

# Recovering Body and Soul: How Massage Therapy Can Help People with PTSD

*By Pamela Fitch and Trish Dryden*

*Published, Massage Therapy Journal, Spring, 2000*

## THE EXPERIENCE OF TRAUMA

Traumatic events happen daily in our society: fire, earthquake, bombing, and hurricane. These often devastating circumstances may cause an acute reaction of fear and terror for individuals who experience them. War, rape, physical assault or abuse, either as a child or as an adult, carries equally frightening results. Post Traumatic Stress Disorder (PTSD) occurs when traumatized individuals cannot safely assign to the past what has happened in their life. The experience of trauma undermines one's expectations of safety and security in the world. Traumatized individuals continue to be aware of what we all know to be true but tend to keep hidden from our consciousness; namely, that bad things can happen to good people, that life is fragile and can be gone or forever changed in an instant, and that our expectation of control in the world is often an illusion.

The majority of individuals who experience severe trauma develop acute, short term symptoms such as sleep disturbances and physical pain, as they struggle to make sense of what has happened to them. Unfortunately, some people develop chronic symptoms related to their experience of trauma. It is these individuals who present significant challenges to our skills and knowledge in the massage therapy treatment room. In this article we will examine the signs and symptoms of chronic PTSD. These symptoms cross physical, emotional and spiritual boundaries and have a neurobiological basis.

It is important for massage therapists to understand the neurobiology of trauma, as well as the risks and benefits that massage therapy treatment offers to clients with PTSD. Many clients have traumatic histories and exhibit the signs and symptoms of PTSD, whether or not the massage therapist is aware. In a National Comorbidity Survey of over 8000 subjects, Kessler et al found that 6.5% of the subjects studied had a lifetime prevalence of PTSD and another 2.8% had a 30 day prevalence of PTSD. Women had twice the risk of men in developing PTSD and those with PTSD were at increased risk of developing other psychiatric disorders, such as anxiety and mood disorders. (Alexander C. MacFarlane and Giovanni De Girolamo "The Nature of Traumatic Stressors and the Epidemiology of Posttraumatic Reactions" in van der Kolk's Traumatic Stress, 1996, p.141) Given that approximately 75% of massage therapy clients are women, (Collis and Read, 1998) and given that a large majority come into massage therapy treatment for what is generally described as "stress", the percentage of clients presenting with PTSD may likely be much higher than the 9.3% suggested by these figures.

McCann and Pearlman (1990) postulate that the experience of trauma undermines 5 basic human needs:

1. *The need to be safe*
2. *The need to trust*
3. *The need to feel some control over one's life*
4. *The need to feel of value*

### 5. *The need to feel close to others*

Nowhere is this more evident than in the extraordinarily intimate surroundings of the massage therapy treatment room. Clients who, from time to time, experience emotional reactions to being touched, often respond to simple human soothing. Crying, being held, being reassured by the massage therapist - “there, there - it’s over now, you are safe with me” most often brings the client back from the terror of remembered trauma and sadness to present reality. The world and the massage proceed as before. Yet those who have experienced a deeply traumatic event may not be so easily soothed by simple words or touch. For some people, the trauma continues to live on in their body and spirit, as if it were still happening in the here and now. Soothing seems hollow, not to be trusted. The loss of confidence in their body’s ability to keep them safe is experienced as the ultimate betrayal of all that they have come to know and trust about the world and other people. The longing for safety remains, but it is buried very deeply under the guard of perpetual mistrust and fear.

## **Clinical Definition of PTSD: Criteria for Post Traumatic Stress Disorder**

The following criteria are taken from the Diagnostic and Statistical Manual of Mental Disorders (DSM IV)

According to the definition of PTSD in the DSM IV, a client must meet the following criteria:

**Criterion A:** has been exposed to a traumatic event involving actual or threatened death or injury, during which the individual responded with panic, horror and feelings of helplessness.

**Criterion B:** re-experiences the trauma in the form of dreams, flashbacks, intrusive memories, or unrest at being in situations that reminds the individual of the original trauma.

**Criterion C:** shows evidence of avoidance behavior – a numbing of emotions and reduced interest in others and the outside world.

**Criterion D:** experiences physiological hyperarousal, as evidenced by insomnia, agitation, irritability, or outbursts of rage.

**Criterion E:** the symptoms in Criteria B, C, and D persist for at least one month.

**Criterion F:** the symptoms have significantly affected the person’s social or vocational abilities or other important areas of life.

PTSD may be either acute or delayed in onset. Acute PTSD occurs within 6 months of a traumatic event. Delayed onset may occur anytime later than six months after the traumatic event. This may be 1 year, 20 years or even 40 years after the event.

## **Signs and Symptoms of PTSD:**

In addition to a history of trauma, there are certain signs and symptoms to watch for when assessing a client for PTSD. Singly, the symptoms are not diagnostic but when observed as a cluster of signs and symptoms, the therapist should consider the possibility of PTSD.

