in a non–massage-specific journal - Journal audience is for scientific research for the evaluation and integration of complementary medicine into mainstream medical practice (*The Journal of Alternative and Complementary Medicine*)	- Published in a peer-reviewed journal - Cited by 120[b]	Involved a cohort in a community setting
Demman, 1984[84]	Yes	Yes	- Published as a thesis - Audience is people searching the library of theses/archives	- Not published in a peer-reviewed journal - Cited by 0[b]	
Finger, 2023[66]	No	Open access if you know to search the massage and bodywork archives	- Published in a massage-specific trade magazine - Magazine audience is massage, bodywork, and somatic professionals (*Massage and Bodywork* published by the Associated Bodywork and Massage Professionals)		
Field, 1995[82] c	Yes	No	- Published in a non–massage-specific journal - Journal audience is clinicians, teachers, and researchers involved in pediatric health care and child development (*Journal of Developmental & Behavioral Pediatrics*)	- Published in a peer-reviewed journal - Cited by 535[b]	
Field, 1997[35] c	Yes	Yes	- Published in a bodywork-specific journal - Journal audience is those in clinical practice either private, community, or primary health-care-based looking at therapeutic techniques and professional debate (*Journal of Bodywork and Movement Therapies*)	- Published in a peer-reviewed journal - Cited by 52[b]	
Fogarty, 2024[49] c	Yes	Yes	- Published in a non–massage-specific journal - Journal audience anyone committed to disseminating rigorous research on preventing, ending, and ameliorating all forms of family violence (*Journal of Family Violence*)	- Published in a peer-reviewed journal - Cited by 1[b]	Yes, engaged massage therapists in clinical practice

TABLE 6 (Part 2 of 3). The Reach of the Included Publications

	General Public and Industry Reach		*Industry Reach*	*Academic Audience and Reach*	*Community Reach*
	Findable on Google Scholar[a]	*Full text available online for free*	*1. Publication in a massage-specific journal or magazine 2. Audience of the journal/magazine*	*1. Peer-reviewed journal published in 2. Number of times cited*	*Community-based program*
Fogarty, 2025[(64) c]	Yes	Yes	- Published in a massage-specific journal - Journal audience is therapeutic massage and bodywork community covering research, education, and clinical practice (*International Journal of Movement and Bodywork*)	- Published in a peer-reviewed journal - Cited by 0[b]	Yes, engaged massage therapists in clinical practice
Hixson, 2006[(73)]	Yes	No	- Published as an electronic book - Audience is commercial (Google Books)	- Not published in a peer-reviewed journal - Cited by 1[b]	
Klein, 2010[(50)]	Yes	Yes	- Published as a thesis - Audience is people searching ProQuest	- Not published in a peer-reviewed journal - Cited by 4[b]	
Mines, 2001[(67)]	Yes	No	- Published in a massage-specific trade magazine - Magazine audience is massage, bodywork, and somatic professionals (*Massage and Bodywork* published by the Associated Bodywork and Massage Professionals)	- Published in a massage trade magazine - Cited by 3[b]	
Page, 2017[(68)]	No	Open access if you know to search the *Massage Magazine* archives	- Published in a massage-specific magazine - Magazine audience is massage therapists and students (*Massage Magazine* was published by Robert Noah Calvert and his wife Judi from 1985 to 2005, then published by The Doyle Group from 2005, then published by Arthur J. Gallagher (Insurance Company) since 2019)	- Published in a massage trade magazine - Not listed in Google Scholar, so citation - Numbers not accessible[b]	
Powell, 2010[(77) c]	Yes	Not free via Taylor & Francis but link to free draft via Google Scholar	- Published in a non–massage-specific journal - Journal audience is research focused on child sexual abuse and sexual victimization (*Journal of Child Sexual Abuse*)	- Published in a peer-reviewed journal - Cited by 12[b]	Involved a cohort in a community setting
Price, 2002[(78) c]	Yes	Yes	- Published in a bodywork-specific journal - Journal audience is those in clinical practice either private, community, or primary health-care-based looking at therapeutic techniques and professional debate (*Journal of Bodywork and Movement Therapies*)	- Published in a peer-reviewed journal - Cited by 28[b]	
Price, 2004[(80) c]	Yes	Link to free version via Google Scholar	- Published in a bodywork-specific journal - Journal audience is those in clinical practice either private, community, or primary health-care-based looking at therapeutic techniques and professional debate (*Journal of Bodywork and Movement Therapies*)	- Published in a peer-reviewed journal - Cited by 23[b]	
Price, 2005[(34) c]	Yes	Yes	- Published in a non–massage-specific journal - Journal audience is medical/scientific journal covering alternative medical treatment health-care providers (*Alternative Therapies in Health and Medicine*)	- Published in a peer-reviewed journal - Cited by 195[b]	

