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Sunshine E. Finneran
Trauma and the Body:
A Survey Examining
the Use of Therapeutic Touch
in Psychotherapy

ABSTRACT

A national purposive expert convenience sample of approximately 76 individuals who either self-identity as having experienced a traumatic event(s), or have a current or past diagnosis of Posttraumatic Stress Disorder responded to an anonymous online survey regarding the use of direct touch as a method of abreaction for trauma-related symptoms. This study sought to answer the question of whether individuals with a trauma history found curative aspects related to using therapeutic touch modalities in the treatment process. The findings showed that people with significant trauma histories found therapeutic, direct touch modalities to be helpful in the recovery process.

**Trauma and the Body:
A Survey Examining the Use of Therapeutic Touch
in Psychotherapy**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Sunshine E. Finneran
Summer, 2009

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This project is lovingly dedicated to my family and the circle of women who envelop my heart and nourish my spirit. Lynn Andrews (2001) writes:

We gain the power because we cannot prepare for surprises life throws at us- loss, betrayal, disappointment, and on and on. Events can take you and fling you out of your reality. The struggle to recapture your balance is one of the mysterious gifts of life. These moments become gifts of strength, spiritual endurance, and power. To find your way back, you have to open your heart, not your mind, and let the Great Spirit flow through you. You will never be the same (p.21).

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CHAPTER I

INTRODUCTION

Touch is a powerful form of communication and when it is excluded from use in psychotherapy because of possible sexual, or erotic implications, we miss an opportunity to integrate the body in process (Zur & Nordmarken, 2008). Acknowledging the possible sexual or erotic implications does not necessarily imply that touch becomes problematic in psychotherapy, but rather touch affords an opportunity for greater connection between therapist and client. Staunton (2002) contends that body psychotherapists have long been viewed with suspicion when working with touch due to concerns about sexuality being inadvertently or even deliberately involved in bodywork. While clinical studies involving direct, therapeutic touch show a significant reduction in symptoms, clinical results are criticized partially due to the bias within the field of psychotherapy regarding the use of touch often referred to as the “slippery slope” approach; meaning once the therapist travels down that road touch automatically leads to sexual intent (Fosshage, 2000; Kerty & Reviere, 1998; Zur, 2007).

Historical attitudes rooted in Puritan ethics view the body through a negative lens, so that the physical body is seen as sinful and erotic. Leijseen (2006) writes:

Closer to the truth is that the patriarchal Anglo-Saxon culture has developed a fear of intimacy and is afraid to be touched at any level. In a feminine tradition, touch is valued as a normal aspect of human communication and a healthy expression that is not necessarily erotic in nature. (p. 126)

This carried over to restrictions placed on the use of touch in therapy and to a lack of attention being paid to positive uses of this powerful modality, particularly in healing the effects of trauma. While touch may be a concern when working with trauma, in part

because so many traumatized individuals have experienced inappropriate painful or sexual touch from others it also opens possibility for greater connection, and for a corrective emotional as well as physical experience wherein a trusted other does not exploit or harm the client. Regardless of the taboo on the use of touch with trauma survivors, direct touch has historical references dating back to the early days of Freud's psychoanalytic practice in his work with hysteria (Aron, 1996; Totton, 2003).

Recent studies involving therapeutic, direct touch with trauma survivors show an increase in participation by populations engaging in psychotherapy to relieve symptoms associated with trauma, which include techniques such as massage, Reiki and Cranio Sacral bodywork and acupuncture (Collinge, Wentworth & Sabo, 2005; Field, 1998; Lee, Pittler, & Ernst, 2008; Piltch, 2007; Price, 2006; Sommers, 2002). Touch therapies may provide a soothing method to address emotionally latent material held in the body, calm distressing internal and external symptoms, and present an opportunity for a deeper connection between client and therapist by reworking damaged or maladaptive attributions regarding touch. Working toward the goal of integration, modalities involving therapeutic touch link differentiated elements into a functional whole.

Little research has been conducted using touch as an adjunct therapy option or as a primary modality with clients who have experienced trauma. The consensus in the field of psychotherapy seems to be that touch may trigger past traumatic events for those who have experienced trauma at the hands of a primary attachment figure (Ogden, 2006; Rothschild, 2000). While this frame points out the fragility of the therapeutic intervention, discounting or excluding the use of therapeutic touch as a modality rules out the body as a tool for awareness and healing.

Furthermore, some proponents of body-centered techniques believe touch does not need to be used in order to address the use of the body in psychotherapy (Levine, 1997; Rothschild, 2002). Sensorimotor techniques, such as Focusing-Oriented Psychotherapy, demonstrate a focus on body awareness through consciously paying attention to sensations and emotions (Gendlin, 1996). Recent research regarding the applications of Hatha yoga with PTSD indicates that clients can experience a decrease in symptoms without the use of touch; in Hatha yoga applications, individuals relearn patterns of movement and reconnection with the physical body (van der Kolk, 2006).

Groundbreaking research in the field of neurobiology suggests a connection between the neurological impact of trauma on the brain and body-centered healing techniques, which may have a greater impact on reducing somatizations due to traumatic memory held in the body (van der Kolk, van der Hart & Burbridge 1995; Rothschild, 2000.) By focusing on the nature of the body in psychological process, we work with the individual in a more holistic sense toward integration, instead of treating and isolating the affected mind.

Neurobiological studies using brain-imaging methods such as functional magnetic resonance imaging (MRI) and Positron Emissions Tomography (PET) images indicate neuropsychological impact of a traumatic event and perhaps hold a key to a more effective approach to trauma therapy. PET scan images of traumatized individuals showed that not only were executive brain functions impaired, but that subjects with PTSD had decreased activation of Broca's area, the expressive speech center in the brain, "the area necessary to communicate what one is thinking and feeling" (van der Kolk, Hopper, & Osterman, 2001, p.12) pointing to the efficacy of body-centered work in

trauma therapy. Nonetheless, healing trauma requires a direct experience with feelings and sensations located in the body (Levine, 1997). Even with innovative techniques examining the impact of trauma on the brain, there is still a great deal unknown as to what is the most beneficial treatment for PTSD related diagnoses.