1. Hypervigilance (wariness of others) and hyperarousal (fight or flight response)
2. Emotional absence and/or unresponsiveness
3. Avoidance of triggers that remind them of the trauma
4. Dreams, nightmares, insomnia
5. Difficulty in concentration
6. Irritability or outbursts of anger
7. Depression
8. Suicidal thoughts, gestures or self destructive behavior
9. Exaggerated startle response or extreme ticklishness
10. Numbness or hypersensitivity to touch over parts or all of the body
11. Overwhelming feelings of anger, sadness, fear, despair, shame, guilt or self-hatred
12. Migrating symptoms of physical pain

13. Migraines, fibromyalgia, extreme myofascial tension
14. Dissociation from self, actions or parts of the body
15. Loss of connection with spiritual aspects of life or the ability to imagine a positive future
16. Distorted relations with the perpetrator or others who remind them of the perpetrator

Massage therapists should be aware that there are many clients who may have experienced significant trauma but whose symptoms will appear more consistent with depression. For a concise description and delineation of responses other than PTSD to trauma, refer to *Trauma and Recovery* (1992) by Dr. Judith Herman. As with all medical and psychiatric conditions, it is extremely important that the client be diagnosed by an appropriate healthcare practitioner. Massage therapists are advised to develop a reliable list of practitioners to whom they can refer clients for diagnosis and with whom they can work to coordinate an effective multidisciplinary, client-centered treatment plan.

## The Neurobiology of Trauma

Individuals experience traumatic events differently. For example, one individual who experiences being mugged at knife point, may respond in the moment by complying with the mugger by handing over her wallet while internally she is memorizing the mugger's face. She thinks to herself that when she gets out of this situation she will go to the police station, identify the perpetrator and have him charged. Another individual may become frozen with fear and go to a place inside herself that is often described as a place of "speechless terror". She cannot communicate rationally with herself, or reassure herself about a course of action she will take in the future. At the time of the traumatic event she is convinced that she will die.

How individuals respond to traumatic events may partially come down to the differences between how individuals process information and feeling. Those individuals who are able to keep talking to themselves while a traumatic event is occurring and who keep planning for a possible future are engaging the left side of their brain. These persons process sequentially and logically. They still feel intense fear, but their left-brain approach to understanding prevents them from being over-ridden with terror. Those individuals who process from the right side of their brain, experience the world from a more sensory, emotion-laden place. They receive the whole image of the event all at once, with emotion, sensation and perception heightened. They cannot, in the instant of terror, manage a sequential understanding of the event, nor can they decide in a rational or logical manner what to do next in order to protect themselves. They no longer experience the world through the filters of their cerebral cortex and are entirely, at the moment of trauma, in the right side of the brain; in other words, in a place of "speechless terror". Individuals who experience "speechless terror" are far more likely to develop PTSD (van der Kolk & McFarlane, 1996).

The brain is exquisitely organized into three basic and highly interrelated parts and functions. The brainstem and hypothalamus monitor one's internal environment regulation and the fight or flight mechanisms. The limbic system balances the internal and external worlds and processes raw emotion. The neocortex analyzes and problem solves and is the part of the brain largely through which we interact with the external world. Together these parts of the brain coordinate the unconscious and conscious functions of feelings, thoughts, memories, communication and actions.

One of the functions of the limbic system, the centre of emotions, is to store fear-based experiences. Rapid and accurate access to experiences of fear and its associations is highly necessary for survival. For example, if a man walks down a forest path and sees a long cylindrical object lying across the path, he may gasp, stop quickly, or run away. The reaction to the object happens before the neocortex gives any information about what that object might be.

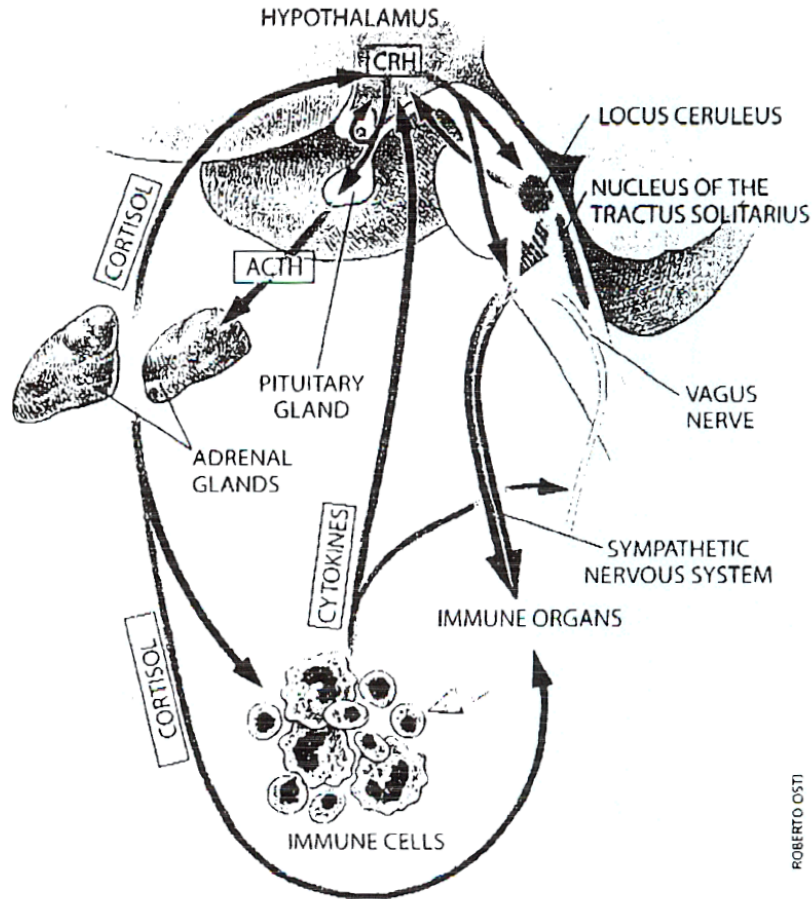
Part of the limbic system, the amygdala, located in the right side of the brain, records fearful experiences and feelings in intense sensory detail, and alerts the man to the possibility of the object being a snake, long before the word snake occurs to him in his left-sided cortex. The amygdala also sends messages to the hypothalamus to activate the HPA axis, the fight or flight mechanisms, so that he will stop, look and get ready to run if necessary before even knowing what the object is.