TABLE 6 (Part 3 of 3). The Reach of the Included Publications

	General Public and Industry Reach		*Industry Reach*	*Academic Audience and Reach*	*Community Reach*
	Findable on Google Scholar[a]	*Full text available online for free*	*1. Publication in a massage-specific journal or magazine 2. Audience of the journal/magazine*	*1. Peer-reviewed journal published in 2. Number of times cited*	*Community-based program*
Price, 2006[75] c	Yes	No (link in Google Scholar is for another Price manuscript)	- Published in a bodywork-specific journal - Journal audience is those in clinical practice either private, community, or primary health-care-based looking at therapeutic techniques and professional debate (*Journal of Bodywork and Movement Therapies*)	- Published in a peer-reviewed journal - Cited by 61[b]	
Price, 2007[81] c	Yes	Yes	- Published in a non–massage-specific journal - Journal audience are health-care professionals to share effective and professional integration of complementary therapies within clinical practice (*Complementary Therapies in Clinical Practice*)	- Published in a peer-reviewed journal - Cited by 96[b]	
Razo, 2009[46]	Yes	Unclear, not able to access online	- Published in a massage-specific magazine - Magazine audience is massage therapists (*Massage Today* was published by MPA (Media Planning Agency) Media in until 2019, owned by The American Massage Therapy Association since 2019)	- Published in a massage trade magazine - Cited by 2[b]	
Scholssberg, 2016[69]	No	Open access if you know to search the *Massage Magazine* archives	- Published in a massage-specific magazine - Magazine audience is massage therapists and students (*Massage Magazine* was published by Robert Noah Calvert and his wife Judi from 1985 to 2005, then published by The Doyle Group from 2005, then published by Arthur J. Gallagher (Insurance Company) since 2019)	- Published in a massage trade magazine - Not listed in Google Scholar, so citation - Numbers not accessible[b]	Involved a cohort in a community setting
Sigurdardottir, 2015[79] c	No	Link to free version via Google Scholar if you know to search for the article	- Published in a non–massage-specific journal - Journal audience is those who have a patient, family, or community focus and promote an interdisciplinary team in research (*Scandinavian Journal of Caring Science*)	- Published in a peer-reviewed journal - Cited by 27[b]	
Weingarten, 2023[72] c	No	No	- Published in a non–massage-specific journal - Journal audience is the publication of research and information on all aspects of the problem of violence against women (*Violence Against Women*)	- Published in a peer-reviewed journal - Cited by 2[b]	
Wusler, 2023[71]	No	No	- Published as a thesis - Audience is people searching ProQuest	- Not published in a peer-reviewed journal - Cited by 1[b]	

Massage-specific database refers to a central search location for massage-related publications such as massage journal archives. This does not refer to journal databases such as PubMed.
Reach refers to the extent to which the publications might influence or are disseminated to various stakeholders including but also beyond the academic community and if the intervention had community reach e.g., community-based research projects prioritize reaching the communities they aim to serve.
[a]The first 10 pages of a Google Scholar search for "massage & abuse" or "massage & domestic violence".
[b]Source of citations is Google Scholar.
[c]Peer-reviewed publication.

Table 7. The JBI QARI Critical Appraisal Checklist for Text and Opinion Pieces

Text and Opinion Pieces Checklist							
Checklist Questions	*Benjamin, 1991*[70]	*Clark, 2017*[65]	*Finger, 2023*[66]	*Mines, 2001*[67]	*Page, 2017*[68]	*Razo, 2009*[46]	*Schlossberg, 2016*[69]
1. Is the source of the opinion clearly identified?	✓	✓	✓	✓	✓	✓	✓
2. Does the source of opinion have standing in the field of expertise?	✓	✓	✓	✓	Unclear	Unclear	Unclear
3. Are the interests of the relevant population the central focus of the opinion?	✓	✓	✓	✓	Unclear	✓	Unclear
4. Does the opinion demonstrate a logically defended argument to support the conclusions drawn?	✓	✓	✓	Unclear	Not applicable	✓	×
5. Is there reference to the extant literature?	✓	✓	×	Unclear	×	✓	×
6. Is any incongruence with the literature/sources logically defended?	Not applicable	Not applicable	Not applicable	×	Not applicable	✓	Not applicable

JBI = Joanna Briggs Institute; QARI = Qualitative Assessment and Review Instrument.