Examining the efficacy of touch in trauma therapy supports an open professional dialogue regarding the uses of touch in conjunction with psychotherapy; such open exploration may facilitate the growth of social work and psychotherapy practice. When we establish a “no touch” policy we, as practitioners, close a door to a deeper understanding of trauma therapy and possible effective methods such as therapeutic touch, which may prove to have significant curative results. Body-centered therapies are predicated on the idea that past experience is embodied in present physiological states and action tendencies -- that trauma is experienced in the body through “breath, gestures, sensory perceptions, movement, emotion, and thought” (van der Kolk, 2006, xxiv).

Using touch as a method of healing trauma through body-centered work allows a space for genuine relationship. Body-centered psychotherapy offers a relational model that “attempts to collaborate rather than treat, in which the practice is based on very real people: that the wounds suffered in relationship must be healed in relationship” (Staunton, 2002, p.58). Staunton further points out that if the use of touch is prescriptive and not relational, if therapists adopt the stance “I never touch my clients,” or similarly if a body centered psychotherapist applies touch as a matter of course, a valuable therapeutic tool is missing. Having an on-going dialogue about the use of touch in psychotherapy and its curative application in body-centered work furthers the study and academic fervor of social work practice.

The current study investigates the use of systematic, direct touch modalities such as massage, Reiki, Cranio Sacral, Rosen Method and Hakomi bodywork when working with clients who have experienced trauma and whether the chosen modality resulted in therapeutic, curative benefits. The term *therapeutic touch* is defined as a method involving intentional, direct touch as a systematic approach to assist clients in the integration of traumatic memory from non-traumatic memory and body awareness.

The following review of literature will address the historical applications of therapeutic touch in trauma work, current neurobiological studies, and how body-centered modalities involving direct touch play an intricate role in the abreaction of trauma.

CHAPTER II

LITERATURE REVIEW

Literature suggests therapeutic touch has curative properties but has been held in disregard because of the history of psychodynamic theory and Freud's view of sexuality as related to repressed unconscious drives (Aron, 1996; Levitan & Johnson, 1986; Torres, 2005). Driven by this Victorian era mentality of sex and the body, we have discounted therapeutic touch as a credible healing tool. Reframing sexuality in Jungian terms (Staunton, 2002), we can lift the veil of repressed latent material and reestablish human connection through touch where sexuality is viewed as an energetic psychic source. Once the veil is lifted, we can examine the curative aspects of therapeutic touch and body-centered psychotherapy to explore new dimensions in healing and open possibilities for clients to experience well-being.

The following pages of this literature review introduce the reader to the issues addressed in this paper. The first section deals with policies surrounding the use of therapeutic touch and how the field of social work contributes to the socio-cultural implications of touch, which historically have framed consciousness regarding therapeutic touch as innately sexual. The second section addresses the history of touch in early psychoanalytic work and an understanding of Freud's turning away from non-pure psychoanalytic theory. The third section in this paper begins to map out body-centered work, and how working closely with the body-mind integration through relational theory combines a full use of self on the part of the therapist or practitioner. The fourth and last section examines how this relational model integrates body-centered work when working

with individuals who have experienced trauma, the neurobiological implications of trauma on the body and how body centered work impacts fragmentation of the traumatized self. By focusing on the bodily experience in the present moment, individuals can experience what is happening immediately in the here and now. Bringing awareness back to the body, we begin to build a cohesive, integrated sense of self and facilitate the clients' capacity to heal themselves, while the therapist is a mere facilitator of the healing process. Bessel van der Kolk (as cited in Rothschild, 2000) confirms:

If it is true that at the core of our traumatized and neglected patients' disorganization is the problem that they cannot analyze what is going on when they re-experience the physical sensations of past trauma, but that these sensations just produce intense emotions without being able to modulate them, then their therapy needs to consist of helping people to stay in their bodies and to understand these bodily sensations (p. 3).

To Touch or Not to Touch

National Association of Social Workers' Code of Ethics states that social workers should not engage in physical contact in a way that may be psychologically harmful to the client. While the Code of Ethics does not prohibit all touch, it does not support the use of touch and its therapeutic benefits -- focusing on potential negative consequences instead of possible benefit. Zur (2007) adds, "Ignoring years of clinical and developmental research, many risk management experts, traditional psychoanalysts, consumer protection agencies, insurance companies, and malpractice attorneys have promoted the notion that any touch beyond a handshake is clinically inappropriate, unethical or below the standards of care" (p.61). In fact, underscoring the negative bias in the 2006 National Association of Social Work Code of Ethics, the topic of physical

contact is located between 1.09 Sexual Relationships and 1.11 Sexual Harassment categorizing inappropriate touch as “cradling or caressing clients” (p. 13), pointing to our own profession’s cultural assumptions about the use of touch in a therapeutic context.

However, significantly, Tirnauer, Smith and Foster’s study (as cited in Leijssen, 2006), notes “A survey of members of the American Academy of Psychotherapists indicated that only 13% ‘never touch’ their clients” (p.139). The fact that the majority does use touch leads one to question the feasibility of the “no touch” policy and to consider instead the positive benefits, which can be derived from body-centered work. In defense of the use of touch, Milakovich (1998) contends that there is no statistical association between sexual experiences with therapists and therapists who use body-orientated therapies. Zur (2007) points out that the problem of some statistical reasoning is that it draws causal conclusions from statistical correlations. Furthermore, Zur (2007) concludes, “sequential relationships and statistical correlations cannot be equated with causal relationships” (p.52). Yet even a low percentage of abusive reports stirs controversy -- feeding the fear of inappropriate boundaries and the harmful uses of touch in psychotherapy, while the mistaken belief that touch does not occur has precluded any guidelines governing its use nor recognizing the ways in which it is curative. Unfortunately, the effective uses of touch in psychotherapy are quickly dismissed along with its therapeutic value because of a lack of understanding of the multi-layered dimensions to touch and its benefits in facilitating the healing process (Zur, 2007; Zur, 2008).