The hypothalamus-pituitary-adrenal axis is triggered by fear (among other emotions):  
*(diagram attached – taken from Scientific American (ref. to follow if you choose to use this one))*

1. Hypothalamus secretes CRH (corticotropin releasing hormone)
2. CRH activates the pituitary gland to release ACTH (adrenocorticotrophic hormone)
3. ACTH activates the adrenal glands to release cortisol
4. Cortisol stimulates the heart, brain, and skeletal muscle etc. for the fight or flight response
5. Cortisol suppresses the immune system
6. The presence of cortisol in the blood eventually signals the hypothalamus to stop secreting CRH and the HPA axis slows.

(see diagram below)

## Interaction of the Brain and Immune System



Under ordinary circumstances, the presence of high levels of cortisol in the blood stream as an indicator of stress, will activate the process of *homeostasis* in the body. From the Greek meaning “to keep things the same”, homeostasis is a complex process wherein the body maintains a finely tuned balance between all systems that a human being needs to survive. After the danger (real, perceived, external or internal) has passed, our neurohormonal system will right itself. However, for persons who experience PTSD, their neurohormonal systems are often stuck in the fight or flight mode, remaining hypervigilant or hyperalert. Clinically high levels of cortisol and norepinephrine result in hypervigilance – relational wariness, and

neural hyper-reactivity. Another way that this break in the neurohormonal cycle manifests is as a cortisol and norepinephrine burnout. In this type of stress hormone burnout, clients may experience numbness in parts of their bodies, lethargy, and depression. PTSD clients may present with one or both of these conditions.

PTSD has been described as the failure of time to heal all wounds, because the experience of trauma, for some individuals, is encoded entirely in the amygdala without reference to time and space. The cerebral cortex, which helps to shut off the floods or cascades of hormones, cannot be accessed. For people with PTSD, flashbacks of the traumatic experience occur when the flood gates of the amygdala are triggered open. The sights, sounds, smells and feelings of the trauma return unexpectedly and intrusively, causing the person to re-experience aspects of the original trauma as if it were happening in the here and now.

For example, a woman survives a severe car accident that occurs during a severe storm. She develops intrusive flashbacks of the pressure of the seatbelt on her chest at the time of the accident, symptoms which have persisted long after the physiological damage to her chest muscles has healed. She comes to massage therapy complaining of chest pain for which she has no clear explanation. She is also baffled by the fact that the chest pain gets worse when it rains. At the time of the accident it was raining heavily. The intense fear and pain experienced and encoded in the amygdala was encoded with the accompanying sensory awareness of rain. Like any other form of conditioned response, now when the client is triggered by a sensory stimulation that reminds her of the car accident (however subtly and unconsciously) she gets chest pain, especially when it rains. In addition, at the moment she is flooded with the memory, she re-experiences many of the sensations that occurred during the accident: sweating, racing heart, intense fear, shallow breathing. This woman may now actively find ways to avoid stimulus that triggers these floods of stress hormones, such as staying indoors when it rains, or developing numbing strategies such as narcotics or alcohol abuse. It is not uncommon for individuals with PTSD, to develop addictions to alcohol or drugs, to work extremely long hours or find other ways to reduce or ignore the unwanted and frightening sensations.

Bessel van der Kolk (1996) refers to the normal neural encoding of experiences as *narrative memory* (located in space and time, without the intrusive neurohormonal cascade) and the kind of memory that people with PTSD suffer from as *traumatic memory*. He theorizes that the fundamental task of therapy – whether it is psychotherapy or massage therapy, is to help clients regain a sense of safety in their bodies, free of the flooding of stress hormones. Perhaps Freud was right when he said that the task of therapy is to transform extraordinary unhappiness into ordinary unhappiness.

In talk therapy or psychotherapy, intrusive neural symptoms are transformed, in the context of a safe, boundaried, therapeutic relationship. By encouraging the client to talk about the traumatic event, the unpleasant memories get re-encoded from traumatic memory into narrative memory. In other words, people learn to use their left brains (cortex) to co-ordinate their right-brained feelings. This prevents the discharge of stress hormone discharge from the amygdala. Once talk therapy has helped the client establish some degree of narrative memory and experience of safety, clients may face intrusive body sensations with a massage therapist. Massage therapy can help clients to reframe their experience of trauma from a kinesthetic perspective.

Serotonin, along with the body's natural painkillers or opiates, is naturally produced in the anatomical bridge between the right and left hemispheres of the brain - the corpus collosum. Since PTSD clients cannot easily access the serotonin needed to soothe the fight or flight response, the use of medications such as Prozac, Zoloft and Paxil – the SSRIs (selective serotonin reuptake inhibitors) are often used to help create or coordinate a chemical bridge between the left and right hemispheres of the brain. Some clients may, with therapy, be able to enhance their bodies' serotonin pump. Other clients who have severe PTSD, may require SSRI medication on an ongoing basis in order to balance their reactions to general life stressors. We believe that massage therapy, in the hands of a skilled practitioner, can also aid in the coordination between the left and right hemispheres of the brain thereby reducing intrusive symptoms and in the creation of self-soothing strategies for clients with PTSD.