Table 8. The JBI QARI Critical Appraisal Checklist for Case Reports

Case Study Checklist			
Checklist Questions	*Ben-Shahar, 2002*[74]a	*Field, 1995*[82]a	*Price, 2002*[78]a
1. Were patient's demographic characteristics clearly described?	×	✓	✓
2. Was the patient's history clearly described and presented as a timeline?	×	×	×
3. Was the current clinical condition of the patient on presentation clearly described?	✓	✓	✓
4. Were diagnostic tests or assessment methods and the results clearly described?	Unclear	✓	✓
5. Was the intervention(s) or treatment procedure(s) clearly described?	×	✓	✓
6. Was the post-intervention clinical condition clearly described?	✓	✓	✓
7. Were adverse events (harms) or unanticipated events identified and described?	Unclear	×	✓
8. Does the case report provide takeaway lessons?	Unclear	✓	✓

JBI = Joanna Briggs Institute; QARI = Qualitative Assessment and Review Instrument.
[a]Peer-reviewed publication.

concealment or blinding, increasing the risk of bias. The reporting of trade publications and educational resources was the most variable with several opinion pieces lacking a clear rationale for the author's expertise or failure to reference existing literature. While the case reports often omitted essential clinical details such as clearly described or presented patient's history timelines which reduced their interpretability and reproducibility, this might reflect the standards for reporting case reports at the time as all were published over 23 years ago.

DISCUSSION

The aim of this scoping review was to explore the massage and research lit-

Table 9. The JBI QARI Critical Appraisal Checklist

Case Series Checklist		
Checklist Questions	*Price, 2004*[(80)a]	*Price, 2007*[(81)a]
1. Were there clear criteria for inclusion in the case series?	✓	✓
2. Was the condition measured in a standard, reliable way for all participants included in the case series?	✓	✓
3. Were valid methods used for identification of the condition for all participants included in the case series?	✓	✓
4. Did the case series have consecutive inclusion of participants?	✓	✓
5. Did the case series have complete inclusion of participants?	✓	✓
6. Was there clear reporting of the demographics of the participants in the study?	✓	✓
7. Was there clear reporting of clinical information of the participants?	✓	✓
8. Were the outcomes or follow-up results of cases clearly reported?	✓	✓
9. Was there clear reporting of the presenting site(s)/clinic(s) demographic information?	Not applicable	Not applicable
10. Was statistical analysis appropriate?	✓	✓

JBI = Joanna Briggs Institute; QARI = Qualitative Assessment and Review Instrument.
[a]Indicates peer-reviewed paper.

Table 10. The JBI QARI Critical Appraisal Checklist for Prevalence Studies/Surveys

Prevalence Study/Survey Checklist			
Checklist Questions	*Fogarty, 2024*[(49)a]	*Fogarty, 2025*[(64)a]	*Weingarten, 2023*[(72)a]
1. Was the sample frame appropriate to address the target population?	✓	✓	✓
2. Were study participants sampled in an appropriate way?	✓	✓	✓
3. Was the sample size adequate?	✓	✓	✓
4. Were the study subjects and the setting described in detail?	✓	✓	✓
5. Was the data analysis conducted with sufficient coverage of the identified sample?	✓	✓	✓
6. Were valid methods used for the identification of the condition? Defended?	✓	✓	✓
7. Was the condition measured in a standard, reliable way for all participants?	✓	✓	✓
8. Was there appropriate statistical analysis?	✓	✓	✓
9. Was the response rate adequate, and if not, was the low response rate managed appropriately?	✓	✓	✓

JBI = Joanna Briggs Institute; QARI = Qualitative Assessment and Review Instrument.
[a]Peer-reviewed publication.

erature that reports on the mental health impact of massage for survivors of and those experiencing DFV and/or SA. The review demonstrated multiple psychological benefits of massage with most of the interventional benefits coming from SA research.[(34,35,70,71,73–76,78,79,83,84)] The review also found that the majority of publications presented mental health improvements as the predominant impact of massage therapy on individuals who had experienced DFV/SA.