Fosshage (2000) notes that two paradigmatic shifts have occurred within psychoanalysis: the change from a positivistic to a relativistic science and the movement

from intrapsychic to an intersubjective, or relational model; moreover, these two changes have “profound implications” on the use of touch in psychotherapy (p.24). Combining these two paradigmatic shifts acknowledges the inter-relational component that any action or non-action of the analyst variably affects the relational field, and the analysand’s experience of the therapeutic relationship. Touch used in relational context points to the fact that clinicians must be alert to the client’s sensitivities to touch when bodywork is offered, based on cultural, religious, gender, or personal preferences. The clinician also needs to take into account the most appropriate bodywork modality given the client’s current presentation (Vargas, O’Rourke & Esfandiari, 2004). Geib’s (1982) study with a small homogeneous sample (10 female clients with male therapists) identified four factors associated with a client’s positive or negative evaluations of touch in psychotherapy: (1) clarity regarding touch, sexual feelings, and boundaries of therapy; (2) client control in initiating and sustaining physical contact; (3) congruence of touch with the level of intimacy in the relationship and with the client’s issues; and (4) client’s perception that the physical contact is for his/her benefit, rather than the therapist’s.

Furthermore, the gender implications in Geib’s study using female clients with male therapists suggest a sexual overtone, which might not have been evident if Geib’s study would have consisted of female clients with female therapists. Creating safety in trauma therapy is essential in taking into account gender roles and how these roles may be counter to an individual’s traumatic experience. Therefore, it is imperative to create relationship through traditional psychotherapy before embarking into bodywork modalities involving direct touch.

History of Touch in Psychoanalytic Practice

The field of psychology, which later became known as psychoanalytic theory, began with an organic view of the relationship of body and mind, and most psychiatric approaches were physical. Pierre Janet's (1925) early work in the late 1800's focused on dissociation in relation to trauma; how traumatic memories cannot be integrated into one's general experimental schemes and are split off from the rest of personal experience (van der Kolk, van der Hart & Burbridge, 1995). Freud (1960) postulated that the "ego is first and foremost a body ego" pointing out the ego is ultimately derived from bodily sensations characterized as a psychical projection of the body surface. Here the ego synthesizes all impulses and energies of body and mind in order to establish somatic integration. "The developmental and therapeutic implications of Freud's view of the ego as a "body-ego" provide theoretical rationale for using touch in psychotherapy" (Smith, Clance & Imes, 1998, p.6).

During the early foundation of psychoanalytic practice, Freud's interest in studying hysteria and what lies beyond conscious life led him to study with the famous French neurologist Jean-Martin Charcot of the Salpetriere Hospital in Paris. In 1885 Freud trained with Charcot on massage techniques and their application to hysteria, referring to massage as a "strengthening remedy" (Freud, 1888, p.55). Although Freud's primary interest in studying with Charcot stemmed from neurological aspects of hysteria and the use of hypnosis, his fascination with symptoms resulting from traumatic hysteria drew attention to the use of the body as a cathartic method of treatment. "Hysteria and hypnosis dominated Freud's imagination, yet in his practice he relied on the traditional techniques of electrotherapy, hydrotherapy, massage, rest cures, and perhaps most

importantly, suggestion and manipulation (Aron, 1996, p.103). Freud and Breuer (2004), in their work with the famous Anna O., prescribed “the treatment of warm baths, twice daily massage and hypnotic suggestion” (p.53) as a possible cure for hysteria. Because of Freud and Breuer’s work with Anna O., in which she developed an eroticized transference toward Breuer that clearly frightened both men, Freud postulated that touch interfered with transference and countertransference, and confused ego boundaries (Torres, 2005). Early psychoanalytic techniques dealt with recognizing “somatic symptoms typical of traumatic hysteria” through catharsis and abreaction. Freud began to use the “pressure technique” when applying hypnosis by placing his hands on the patients head and applying pressure (Aron, 1996, p. 104; Levitan & Johnson, 1986; Ventling, 2002).

In the case of Lucy R. Freud (1893) writes, “I placed my hand on the patient’s forehead or took her head between my two hands” as a means of applying pressure to aid in the effectiveness of concentration and emphasizing a hypnotic technique as a cathartic approach to investigating the psychological origins of his patient’s symptoms (p.110). Through the use of physical touch, internal material held in the body can be felt by the practitioner and brought to the surface to be discussed seen in Freud’s use of physical touch in the case of Lucy R. Freud’s work with Charcot helped him to reframe trauma in terms of its physical characteristics to a psychical notion of trauma in his work with hysteria where he surmised that the stress of an event thwarted the patient’s defense structure. “Pain, too, seems to play a part in the process, and the way in which we gain new knowledge of our organs during painful illnesses is perhaps a model of the way by which in general we arrive at the idea of our body” (Freud, 1960, p. 16).

Body-centered and talk therapy methods when used together create a visceral experience where the “body talks and that real talk lives in the body” (Pizer, 2002, p.840). Freud (1893) conceived the “idiopathic products of hysteria” directly correspond to precipitating trauma experienced in the body as disturbances of vision, chronic vomiting, anorexia, *petit mal* seizures etc (p.4). Touch not only facilitates the nature of healing but also acts as a means of cathartic expression resulting in abreaction.

Toronto (2002) observes that the body in psychoanalysis is largely viewed in terms of biology and drives perpetuating sexual overtones as bodily sensations and somatizations; moreover, “psychically repressed material exists in verbal form” (p.74). Experimental methods of abreaction are also evident in the work of Freud’s student Sandor Ferenczi in his “hazardous technical experiments” with explicit active technique. “Remaining strictly within Freud’s framework, he drew particular attention to the patient’s non-verbal communications, especially their bodily expression, as well as to the manifestations and handling of the countertransference” (Grubrich-Simitis, 1986, p.261). Ferenczi’s use of negative transference and “nurturant touch in order to help clients tolerate the pain that was avoided by means of characterological defenses” (Smith, 1998, p.8), as well as his well documented romantic and sexual relationships with clients contributed to Freud’s turn toward classical psychoanalytic technique as he felt that active technique could lead away from psychoanalysis (Fosshage, 2000; Geib, 1982; Strozier & coauthors; Totton, 2003). Because of these non-traditional approaches by some of his contemporaries, Freud was concerned with ethical violations that used touch as a cathartic method of treatment from which sexual or romantic relationships ensued. Levine (1997) points out that some cathartic methods of treatment involving intense

emotional reliving of the experience may be harmful seen in Ferenczi's work with negative and eroticized transference and the dangers that may ensue.