## **The Benefits of Touch: Physiological, Social and Developmental**

Massage therapy can inadvertently trigger traumatic memory, but as massage therapists know, it can also be a powerful tool for healing and growth. For example, it has been well documented that touch stimulation is essential for babies to thrive. The results of the Field research on pre-term infants is most compelling, where each was given 15 minute massages three times a day for 10 days while still in incubators (Field et al, 1986; Scafidi et al., 1990). The treated infants gained 47% more weight and were hospitalized for 6 days less. They performed better on the Brazelton Neonatal Behavior Assessment Scale (Brazelton, 1973). The babies averaged 12 points higher on the mental scale and 13 points higher on the motor scale than the control group. In another experiment (Brazelton, 1990) rat pups were stimulated with tiny wet paintbrushes, a procedure designed to mimic the licking that the mother does on her newly born litters. The rat pups, which were “licked” with the paintbrushes, thrived similarly to those which had received normal care by their mother. Those that received no stimulation became ill, bore small growth rates and failed in many instances to thrive. One may compare these findings with the reports of emaciated, touch-deprived infants found in Romanian orphanages after the overthrow of Ceaucescu. The Romanian orphans had difficulty relating to other humans, exhibited little or no language skills and showed little or no emotional response or affect. It is clear that healthy nurturance and loving touch is essential in order for human beings to develop and thrive.

### **How Does a Client with PTSD Respond to Massage Therapy?**

*“The modality of touch serves first to make human survival possible and then to make life meaningful.”*

Barnard & Brazelton (1990) **Touch the Foundation of Experience**

Many therapists express frustration with clients who are unable to receive the massage treatment and indeed, in some circumstances a powerful battle of wills ensues when the client appears to put up barriers against each effort of the therapist to encourage the client’s relaxation. Experience shows that if a therapist demonstrates close attention, acknowledgement and respect for such survival mechanisms, the client will eventually come to trust the process of massage as a safe way to receive the soothing so deeply craved. With soothing comes a thawing from longstanding fear and the opportunity to re-acquaint the client with normal body signals.

In the ordinary course of events, massage therapy can offer a profound sense of peace to those who are able to feel strong enough at their core to let go and relax. For those who carry the effects of trauma however, the world does not feel safe and they cannot trust their bodies to give them the appropriate signals of safety. Alarm bells are always ringing from the flooding of stress hormones and they remain on full alert or alternate between numbness and hypervigilance.

If the trauma relates to sexual abuse, the intimacy of the massage treatment room may increase their sense of fear and touch of any kind may trigger memory of both desired and unwanted information. One way individuals manage to live with the memory of a traumatic event is to simply not think about it, to deny its existence or at the very least, never to allow themselves to consciously dwell on the horrible event. So for a client who may not think too much about *what really happened*, but who is plagued by extraordinary levels of tension, the touch of the therapist may open the floodgates of sensation which the client had carefully kept closed in order to avoid reliving the traumatic memory. If traumatic memory, stored in the amygdala of the limbic system, is triggered, then flashbacks, speechless terror, numbing, hyperarousal and/or dissociation may result. For therapists who do not expect such occurrences or who are unaware of the signs and symptoms of PTSD, this may be alarming and frightening to witness.

If clients were coddled, held, stroked and massaged in a boundaried and sensitive way as babies and small children, chances are that they have grown up with a strong sense of self and safety in the world. If, on the other hand, touch had been forbidden or abusive, laced with malevolence or manipulation, they may not have developed ways of appreciating healthy, boundaried and safe touch. A person’s frame of reference with respect to touch history may dictate how that individual will respond to touch as an adult.

When clients lay on a massage table, without clothes and between two sheets, the very act of lying down nude may evoke sensorial and historic responses that are deeply attached to how they perceive themselves

in the world. If gentle touch was historically associated with a subsequent beating or assault, then the gentle touch of a massage therapist may have surprising and unpleasant associations for the client. If, in addition, the client was constantly criticized for the size and shape of her body, she may feel a deep sense of shame, disgust and vulnerability at exposing herself to the massage therapist.

Massage therapists may feel frustrated at the non-compliance of clients and their seeming inability to allow the therapist to work deeply when trying to alleviate tension and muscle pain. A more helpful approach may be to look more closely at the reactions of clients, observing these reactions as the client's courageous efforts to keep themselves together in the face of overwhelming fear. By consciously working with a client's strengths and repeatedly offering her the opportunity to experience her body in the present in a respectful, nonjudgmental environment, a massage therapist can assist a client to "climb back into herself", putting the memory of trauma in context and living more fully in the present.

## **Treatment Considerations for Clients with PTSD**

*"Treatment of PTSD needs to address the twin issues of helping patients*

1. *Regain a sense of safety in their bodies*
2. *Complete the unfinished past.*

*It is likely, though not proven, that attention to these two elements of treatment will alleviate most traumatic sequelae."*

Bessel van der Kolk, 1996, **Traumatic Stress**

Establishing trust is essential when working with clients with PTSD. In order to treat a client with PTSD successfully, the massage therapist must understand the nature and essence of the therapeutic relationship and behave at all times in a trustworthy manner. It is the therapist's role to create a safe place in which the client may regain confidence in her self and in her body.