The review highlighted a major void in the interventional research on massage

TABLE 11. The JBI QARI Critical Appraisal Checklist for Qualitative Studies/Projects

Qualitative Checklist					
Checklist Questions	*Campbell, 2015*[83]	*Klein, 2010*[50]	*Powell, 2010*[77]a	*Sigurdardottir, 2015*[79]a	*Wusler, 2023*[71]
1. Is there congruity between the stated philosophical perspective and the research methodology?	✓	×	✓	✓	✓
2. Is there congruity between the research methodology and the research question or objectives?	✓	×	✓	✓	✓
3. Is there congruity between the research methodology and the methods used to collect data?	✓	✓	✓	✓	✓
4. Is there congruity between the research methodology and the representation and analysis of data?	✓	✓	✓	✓	✓
5. Is there congruity between the research methodology and the interpretation of results?	✓	✓	✓	✓	✓
6. Is there a statement locating the researcher culturally or theoretically?	✓	✓	✓	×	×
7. Is the influence of the researcher on the research, and vice versa, addressed?	×	×	✓	×	×
8. Are participants, and their voices, adequately represented?	✓	✓	✓	✓	✓
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	✓	Unclear	✓	✓	Unclear
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	✓	✓	✓	✓	✓

JBI = Joanna Briggs Institute; QARI = Qualitative Assessment and Review Instrument.
[a]Peer-reviewed publication.

TABLE 12. The JBI QARI Critical Appraisal Checklist Quasi-Experimental Study

Quasi-Experimental Study Checklist	
Checklist Questions	*Denman, 1984*[79]
1. Is it clear in the study what is the "cause" and what is the "effect" (i.e., there is no confusion about which variable comes first)?	✓
2. Was there a control group?	✓
3. Were participants included in any comparisons similar?	✓
4. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	✓
5. Were there multiple measurements of the outcome, both pre and post the intervention/exposure?	✓
6. Were the outcomes of participants included in any comparisons measured in the same way?	✓
7. Were outcomes measured in a reliable way?	×
8. Was follow-up complete and if not, were differences between groups in terms of their follow-up adequately described and analyzed?	Unclear
9. Was appropriate statistical analysis used?	✓

JBI = Joanna Briggs Institute; QARI = Qualitative Assessment and Review Instrument.

TABLE 13. The JBI QARI Critical Appraisal Checklist for RCTs

Randomized Controlled Trial Checklist			
Checklist Questions	*Field, 1997*[(35)a]	*Price, 2005*[(34)a]	*Price, 2006*[(75)a]
1. Was true randomization used for assignment of participants to treatment groups?	✓	✓	Unclear
2. Was allocation to treatment groups concealed?	Unclear	Unclear	Unclear
3. Were treatment groups similar at the baseline?	✓	✓	✓
4. Were participants blind to treatment assignment?	×	×	×
5. Were those delivering the treatment blind to treatment assignment?	×	×	×
6. Were treatment groups treated identically other than the intervention of interest?	Unclear	✓	Unclear
7. Were outcome assessors blind to treatment assignment?	Unclear	Unclear	Unclear
8. Were outcomes measured in the same way for treatment groups?	✓	✓	✓
9. Were outcomes measured in a reliable way?	✓	✓	✓
10. Was follow-up complete and, if not, were differences between groups in terms of their follow-up adequately described and analyzed?	×	✓	✓
11. Were participants analyzed in the groups to which they were randomized?	Unclear	✓	Unclear
12. Was appropriate statistical analysis used?	✓	✓	✓
13. Was the trial design appropriate and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?	✓	✓	✓

JBI = Joanna Briggs Institute; QARI = Qualitative Assessment and Review Instrument; RCTs = randomized controlled trials.
[a]Peer-reviewed publication.

with no interventional study focusing on DFV and massage solely despite anecdotal evidence of benefit. This void in research on the role of massage in care for individuals experiencing DFV is important as it is unknown if massage has the same mental health effects on individuals who have experienced nonsexual forms of DFV as it does with those who have experienced SA. Research on the impact of massage, especially mental health impacts, for individuals who have experienced DFV is needed. Additionally, physical injuries, both acute and chronic, can be a consequence of DFV and future research could explore the role of massage in assisting with the management of both acute and chronic DFV-related injuries and the mental health sequelae of these physical injuries.