Wilhelm Reich, a critical student of Freud, as well as a student of Ferenczi, is responsible for body-centered psychotherapy, as we know it today; Reich focused on character structure instead of individual neurosis. Reich coined the term *body anchoring* as a means of exploring unreleased psychosexual energy stored in the body producing physical blocks within the muscles and organs (Ventling, 2002; Caldwell, 1997). His concept exploring uses of the body as a defense structure expanded Freud's early notions of cathartic treatment and how the body holds emotionally latent material as a result of traumatic hysteria. Developing on Ferenczi's concept of dealing with manipulation of the body as a direct access to feelings held unconsciously in the body, Reich (1942; 1973) wrote that the body used as a method of treatment offered the "possibility of avoiding, when necessary, the complicated detour via the psychic structure and of breaking through to the affects directly from the somatic attitude. In this way, the repressed affect appears before the corresponding remembrance" (p.301). Reich's work in body-centered perspective influenced Gestalt therapy (Perls, 1969), and branched off into numerous techniques known as Bioenergetics (Lowen, 1976), and Hakomi (Ogden, 1997) – all methods that focus on the healing power of touch.

Mapping Out Body Centered Work

My belief is in the blood and flesh as being wiser than the intellect. The body-unconscious is where life bubbles up in us. It is how we know that we are alive, alive to the depths of our souls and in touch somewhere with the vivid reaches of the cosmos (as cited in Levine, 1997, p.65).

- D.H Lawrence

The Greeks defined body as *soma*, “the body of an individual contrasted with the mind or psyche” (The American Heritage College Dictionary, 1993), separating the body from psychological process. Somatics in particular can be regarded as “brain work”; while the practitioner does manipulate the client’s body, these movements are for the purpose of altering neurological signals in the central nervous system to change how the nervous system interacts with and controls the body (Aronstein, 2007). Nonetheless, Descartes who treated the body as a separate entity, furthering the Greek notion of *soma*, the philosophical underpinning of Western medicine, historically influenced the separation between body and mind. The body has been subsequently ignored in psychotherapy partially due to the philosophical underpinnings of the Cartesian model, as well as Freud’s turning toward classic psychoanalytic practice, resulting in a growing trend of disownment of the body, paralleling the growth of understanding about the mind (Young, 2006). This separation of body and mind is slowly being overcome and the body is gradually beginning to come back into psychological process. Damasio (1994) writes,

1) The human brain and the rest of the body constitute an indissociable organism, integrated by means of mutually interactive biochemical and neural regulatory circuits (including endocrine, immune, and autonomic neural components); (2) The organism interacts with the environment as an ensemble: the interaction is neither the body alone nor the brain alone; (3) The physiological operations that we call mind are derived from the structural and functional ensemble rather than from the brain alone: mental phenomena can be fully understood in the context of an organism’s interacting in an environment (xvi-xvii).

Thomas Hanna (1992) redefined *soma* as a bodily being, capable of perceiving feelings, movements, and intentions and controlling how we function. Hanna further spoke of the body in what he termed *Somatic Education*, viewing the body more in terms of the Sanskrit word *maya* (illusion or deception): “the human body may appear solid, but it is actually a constant, ongoing process of change and renewal” (p. 73). Brain, mind and body are all inextricably linked, and it is only for heuristic reasons that we seek to discuss these functions as separate entities (van der Kolk, 1996).

Damasio (1994) defines the somatosensory system consisting of both the external senses of touch, temperature, pain and the internal states of joint position, visceral state and pain. Emotions arise by disposition illustrated through the limbic system structures, such as the amygdala which interprets incoming stimuli and determines emotional significance (van der Kolk, 2006), creating what Damasio (1994) calls *somatic markers*, “special instances of feelings generated from secondary emotions” which highlight either danger or pleasant experience (p. 174). The author adds that somatic markers, at a neural level, depend on learning within a system that can connect certain events with an enactment of a bodily state, whether that somatosensory experience is positive or negative. More importantly, somatic markers are not deliberated but rather autonomic responses to particular stimuli, illustrating the physiological context of emotion. Body-centered psychotherapists work with some aspect of somatic memory (van der Kolk, 1994); by releasing emotional memory, a person can dissolve a corresponding pattern of psychological constraint (Totton, 2003). Ogden (1997) agrees that for every body sensation, movement, or posture, “a related memory, emotion, image, or thought can be revealed” (p.156). Thus, body-centered psychotherapists tend to encourage and support

spontaneous bodily impulses and experiences with the expectation that these bodily sensations will lead to a form of completion, reenactment and/or discharge.

Totton (2003) notes three core models in body-centered psychotherapy- *Adjustment* model, *Trauma/Discharge* model, and the *Process* model. These models may overlap and may not only be modalities found in body-centered work but are also used in more traditional verbal psychotherapies. The Adjustment model relies foremost on the body with the mind as a secondary consideration. This model serves to realign the body physically, energetically or both; thus removing blocks and increasing the flow of energy. The Adjustment model is “directly Reichian in tone and content” (Totton, 2003, p.55.) The Trauma/Discharge model was first found in the work of Freud and Breuer working with hysteria and specifically related to bodily symptoms and experiences (Totton, 2003). Healing from trauma related experiences occurs in emotional abreaction, “the release and full conscious expression of old emotions held or locked into rigid musculature” (p. 57.) Limitations of the Trauma/Discharge model rests in the implications of countertransference/transference issues; the model fails to incorporate the lived-body paradigm, the intersubjective space between client and therapist (Shaw, 2004). Lastly, the Process model enlists free association to allow the client’s body-mind to guide the therapeutic journey and follows what Bion (1967) describes as “no desire, no memory, no understanding” (p.243). Entwining the three models discussed above is more of the rule than the exception in body-centered psychotherapy and points to the flexibility of methods within the body-centered framework, which creatively uses effective and appropriate modalities based on the needs of the client.

Mathew (1998) points out that the body is clearly an instrument of physical processes, an instrument that experiences and interprets sensorial information in the milieu. Most therapists are trained to notice the client's physical presentation and even the movements of the client's body, but working with the client's embodied experience is largely viewed from a traditional psychotherapeutic framework involving treatment plans and interventions (Ogden, Minton & Pain, 2006). Issues related to transference and countertransference can be expressed as bodily states within the therapeutic context whereby the therapeutic relationship consists of two persons in the room, the client and the therapist, experiencing a shared felt experience (Ogden, 1997), or somatic transference/ countertransference (Mathew, 1998; Totton, 2003). The therapist's spontaneous or intentional awareness of his/her own bodily process presents an opportunity for further exploration in the dyadic relationship and can be tremendously helpful to the therapeutic process (Aposhyan, 2004). Being comfortable with one's own body and processing bodily experiences in the context of the therapeutic encounter is essential in doing body-centered work.