The overall goal in the massage therapy treatment of PTSD, is to help the client to become safely "embodied within the self". Massage therapists can teach clients safe and effective ways of self-soothing and stress management. People who have been traumatized are no longer at home in their bodies. Talk therapy alone does not always adequately address the fear and mistrust that has been encoded into their bodies. In a multidisciplinary context, massage therapy can help bring clients back into themselves, by increasing their ability to feel safety and mastery in the world, to be freely curious without fear, to feel comfortable with their body and to experience boundaried intimacy with another human being.

Philosophically, engaging in massage therapy represents a commitment to wellness on the part of the client and the therapist. It is a caring, safe way for individuals to experience touch and receive release from pain. It offers intimacy that is non-sexual, thereby providing an opportunity for clients who are fearful of intimacy, to experience it safely. Massage therapy communicates support, acceptance, positive regard and pleasure, through the modality of the therapist's hands and it empowers the client to take charge of how she wants her body to be touched. Respectful touch can be healing. Massage therapists offer a safe place to clients who in turn may learn to trust that touch does not have to be associated with pain, fear or anger.

In a healthy therapeutic massage therapy relationship, the client participates in creating accomplishable treatment plans. Decisions for her care are widely discussed and the process is one of consensus and cooperation. This approach is critical for the successful treatment of clients with PTSD. A client with PTSD needs safety to be paramount and to know unequivocally that she may stop, change or modify a treatment at any time. By giving the client a choice over how she wants her body to be touched, the client with PTSD discovers in both a kinesthetic and cognitive way that the trauma is in the past and that here, in the present, she is in charge.

## **Intention**

Intention is the term used to describe the therapist's purpose and intent under any given circumstance during treatment. It is always the therapist's intent to do no harm but unless she is aware of the potential traps and pitfalls of the therapeutic process, she may do harm unintentionally. It is imperative that she consider exactly how far she is willing to journey with each client, to assess her level of commitment and to know what her boundaries are before embarking on any therapeutic relationship. Devastating consequences may arise for the client if a therapist discovers once therapy has begun, that she is unwilling, unable or too inexperienced to complete the work with a client. A therapist may have the capacity to be clear about such things without the aid of supervision but most therapists benefit from consulting a more experienced therapist or seeking peer supervision in order to remain clear about their intent, including unconscious material that may surface for the therapist during treatment.

There are no specific physical manipulation techniques for working with trauma clients. Swedish massage can be as effective and enlightening to a client as the most advanced fascial mobilization. The technique is far less important than the therapist's intention. For the sake of both the client and therapist, it is imperative for the massage therapist to know at all times what her role is and what her intention is in the therapeutic process.

The massage therapist takes the role of listener, teacher, coach and surrogate caregiver. She will likely play an exceptionally important role in the life of the client. Occasionally, a client will want the massage therapist to respond in ways that would be counterproductive to the therapy. She may desire "friendship" or access to the therapist outside clinic hours. The client may test the established boundaries of the therapeutic encounter by asking for more intimate touch than is appropriate. The responsibility for clarity, intention and understanding of therapeutic role is not to be taken lightly and is always the responsibility of the therapist.

### **The Treatment Continuum**

(diagram)

#### **Treatment Continuum**

##### **Therapeutic Process**

Building the safe container (beginning)	Exploration of sensation (middle)	Closing the container (ending)
--	--------------------------------------	-----------------------------------

##### **Timing**

1-15 minutes	15-45 minutes	Last 15 minutes
1-9 months	3-12 months	1-4 months

##### **Degree of Connectedness**

Dependency	Interdependency and mutuality	Autonomy and Empowerment
------------	-------------------------------	--------------------------

(Fitch and Dryden, 1996)

Whether embarking on the first treatment, or considering how the overall treatment plan is going, it is essential for the massage therapist to be able to articulate to herself and to the client where in the treatment continuum she is. This helps to ensure the safety of the client, increases the effectiveness of the treatment and reduces the potential for conflict and inadvertent re-traumatization by the massage therapist.

Predictability and routine can be a great solace and comfort for clients with PTSD. It is important for the massage therapy treatment hour to include a well-understood beginning, middle and end. Beginnings and endings should have familiar, repetitious aspects that signal to the client where they are in the treatment hour. The beginning of the treatment hour establishes safety, boundaries and goals for the day. The middle

part of the treatment hour is primarily experiential and builds on the client's capacity to sustain safe touch. The ending of the clinic hour provides an opportunity for the client to articulate some of what has occurred during the treatment hour, to acknowledge what may need to be processed in her psychotherapy and to take home strategies for healthy self-care and self-soothing.

Likewise, the overall treatment plan follows a predictable course where there is a definitive beginning phase, an exploratory mid-phase and a concluding phase. Judith Hermann (1992) calls these stages "Safety, Remembrance and Mourning, and Reconnection". The initial stage of massage therapy treatment may take anywhere from one month to several months before the client feels genuinely safe in the treatment room. Emphasis at this stage of the treatment plan is on offering choices and establishing ways of contracting how the client wishes to be massaged. When she feels confident enough and ready for whatever sensory and emotional material may surface, the client generally expresses a wish to explore sensation in parts of her body that have previously not been touched or have been hypersensitive or numb during the massage.