Many of the interventional studies and the trade publications provided or discussed massage within the context of other supports, with one of the requirements for participating in research studies being regular visits with a psychologist or counselor or providing the massage intervention alongside psychological or other "holistic" care. This integrated care approach was common and thus may potentially be ideal in a clinical practice setting; however, as highlighted by Fogarty et al. (2024 and 2025), many massage therapists do not feel resourced to support individuals experiencing DFV or with a history of DFV. Ensuring that massage therapists have the knowledge, awareness, and networks to encourage an integrated care approach is vital in the provision of best practice care. Additionally, Price raised the idea that the research study and the study setting itself could have fostered a feeling of safety and trust which contributed to the effects of massage.[(34)] Finding a way that massage therapists in clinical practice can replicate that feeling of safety and trust purported to be established in research environments is important as it is unclear what role massage can play in a clinical setting with no other forms of support. Accreditation or recognition for massage

TABLE 14. Mixed Methods Appraisal Tool (MMAT)

Mixed Methods Checklist		
Checklist Questions	*Collinge, 2005*[76]a	*Hixson, 2006*[73]
S1. Are there clear research questions?	✓	Unclear
S2. Do the collected data allow to address the research questions?	✓	✓
Qualitative 1.1. Is the qualitative approach appropriate to answer the research question?	✓	✓
Qualitative 1.2. Are the qualitative data collection methods adequate to address the research question?	✓	✓
Qualitative 1.3. Are the findings adequately derived from the data?	✓	×
Qualitative 1.4. Is the interpretation of results sufficiently substantiated by data?	×	×
Qualitative 1.5. Is there coherence between qualitative data sources, collection, analysis, and interpretation?	×	✓
Quantitative descriptive 4.1. Is the sampling strategy relevant to address the research question?	✓	✓
Quantitative descriptive 4.2. Is the sample representative of the target population?	✓	✓
Quantitative descriptive 4.3. Are the measurements appropriate?	✓	✓
Quantitative descriptive 4.4. Is the risk of nonresponse bias low?	✓	✓
Quantitative descriptive 4.5. Is the statistical analysis appropriate to answer the research question?	✓	✓
Mixed methods 5.1. Is there an adequate rationale for using a mixed-methods design to address the research question?	✓	✓
Mixed methods 5.2. Are the different components of the study effectively integrated to answer the research question?	×	×
Mixed methods 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	✓	✓
Mixed methods 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	N/A	✓
Mixed methods 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	✓	✓

[a]Peer-reviewed publication.

therapists who have experience or additional training in DFV/SA is one potential way that massage consumers might feel the sense of safety and trust purported to be established in research environments.

The scoping review found an interesting juxtaposition between the experiences where massage was applied without knowing if an individual had experienced DFV/SA such as women who self-sought massage as consumers[73] or massage was provided in a learning environment such as a massage classroom[50] and research studies which actively recruited individuals with a history of DFV/SA. The studies recruiting participants with a history of DFV/SA reported predominantly positive findings, whereas the projects surveying individuals where a history of DFV/SA was unknown at the time of the massage treatment reported more mixed findings indicating that massage, while beneficial, could also be triggering.[50,73] Not knowing if a client has a history of DFV/SA or is currently experiencing DFV/SA is probably the norm for massage therapy providers.[47] Whether massage therapists should ask about DFV or SA during consultations is a complex and context-dependent issue.[64] While massage therapists are not typically trained or mandated to screen for DFV, they often work in close, trusting relationships with clients, which may create opportunities for disclosure.[85] Talking a trauma-informed approach focused on creating safety, choice, collaboration, and empowerment[86] for every client, regardless of DFV/SA history, may be more appropriate in therapeutic massage settings than asking specifically about DFV/SA. Massage therapists might choose to undertake

trauma-informed training to upskill in this area. Future research into massage and DFV/SA should highlight any massage trauma-informed care training and document any triggers.

A number of reporting issues were highlighted with not many of the studies providing information on the time since the abuse, varied reporting of the massage techniques or styles used, and not many studies reporting on side effects, both mental and physical, from the massage. This makes replication of the massage in a clinical setting difficult. Reporting on current abuse or time since the abuse would allow for a clearer picture of the role massage can play at different time points of an abuse journey and highlight if massage provides different benefits or effects at different time points. This information could help clinicians, other health-care providers, and domestic violence support services to ensure safe provision of massage, provide more informed expectations of potential massage effects, and inform non-hands-on massage care such as education and appropriate referrals at specific time points. More research on massage effects at different time points of abuse is warranted.