Trauma and the Body

Ford (2008) writes that the term *trauma* is derived from the Greek word for wound. The oldest known description depicting traumatic stress was inscribed on "clay tablets 5,000 years ago. The Sumerian *Epic of Gilgamesh* describes a Babylonia king who was terrified and distraught after the death of his closest friend" (p.425). Briere and Scott (2006) contend that the term *psychological trauma* has been misused and misunderstood so much that it has lost some of its original meaning. Often, *trauma* is

used to refer to both the negative events that precipitated the stress and to the distress itself. Technically, according to Briere and Scott, trauma refers to the event and not to the reaction. Upledger (2001) points out:

In 1980, Post-Traumatic Stress Disorder (PTSD) was officially recognized by the American Psychiatric Association in its *Diagnostic and Statistical Manual of Mental Disorders, Volume III*. Before 1980, the condition existed only as titles such as ‘shell shock,’ ‘battle fatigue,’ ‘dissociate amnesia’ and ‘physioneurosis.’ It was the rather high incidence of PTSD in Vietnam veterans that finally prompted inclusion of the condition as a mental disorder in the DSM III (pp.1-2).

Posttraumatic Stress Disorder is characterized by symptoms of intense fear, hopelessness, numbing, avoidance of reexperiencing the original trauma, and hyperarousal following exposure to an “extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury” (American Psychiatric Association, 2000, p. 463). Reexperiencing of the event refers to unsolicited recollections of the incident in the form of distressing images, nightmares or flashbacks (Yehuda, 2002; Young, 2000). Yet despite efforts to capture the essence of an individual’s response to trauma, the PTSD diagnosis does not begin to adequately depict how a person reacts to overwhelming experience (van der Kolk & McFarlane, 1996). Criteria for the diagnosis include persistent symptoms for three months or more, which is categorized as chronic PTSD, and acute PTSD or acute stress disorder if symptoms last less than three months. Events attributed to the diagnosis of PTSD are primarily based on the prototypes of combat, disaster, and rape (Herman, 1992). Moreover, the current DSM IV-TR diagnosis does not account for complex PTSD whereby extreme traumatic stressors are experienced over a long period of time, such as on-going sexual abuse or torture (Vargas, O’Rourke & Esfandiari, 2004). Survivors of prolonged abuse develop

characteristic personality changes, including “deformations of relatedness and identity” (Herman, 1992, p. 119), currently not categorized in the DSM IV-TR diagnosis.

Furthermore, limitations regarding current criteria for PTSD exclude dissociation as a characteristic feature (Rothschild, 2000).

Most psychotherapeutic approaches do not incorporate physiological aspects, but rather concentrate on psychological processes that directly relate to trauma-related bodily responses. Yet for traumatized individuals, “the debilitating, repetitive cycle of interaction between mind and body keeps past trauma ‘alive,’ disrupting the sense of self and maintaining trauma-related disorders” (Ogden, Minton & Pain, 2006, p.3). There is a significant body of ongoing research regarding body-centered modalities involving direct touch bodywork with trauma survivors (see, for example, Collinge, Wentworth & Sabo, 2005; Field, 1998; Price, 2006; Strozier, Randall, & Kuhn, 2008; Wardell & Engebretson, 2001). Nevertheless, the mainstream treatment for trauma-related disorders largely involves psychodynamic, cognitive, behavioral or psychopharmacological interventions that do not address somatic states (Ogden, Minton, Pain, 2006; Rothschild, 2000; van der Kolk, 2000).

Pierre Janet (1932) observed that traumatic memories, and the tendencies and ideas connected to traumatic events, jostle one’s sense of self where the individual tries desperately to eradicate the experience. Janet also noted that traumatic memories lacked integration, which resulted in a fragmented, dissociated experience. Therefore, traumatic memory “free floats” unable to be integrated and accepted as part of one’s personal past; instead it exists independently of previous schemata-- that is, it is dissociated (van der Kolk & McFarlane, 1996). In recent research, dissociation at the moment of a traumatic

event has been shown to be an important predictor of the individual's later development of PTSD (van der Kolk, 1996).

Peter Levine (1996) contends that the nature of traumatic memory lies in implicit memory, which is profoundly unconscious and often termed *procedural memory*. Procedural or body memories are learned sequences stored in the body as action patterns. These memories (action patterns) are formed and expressed largely by the involuntary structures in the cerebellum and basal ganglia. Levine continues, "When a person is exposed to overwhelming stress, threat or injury, they [sic] develop a procedural memory. Trauma occurs when these implicit procedures are not neutralized. The failure to restore homeostasis is at the basis for maladaptive and debilitating symptoms of trauma" (pp.1-2). Nonetheless, the concept of body memory is easily misunderstood and is not the physical body as much as it is how the body holds a memory itself; it is how the brain stores the memory, an intercommunication between body and mind expressed as implicit, autonomic, somatic experience (Rothschild, 2002).

Understanding the nature of traumatic memory holds the key to mapping out the importance of utilizing body-centered methods in the treatment of trauma and its neurobiological concomitants; by engaging the body in psychological process, treatment modalities strive for integration of trauma-related memory and further awareness of somatic states experienced and held in the body. Traumatic memory differs from non-traumatic memory in that ordinarily memories of a particular nontraumatic event are remembered and stored as stories that change over time and do not evoke intense emotions and sensations. To the contrary, traumatic memory in PTSD is stored as a

sensory experience frozen in time, relived with the same emotional intensity as the original trauma, which makes the individual feel the trauma is occurring all over again.

Krystal (1988), a psychoanalyst who studied long term effects of massive traumatization in concentration camp survivors, suggested that extreme trauma leads to blunted affect; the survivors Krystal studied and lacked the ability to interpret body states in terms of emotions or to grasp personal meaning from bodily feelings. Traumatized individuals come to experience emotional reactions merely as somatic states, without being able to interpret the meaning of what they are feeling. According to Krystal, this development of alexithymia is central to the psychosomatic symptoms associated with prolonged traumatic stress. The psychological function of emotion is to alert people to pay attention to what is happening in the milieu. Consequently, this primary function of emotion has been short circuited for individuals with PTSD, namely the ability to interpret incoming stimuli and respond appropriately. Individuals with PTSD instead move immediately from stimulus to response, meaning they respond, or more appropriately stated, they react, moving into fight or flight mode. Unable to achieve affect modulation, trauma survivors experience emotions as dangerous.