The middle phase can be intense, sometimes emotionally painful and often liberating as the client receives validation from her body that she "hasn't made all of it up" and that she can experience her body as it really is in the here and now without being overwhelmed by sensations that originate in the past. It is extremely important to note that it is not the massage therapist's role to analyze or interpret what the client is saying or feeling. In massage therapy, clients may be very vulnerable to accepting the massage therapist's interpretations as literal truth. It is always the client's right to define for herself what she is experiencing. The massage therapist must remain in the role of compassionate witness and never suggest to clients literal explanations of their sensations and musings and experiences.

As treatment shifts to the final phase the therapist begins to notice subtle changes in the client's reactions to being touched. The client may begin talking about simple inconsequential things during the massage, such as what she is planning to have for dinner, that don't relate to the treatment. While she is being touched, she may talk about the ordinary events of her life and yet remain relaxed and present. There are no more "ghosts" of negative forces and people and events who hurt her in the past in the treatment room. The therapist should take this as a cue that the third phase has begun. Good closure is just as important for this client as is a good beginning. In the final phase, the client reviews what has happened over the course of therapy, embraces whatever changes the massage therapy has given, taking her learning out of the treatment room and into her everyday life – a life that is now more enhanced by the possibilities of a more embodied self.

Great care must be taken by the massage therapist during this stage, to abstain from overindulging herself by encouraging the client to stay on in therapy with her. For many clients, the massage therapist is a surrogate caregiver, a stand-in for those who didn't or couldn't protect her in the past. There is often a parent-child quality to the relationship. And as with all children, there comes a time when they must leave the nest and fly on their own. In many ways, the safe, bounded intimacy achieved with the massage therapist, is simply practice for clients in order to enhance their capacity to go back out into the "real" world and develop new and more satisfying relationships with friends and family. At this point, as throughout the treatment process, it is most helpful for the therapist if she has supervision, peer support and has committed herself to her own self-care.

## **Importance of Self-Care**

Self-care is one of the most important preservatives and strengtheners for those who work with clients who have experienced trauma. Without good self-care for the therapist, commitment and compassion weaken, interest wanes and integrity may be challenged. If the therapist is in an unhealthy frame of mind, a client with PTSD, potentially so attuned to the will and interest of others, will often perceive the shift immediately. Clients may then hide aspects of pain and confusion so as to protect the massage therapist, harkening back perhaps to earlier situations in their lives where their needs may have been distorted or ignored. The massage therapist can then be lulled into a false sense of comfort with the client.

It has been said many times that before one attempts to guide another, one should be very sure of one's own ability to tell up from down and left from right. A massage therapist who cannot budget adequate time for relaxation, rest and fun may be a poor example for a client who struggles with over commitment and poor self-care. It is not enough to say, "Do as I say, not do as I do". A massage therapist must model healthy choices regarding self-care. When the massage therapist lets the client know that she does not have to take care of the therapist, and that the therapist can genuinely take care of herself, a burden is lifted from the client. She may proceed with the work of healing herself and not having to worry about pleasing the massage therapist.

On the other hand, if a massage therapist suggests that she can take care of herself and then is discovered by the client, to be overly committed, exhausted and unable to concentrate, the client may become overly concerned to the detriment of the therapy, and her sense of the therapist' integrity will be shaken. "If I cannot trust my massage therapist to do what is necessary to take care of herself, then how will she take care of me and how will I ever learn to take care of myself".

Saakvitne and Pearlman (Transforming The Pain: a Workbook On Vicarious Traumatization,1996), eloquently outline the abc's of self-care as follows:

#### **"The ABC's of Self-Care**

##### **Awareness**

*Be attuned to one's needs, limits, emotions and resources. Heed all levels of awareness and sources of information, cognitive, intuitive and somatic. Practice mindfulness and acceptance.*

##### **Balance**

*Maintain balance among activities, especially work, play and rest. Inner balance allows attention to all aspects of oneself.*

##### **Connection**

*Connect to oneself, to others, and to something larger. Communication is part of connection and breaks the silence of unacknowledged pain. These connections offset isolation and increase validation and hope."*

### **Supervision and Peer Support**

In order to help ensure that the best interests of the client are always at the forefront of massage therapy, it is wise to engage in regular, ongoing supervision or peer support. Supervision describes the process where a massage therapist takes cases and questions to another, more experienced therapist for consultation. The consultation is confidential and usually focuses on the therapist's feelings and responses rather than the client's. It is a strong means of keeping the client's therapeutic process on track by gently and truthfully assessing the therapist's clinical decisions and intention. A good rule of thumb might be that if a massage therapist is uncomfortable describing to another therapist the events of a therapy session with her client, chances are she needs to do just that. Something may be happening which is outside the bounds of safe therapeutic interaction and needs attention and adjustment.

Peer support is another way to provide checks and balances to one's therapeutic approach. In peer support groups, two to six therapists agree to meet confidentially and to share the joys, burdens and confusions of their work with each other. This can be an immensely rewarding and enriching experience, which strengthens each therapist, challenges questionable practices and supports the difficult ethical dilemmas facing each therapist.

When the massage therapist has both professional support and a balanced personal life, the challenges of work are less likely to lead to professional burn-out. When she is confident and solidly based, then she can provide the necessary emotional shelter and support for her client. When the client feels the strength and support of the therapist, the client is able to make choices and question old beliefs in her own life. When the beliefs evolve into new ways of thinking and behaving, the client shifts towards more healthy choices and the wheel of the therapeutic process moves into a new and affirming dimension for the client.