The reach findings suggest a mixed impact in terms of accessibility and influence of publications related to massage and DFV and SA. While most publications (73.1%) were discoverable via Google Scholar, the lack of free access to all publications means that key stakeholders, such as consumers, health-care providers, massage therapists, and policy makers, may not have unrestricted access to the full body of available evidence. Encouragingly, the majority of interventional peer-reviewed papers were open access, increasing the likelihood that consumers seeking information on massage and DFV/SA can access relevant findings. However, most peer-reviewed publications did not include a plain language or lay summary of key findings and implications, which likely limits their usefulness for consumers with varying levels of health literacy and scientific background. While publication in both trade and academic outlets reflects an effort to reach diverse audiences, these results highlight the need for greater emphasis on open access publishing and the inclusion of accessible summaries to enhance community reach and the practical impact of research in this field.

A mixed standard of methodological quality and reporting was reported after completing the critical appraisal of publications. However, given the breadth of years that publications for this review were sought, it is not surprising that the reporting varied. Articles covered a 41-year time period where there were many different reporting standards and conventions. For example, the CONSORT (CONsolidated Standards Of Reporting Trials) statement was published in 1996[87] and the American Psychological Association (APA) only started a formal process of developing reporting standards in 2006.[88] Thus, any publications prior to these dates would not have the same reporting expectations or standards as those published after these dates. The quality of reporting of research studies is continually evolving, for example, scholars have recently identified that many current critical assessment tools fail to address cultural rigor in their tools.[89] Strengthening future research through clearer reporting, adherence to current standardized appraisal criteria, and inclusion of lived experience perspectives will enhance the trustworthiness, relevance, and impact of massage for individuals who have experienced DFV/SA.

An area for development is the theoretical grounding of massage in the context of DFV/SA. Compared to the more nuanced and well-articulated theoretical frameworks in SA publications, the DFV literature, particularly some of the trade publications, relied on vague, unreferenced claims such as massage's ability to "heal inside and out,"[69] or promote "cellular transformation"[46] without citing evidence or theory. No clear principles were offered to explain how massage might support DFV survivors. In contrast, SA studies presented more robust frameworks, including bottom-up trauma approaches,[77] the mind–body connection,[75] the role of massage in enhancing self-care,[34,84] and reconnection with the body to assist with dissociation.[81] These theoretical perspectives support claims that massage may help survivors increase body awareness, a sense of safety, and self-regulation, and serve as a complementary modality to psychotherapy. The development and articulation of theoretical underpinnings are essential to future DFV research to guide research design, interpretation of findings, and application to practice.

Strengths and Limitations

This review expands on the impact of massage for survivors of DFV and/or SA. The differing nomenclature of abuse, such as DFV, intimate partner violence, and SA, makes it difficult to synthesize results/findings. Some relevant publications may not have been included due to the exclusion of publications published in a language other than English. The majority of the interventional studies explored massage and SA, and as such the benefits of massage for individuals with a history of SA is over-represented in this review. This may impact the generalizability of the findings and thus may not be applicable to all individuals who have experienced DFV. Findings in this review may not be transferable for massage to treat sequelae from other forms of violence and SA within the sex worker context due to the scope of this review. There is limited geographic diversity within the publications with most publications from the United States, and this limits generalizability of the findings. Very few studies investigated massage in clinical practice and thus our findings might not reflect what is happening in clinical practice for massage therapists.

CONCLUSION

The positive mental health impacts and experiences of massage for individuals with a history of DFV/SA were commonly reported in all included publications. There was a lack of research evidence for the impact of massage for individuals with a current history of DFV and a lack of evidence of impact of massage in clinical practice for individuals with any history of DFV/SA. The practice- and evidence-based recommendations might provide some interim information for massage therapists until massage therapy- and DFV/SA-specific guidelines can be developed. While the gaps in research are glaring, the findings gathered so far warrant increased attention particularly to the mental health aspect of massage and DFV/SA. There is potential that massage and massage therapy may be a useful tool in aiding survivors' recovery, if administered expertly and with the knowledge and understanding of DFV/SA and trauma, and given the epidemic status of violence occurrence rates, all potential forms of care must be entertained. Future research into massage effectiveness for DFV is needed.

CONFLICT OF INTEREST NOTIFICATION

Both authors are practicing massage therapists.

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Corresponding author: Selina DiPronio, Pacific College of Health and Science, 110 William St FL 19, New York, NY 10038, USA
E-mail: selina.dipronio@gmail.com