The bodies of traumatized individuals portray a snapshot of the biologic aspects of trauma, and points out the elucidation of the biologic changes related to PTSD and why some individuals recover from PTSD and some do not. Van der Kolk & McFarlane (1996), argue that what distinguishes individuals who develop PTSD from individuals who do not is that the individuals who develop PTSD begin to organize their lives around the trauma. Recent neuroanatomical studies identified alterations in two major brain structures- the amygdala and hippocampus-in individuals with PTSD (Yehuda, 2002).

These structures are both parts of the limbic system, thought to be part of the Central Nervous System (CNS) and known as the emotional center of the brain. Positron-emission tomography (PET) and functional magnetic resonance imaging (fMRI) studies comparing non-traumatic memory with traumatic memory, indicated deactivation of Broca's area, located in the left interior frontal cortex responsible for generating words to attach to internal experience, and increased activity in the amygdala and hippocampus, regions of the limbic system associated with interpreting incoming stimuli and communicating danger expressed as --fight or flight-- when subjects with PTSD were exposed to extreme stressors (van der Kolk, Hopper & Osterman, 2001). Exposed to excessive stress, the body's physiological response culminates in the release of cortisol from the adrenal glands. Research reveals that chronic exposure to cortisol can damage neurons associated with the hippocampus affecting explicit memory. As a result, trauma survivors may not be able to recall traumatic experience via explicit memory (Applegate & Shapiro, 2005). It is currently unclear whether high levels of stress hormones, such as cortisol, "impair the consolidation of memories, their retrieval, or both" (Brewin, 2005). The decreased activity in Broca's area coupled with the hyperactivity of the amygdala and hippocampus may account for the observation that trauma may lead to "speechless terror" (van der Kolk, 1996, p. 193).

While it is not within the scope of this paper to extrapolate upon the intricacies of neurobiological aspects of trauma, it is worth noting, however, the deactivation of Broca's area when an individual experiences extreme stress—suggesting the importance of treating trauma from a sensorimotor perspective. Since trauma is expressed within the right hemisphere, the limbic system, as sensorial, implicit memory (somatic memory),

treatment modalities that engage the body in psychological process address the neurobiological aspects of how an individual experiences trauma through the body/mind connection and helps trauma survivors identify somatizations associated with the traumatic experience. The sole use of traditional psychodynamic techniques may be counterindicated neurobiologically because traumatic memory is implicit, emotional memory held in the body; while traditional talk therapy utilizes left brain functions dealing with language and communication with declarative, explicit memory. Since traumatic memory functions and is stored in the limbic system and unable to integrate with left brain functions associated with language, utilizing body-centered modalities involving therapeutic touch address the body/mind continuum blending psychotherapy with physiological process, integrating the right and left hemispheres. Ogden, Minton and Pain (2006) point out that rather than helping to resolve symptoms, attempts to process traumatic events by describing them in words or “venting the associated feelings can precipitate ‘somatic remembering’ in the form of physical sensations, numbing, dyregulated arousal, and involuntary movements” (p.4). Contrary to neurobiological research, Herman (1996) contends that the ultimate goal of trauma therapy involves putting down the story, including its imagery, into words. “The description of emotional states must be as painstakingly detailed as the description of facts” (p. 177).

Nonetheless, talk therapy in conjunction with therapeutic touch can be used to “supplement, rather than replace verbal interactions” (Leijssen, 2006). Psychotherapy aids in initially engaging the client in the therapeutic relationship, developing and maintaining a safe environment where thoughts and feelings, along with bodily sensations, can be brought up and discussed in an open nonjudgmental way. For some

trauma survivors, this may be the first time since the original trauma that feelings and sensations are being felt and experienced. Traditional psychotherapy here provides a space to process --in words-- what was experienced, both by the individual and by the therapist as a “shared felt experience” (Ogden, 1997). Utilizing psychotherapy in conjunction with bodywork, i.e. body-centered psychotherapy, helps integrate explicit and implicit memory in the abreaction, and ultimately, the resolution of trauma.

Summary

Examining the historical context of the uses of touch in psychotherapy helps to elucidate how the “no touch” policy originated, in part, as a social construct of the Victorian era, and as a result of the shame often placed even today on the body and the innate sexual drives inherent in humans. Deconstructing this model and analyzing the historical implications of therapeutic touch used in psychotherapy as a method of healing paves the way to further opening the dialogue about what may be curative in therapeutic touch and how therapists and practitioners can facilitate the individual healing process. Ogden (1997) emphasizes that bodywork involving direct touch with women who have been sexually abused precipitates movement from dissociation to awareness, from fear to empowerment, creating an opportunity to realign maladaptive patterns into healthy modes of attachment and to “restore this simple choice to its rightful owner” (p. 156).

Rothschild (2002) reiterates that traumatic memory differs from that of other events in that it is often nonverbal, somatic, implicit memory. “This makes body psychotherapy a natural for helping to integrate traumatic experiences” (p.101); however, since many traumatized clients have suffered at the hands of others, Rothschild disagrees

with the use of touch as a reparative treatment. Rothschild (2002) further states that therapists who use of touch with clients who are traumatized as a result of violent assaults, rape or abuse, *may find that* touch reactivates the original trauma. While this highlights the importance of exercising sensitivity regarding the use of touch in body-centered psychotherapy, it should not preclude its use or dismiss it entirely. Ogden, Minton and Pain, (2006) reiterate that the primary focus of trauma-related therapy is integrating right brain somatic, implicit memory with left brain declarative memory – thereby abreacting an otherwise visceral experience.