## Conclusions

The experience of trauma assaults one's sense of safety in the world and can destroy one's ability to control what happens to oneself. Post Traumatic Stress Disorder, like a noxious presence, can demolish confidence, enhance shame and have terrible consequences on social relationships; yet it is considered to be one of the most treatable manifestations of psychic pain. The massage therapy treatment of PTSD must take into consideration the neurobiological consequences of the human experience of severe trauma. As massage therapists, we must offer choices in treatment, ways of being massaged, that help to restore safety and control.

This is client-centred care at its best. In the hands of a skilled therapist, massage therapy for clients with PTSD acknowledges and helps to restore the five most basic of human needs – the need for safety, trust, control, self-worth and intimacy. When the ability to satisfy these fundamental needs is damaged, an individual may be unable to function easily or happily in the world. When these needs are satisfied in the context of a healthy therapeutic relationship, an individual may not only survive but relearn or discover for the first time how to thrive. If a client with PTSD has the courage to transform her “speechless terror” into narrative memory, the traumatic memories become woven into the ordinary fabric of her life. When she is given the opportunity to learn to be touched safely and with compassion by another human being, she enhances her ability to reconnect with others in her real life and to rekindle her hope and belief in the future.

---

**Trish Dryden, M Ed, RMT** is a director and co-owner of the Sutherland-Chan School and Teaching Clinic and a professor in Applied Arts and Health Sciences at Centennial College in Toronto, Ontario, Canada. As a clinician, teacher, writer and researcher, her areas of specialization include health ethics and law, the helping relationship, and massage therapy treatment of PTSD. Trish received her massage therapy training from Sutherland-Chan in 1981 and her master's degree in adult education from the University of Toronto in 1993. She is an experienced workshop facilitator and lecturer and has published numerous articles and papers. Maintaining a private practice in Toronto and consulting internationally, Trish spends her free time joyfully with her husband, two children and numerous animals in their garden.

**Pamela Fitch, BA, RMT** has been in private practice since graduating from Sutherland Chan in 1988. She worked for over 11 years in Ottawa, and currently resides in Hong Kong. She specializes in treating trauma and body image, and her treatments employ a variety of direct and indirect fascial, postural and breathing techniques, visualization and humour. She has written extensively on ethics, professional boundaries, and breast massage, and has been published in both the *Journal of Soft Tissue Manipulation* and the *American Massage Therapy Journal*. Pam contributed widely to her profession when she was president of the Ontario Massage Therapist Association, transforming those skills into experience as a dynamic group facilitator, speaker, and consultant. When not hiking or shopping in Hong Kong, she may be found writing, massaging, cooking, travelling throughout Asia, or exploring a number of eastern and complimentary healthcare modalities.

Trish and Pam discovered several years ago that they work similarly when treating PTSD. Since that time, they have collaborated at a number of workshops across Canada and are currently working on a book about massage therapy, trauma and the body-mind connection.

**MESSAGE THERAPY IN THE TREATMENT OF  
POST-TRAUMATIC STRESS**

**RESOURCE LIST**

**BOOKS:**

***AFTERMATH Survive and Overcome Trauma***, Hybels-Steer, Mariann, Simon and Schuster, New York, 1995

***BEYOND THERAPY, BEYOND SCIENCE A New Model For Healing the Whole Person***, Shaef, Ann Wilson, Harper Collins, New York, 1992

***CHILD ABUSE TRAUMA Theory and Treatment of the Lasting Effects***, Briere, John N., Sage Publications, California 1992

***DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, DSM IV***, Fourth Edition, American Psychiatric Association (APA), 1994.

***EMBODYING HEALING: Integrating Bodywork and Psychotherapy in Recovery from Childhood Sexual Abuse***, Timms, Robert and Connors, Patrick, Safer Society Press, #9, Vermont, 1992

***HEALING VOICES Feminist Approaches to Therapy with Women***, Laidlaw, Toni Ann, Malmo, Cheryl and Associates, Jossey-Bass, California, 1990

***I CAN'T GET OVER IT a handbook for trauma survivors***, Matsakis, Aphrodite, New Harbinger Press, California 1996

***I NEVER TOLD ANYONE Writings by Women Survivors of Child Sexual Abuse***, Bass, Ellen and Thornton, Louise, editors, Harper Perennial, New York, 1983

***LIFE AFTER TRAUMA***, Rosenbloom, Dena & Williams, Mary Beth, The Guilford Press, New York, 1999

***MOLECULES OF EMOTION***, Pert, Candace, PhD, Touchstone, Simon & Schuster, New York, 1997

***SKILLS TRAINING MANUAL FOR BORDERLINE PERSONALITY***, Linehan, Marsha, The Guilford Press, New York 1993

***THE COURAGE TO HEAL A guide for Women Survivors of Child Sexual Abuse***, Bass, Ellen and Davis, Laura, Harper and Row, New York, 1988

***THE DEVELOPING MIND***, Siegel, Daniel, The Guilford Press, New York 1999

***TOUCHING the Human Significance of Skin***, Montagu, Ashley, Harper and Row, New York, 3<sup>rd</sup> edition, 1986

***TRANSFORMING THE PAIN A Workbook on Vicarious Traumatization***, Saakvitne, Karen & Pearlman, Laurie Anne, W. W. Norton, New York 1996

***TRANSFORMING TRAUMA A Guide To Understanding and Treating Adult Survivors of Child Sexual Abuse***, Salter, Anna, Sage Publications, California, 1995