Herman (1992) emphasizes that traumatic experience damages relational life, impacting not only the psychological structure of the self but also impacting system of attachment and the meaning of interpersonal and communal safety. Thus, Staunton (2002) acknowledges the importance of touch used within a relational model and should never be used as a prescriptive method imposed upon the client. To reiterate, when working with clients who have experienced trauma, therapists must use touch within a consensual, relational model, creating in clients a sense of holding and safety (Ogden, 1997). Using therapeutic modalities involving direct touch allow for correcting maladaptive patterns in attachment in the context of a professional therapeutic relationship. Staunton (2002) concludes, “The question of when to touch and when not to touch is not a theoretical one, but a relational one” (p.72), and is the primary consideration regarding the use of therapeutic touch in trauma therapy. A client-centered approach in body-centered psychotherapy allows for full control and empowerment given to the client, soothing anxious latent emotional material; however, it is a challenge to predict or know the difference. “The best expert on whether touch is calming or not is the

client” (Rothschild, 2002, p.105), aided by a therapist attuned to the client’s bodily reactions.

With the assistance of body-centered psychotherapy, the therapist may help integrate the separation of body-mind, which occurs as a result of trauma related experiences, utilizing implicit memory in order to integrate traumatic experience into explicit memory. Achieving body awareness through the use of touch aids individuals in locating emotional pain held in the physical body. By accessing emotional memory stored in the body, individuals can begin to reintegrate the fragmented self, which occurred as a result of a traumatic event or events. Body-centered psychotherapies can possibly accelerate internal process by focusing on bodily experiences and how pain and loss are experienced as somatizations. Conjoining bodywork involving direct touch with psychotherapy allows the body-centered psychotherapist to reflect back feelings to the client throughout the session and encourages awareness of sensations and emotions, emotional release, as well as revealing bodily patterns and beliefs previous unconscious (Ogden, 1997). Since the body is experienced in present time, individuals can use the body as an anchor in the here and now as a tool to explore traumatic experience safely. Grounded in the present moment, individuals may safely explore the nature and origins of somatizations held in the body known as somatic memory.

CHAPTER III

METHODOLOGY

Formulation

The purpose of this study was to answer the following question: Do individuals who self identify as having experienced a traumatic event or who have a current or past diagnosis of PTSD find relief from their symptoms using body-centered approaches involving therapeutic, direct touch? The term *trauma* used in this study followed the DSM IV -TR (2000) criteria, according to which clients who self-identify as having had experiences of hyperarousal, reexperiencing, and numbing/avoidance symptoms more than three months post-trauma were considered appropriate candidates for inclusion.

This study was conducted using a mixed method, both quantitative and relational design. Anastas (1999) observes, “The goal of relational research is to describe whether or not a phenomenon or a characteristic of it is systematically associated with another phenomenon, and if so, how (p.150). The study used primarily quantitative survey questions with a limited number of qualitative questions. The participants were between the ages of 25 and 65 years old, self-identified as having experienced a traumatic event or have a current or past diagnosis of PTSD, and as having experienced therapy using a body-centered modality involving direct therapeutic touch, and one year of additional psychotherapy.

The mixed method design was appropriate for this study for three reasons: first, the mixed method provided a sense of containment and clear boundaries by having a fixed set of survey questions, which seemed imperative when working with this vulnerable population. Second, the survey questions’ content allowed participants to talk

about their method of treatment and interventions without divulging traumatic details of events. Third, the mixed set of survey questions allowed for a fixed but flexible design by having several qualitative questions, which allowed for more in-depth, personal narratives to emerge.

The shortcomings of this study were that the sample size was small, and participants were recruited mostly from bodywork sources, regardless of recruitment through various psychotherapy offices, possibly making the survey data bias. Another limitation of this study was that possible participants were not initially screened for PTSD using diagnostic assessment tools such as *Trauma Symptom Inventory* (TSI) in order to qualify; it is unclear if all participants had full-blown PTSD since participation criteria allowed for self-identification of trauma-related symptoms. It is also unclear from the survey questions whether respondents used traditional psychotherapy conjoined with a body-centered modality. Nonetheless, the positive feedback I did receive from various people in the healing community who volunteered for this study led me to believe they have experienced efficacy in therapeutic touch as a healing intervention with trauma survivors and that further research would be useful.

In analyzing rich qualitative data, it is difficult to find similarities in every answer. Anastas (1999) notes, “ No one study can presume to isolate, measure, and discuss every variable of possible interest. Each study must, of necessity, focus on only a limited number of variables or factors (p. 157). With those limitations in mind, the vision of this study is to serve as a preliminary source -- pulling together not only current research but also historical instances of therapeutic touch and examples of efficacy of

body-centered work as it applies to trauma-related therapy, with the hope of inspiring more research on this subject.

Sample

A purposive expert convenience sample of 45 respondents participated in this study. Participants were asked to fill out the survey if they were between the ages of 25-65 years old, self-identifying as having experienced a traumatic event(s) or having a current or past diagnosis of PTSD, for which they sought a body-centered modality involving direct, therapeutic touch to ease the symptoms associated with trauma, as well as a minimum of one year of psychotherapy.

Those excluded from the sample were individuals whose trauma occurred within one year prior to taking the survey, along with individuals who perhaps engaged in some form of bodywork that did not involve direct touch, or who had not undergone at least one year of psychotherapy. Participants needed to read and write English and have access to a computer and the Internet. Diversity of participants regarding race, class, gender, sexual orientation, and various treatment modalities was sought as much as possible through the use of various organizations and schools where the survey was posted. The actual diversity of the sample recruited is present in Chapter IV, *Findings*.

Ethics and Safeguards

Emotional risks of participating in this study were considered to be moderate-to-high due to the nature of the material- trauma and the therapeutic use of touch as a healing modality. Direct touch used in trauma therapy has been controversial, in part because often traumatic events occurred at the hands of other human beings. Thus,

emphasis of the survey instrument relied on interventions used and not on traumatic experiences in an attempt to create clear boundaries and to avoid possible retraumatization. However, because of the risk of retraumatization, an online referral list of mental health professionals was included.

Conducting this survey over the Internet provided a sense of containment where participants had the opportunity to complete a twenty-five minute survey at their convenience, possibly easing the stress of the material covered, as well as providing anonymity. Participants knew that their identities and personal information would never be accessible, or this information linked to their experiences as reported in the survey.

Participants may have benefitted from their involvement in this research by providing first hand, personal data regarding the treatment modalities they found most beneficial when healing from trauma. Questioning trauma survivors provided direct data and moves the discussion about the efficacy or non-efficacy of touch as an intervention in trauma therapy from a theoretical discussion to the empirical examination of practical applications.