***TRAUMA AND RECOVERY***, Herman-Lewis, Judith, MD, Basic Books, Harper Collins, New York, 1992

***TRAUMATIC STRESS The Effects of Overwhelming Experience on Mind, Body and Society***, ed. by van der Kolk, Bessel A., McFarlane, Alexander C. and Weisaeth, Lars, Guilford Press, New York, 1996

***TOO SCARED TO CRY How Trauma Affects Children - and Ultimately Us All***, Terr, Leonore, MD, Basic Books, New York, 1990

***TOUCH The Foundation of Experience***, ed. by Barnard Kathryn and Brazelton, T. Berry, International University Press, Madison, 1990

***WOMEN'S BODIES, WOMEN'S WISDOM Creating physical and Emotional Health and Healing***, Northrup, Christiane, MD, Bantam, New York, revised edition, 1998

### ***Journal Articles:***

#### ***"Post-traumatic Stress Disorder"***

The Harvard Mental Health Letter, June (Part I), July 1996 (Part II)

#### **" Post-Traumatic Stress Disorder: Identification and Diagnosis"**

Babette Rothschild, MSW, LCSW, Soziale Arbeit Schweiz (The Swiss Journal of Social Work), February 1998

**"Dissociation, Development and the Psychobiology of Trauma"**, Loewenstein, Richard, J., M.D., Journal of the American Academy of Psychoanalysis, 21(4), 1993.

**"Defining Shock and Trauma in Bodypsychotherapy"**, Rothschild, Babette, M.S.W., Energy and Character, Vol.26, No.2, September 1995.

***"Vicarious Traumatization: The Emotional Costs of Working With Survivors"***. McCann, I.L., & Pearlman, L.A., The Advisor: Newsletter of the American Professional Society on the Abuse of Children, 3(4), Fall, 1990.

### ***Websites and other resources:***

**National Center for PTSD, Department of Veteran Affairs**, VA Medical Center, White River Junction, Vermont 05009, 802-296-5132. [www.iver.net/~schwcof/ptsd.htm/](http://www.iver.net/~schwcof/ptsd.htm/)

**Internet Mental Health** ([www.mentalhealth.com](http://www.mentalhealth.com))

#### **CIVITAS Child Trauma Programs**

Dr. Bruce Perry, a noted neurobiologist, explains how many disorders such as Post Traumatic Stress Syndrome begins with childhood trauma. Many excellent scientific papers on the causes, consequences and ...

<http://www.bcm.tmc.edu/civitas/>

#### **David Baldwin's Trauma Information Pages**

A huge volume on emotional trauma and traumatic stress, including PTSD. The purpose of this Award-winning site is to provide information for clinicians and researchers in the traumatic-stress

field. <http://www.trauma-pages.com/index.phtml>

### **Measures of Traumatic Stress**

For clinicians and researchers, this site by Dr. B. Hudnall Stamm, formerly at the National Center for Posttraumatic Stress Disorder, carries all of the recognized tests and clinical instruments for ...<http://www.isu.edu/~bhstamm/tests.htm>

### **The Traumatology Institute**

The Traumatology Institute brings together health, mental health, and emergency services professionals from around the world to develop cutting edge research, treatment approaches, and training programs ...<http://www.cpd.fsu.edu/pet/TRAUMA.htm>

### **About Medications for Combat PTSD**

A large index of links to information about post traumatic stress disorder and related medications. <http://uhs.bsd.uchicago.edu/~bhsiung/tips/ptsd.htm...>

### **International Society for Traumatic Stress Studies**

About the organization, their annual conferences, publications, and an index of traumatic stress links. <http://www.istss.com/>

### **Internet Mental Health Resources**

An extensive index of educational and commercial reference  
<http://www.med.nyu.edu/Psych/src.psych.html>

### **Post Traumatic Stress Resources**

Scientific and research information on traumatic stress caused by war, disaster or other trauma.  
<http://www.long-beach.va.gov/ptsd/stress.html>

### **Post-Traumatic Stress Disorder**

Information about the disorder: an overview, diagnosis, treatments, booklets, magazine articles, and other resources.<http://www.mentalhealth.com/dis/p20-an06.html>

### **Post-Traumatic Stress Disorder Bibliography**

An annotated list of books and articles about the emotional aftershocks of rape, incest, child abuse, street crime, family violence, war, and other forms of trauma.  
<http://www. Dover.net/~schwcof/ptsd.html>

### **Traumatic Incident Reduction: Trauma, PTSD**

Literature, workshops, links, practitioners, and more.  
<http://www.healing-arts.org/tir/>

### **Crisis Fact Sheet: 10 Ways to Recognize Post-Traumatic Stress Disorder**

A list of symptoms from the American Counseling Association.  
[http://www.counseling.org/consumers\\_media/facts\\_pt...](http://www.counseling.org/consumers_media/facts_pt...)

### **Post-Traumatic Stress Disorder (PTSD)**

Background and treatment information with a bibliography and list of support organizations.  
[http://www.psych.org/public\\_info/PTSD~1.HTM](http://www.psych.org/public_info/PTSD~1.HTM)

### **PTSD.Com - Post Traumatic Stress Disorder Resources**

...information about Post Traumatic Stress Disorder, ...Noble Online. What is Post Traumatic Stress Disorder?... [www.ptsd.com/](http://www.ptsd.com/)

### **Massage Research**

General info about massage with links to other massage therapy research  
[massagenetwork.com](http://massagenetwork.com)