Again, participation in this study was completely anonymous and no specific answer can be traceable to any particular respondent due to the use of encrypted software, via SurveyMonkey.com. Prior to answering survey questions online, participants were first asked to acknowledge consent or refusal to participate in the survey by clicking the “yes” button at the end of the informed consent letter. If they chose to participate, they were then directed to the first survey question. If they declined participation, they were directed to exit the survey thanking them for their time.

All research material derived from this study will be kept stored in a secured, locked location, for a minimum of three years, consistent with federal requirements, and after three years all data will be destroyed unless otherwise used by the researcher for future publications and presentations. If retained, the data will remain in a secure, locked location.

Data Collection

Participants were asked to complete a twenty-five minute, twenty-two question, anonymous online survey about their experience using therapeutic direct touch as a healing modality when treating symptoms resulting from trauma. Questions centered on symptoms experienced as a result of a traumatic event and whether individuals experienced relief or felt their symptoms increased after experiencing direct touch bodywork. People were also asked what specific bodywork hands-on technique was used and why they chose that particular approach. Modalities listed in the survey included massage, Reiki, Hakomi, Rosen, Rolfing, Bioenergetic methods, or “please specify” technique used in treatment. There was also a set of demographics questions for participants to answer (see a copy of the complete survey in Appendix E).

Quantitative data were collected because they allowed for concrete answers in an attempt to create a sense of boundaries and containment, as well as affording the opportunity for correlational analysis. Likewise, questions in the survey dealt with treatment and interventions used and did not focus on details related to traumatic experience, since approaching trauma therapy from a therapeutic touch perspective may be controversial, especially if individuals were harmed at the hands of another human

being. The mixed method allowed for a concrete, structured experience while allowing for brief narrative responses, mixed with multiple choice, and fill in the blank responses.

Participants who either self-identified or had a current or past diagnosis of PTSD were recruited through various bodywork Internet sources, such as massage, Reiki, Hakomi and energy work practitioners, as well as the United States Association of Body Psychotherapy, Naropa University, California Institute of Integral Studies, and training programs for Hakomi and Rosen Method (see Recruitment Letter Appendix B). Flyers were also posted in both body-centered and traditional psychotherapy offices (see Appendix D for a copy of the flyer posted). Participants were also identified through association or a snowball sampling method by which participants were encouraged to pass along the survey to others they knew who might fit the criteria.

Recruitment began by establishing a URL over traumaandthebody.net and posting the survey link on site after approval from Smith College School for Social Work's Human Subjects Review Committee (see Appendix A for a copy of the HSRC approval letter). Once the URL was posted and the survey established on SurveyMonkey.com, the recruitment letter was sent electronically to various psychotherapists, both body-centered and traditional, nationwide; those recruited also included massage therapists and Rosen Method practitioners. The recruitment email provided information about the intent and description of this study, participation criteria and the risks and benefits involved.

Once the survey was available online, flyers were distributed to various traditional and body-centered psychotherapy offices to recruit possible participants where possible participants who were then directed to the survey link. The first page of the survey consisted of the informed consent (see Appendix C for a copy of the informed consent

document) to which respondents answered yes or no prior to entering the survey. If they answered “yes” they were prompted to begin the survey. If they answered “no,” they exited the survey and were thanked for their time.

Further limitations of the study design included both the sampling limitations discussed above as well as the problematic aspects of creating an online survey targeting an at risk population. Participants can easily dismiss a survey without attending to it when not approached by an individual researcher, which was evident during this data collection in that of seventy-six respondents who began the survey, only forty-five (59%) completed it. The cause of this noncompletion is unknown; however, it is highly likely that because possible respondents consisted of an at risk, traumatized population, individuals may have felt overwhelmed participating in the survey and failed to complete it in order to avoid uncomfortable feelings.

Participants were also asked to provide demographic information including age, gender, education, annual income, occupation, religious or spiritual practice and ethnic background so that it would be possible to assess the diversity of the respondent sample and perhaps to relate responses to some demographic aspects during data analysis.

Data Analysis

Once the data were collected, descriptive statistical tests were used to derive percentages of respondents who reported curative benefits from therapeutic, direct touch modalities and those who found their chosen modality harmful. Later, statistical tests were run with the help of the Smith College statistical analyst to find relationships that might exist between participant characteristics and responses to particular survey

questions. Chi-square and T tests were conducted in order to measure the relationships between spiritual practices in those participants who reported such practices versus those who did not list being involved in a spiritual or religious practice. Results from these tests are reported in the *Findings* chapter below.

Qualitative data collected from structured, narrative questions were coded for themes concerning the risks and benefits of using therapeutic, direct touch as a mode of treatment to alleviate symptoms associated with trauma. Respondent quotes appear in the *Findings* chapter to more vividly and individually illuminate themes or ideas also described in the quantitative data.

CHAPTER FOUR

FINDINGS

Regardless of the controversy regarding the use of therapeutic touch to alleviate symptoms associated with past traumatic experiences, the majority of respondents surveyed found positive benefit from their chosen modality. This research project focused on direct experience from a small sample of individuals who identify as trauma survivors and asked whether they found relief from trauma-related symptoms using modalities involving therapeutic, direct touch in various body-centered modalities, the questions in professional social work of whether therapeutic touch is harmful or beneficial in trauma therapy could be directly addressed. The major finding of this study is that body-centered modalities involving therapeutic, direct touch were found to be beneficial, especially for those individuals who suffered from traumatic episodes as a result of interpersonal trauma.

Characteristics of Respondents

Seventy-six respondents between December 2008 and April 2009 started online surveys. Forty-five surveys were completed and useable. Surveys were eliminated due to lack of completed informed consent forms, body-centered modalities used *not* involving therapeutic, direct touch, along with those respondents who skipped numerous questions. The following demographic information is for the remaining sample (N=45). Respondents to the survey were a diverse group across age, religious or spiritual practice, socio-economic standards, occupation, and level of education (see Table 1).

TABLE 1

Demographic Characteristics of Respondents

	Frequency	Percent
Female	39	86.7
Male	5	11.1
Intersexed	1	2.2
Ethnic Identity		
Caucasian or White	32	71.1
African American or Black	1	2.2
Jewish	2	4.4
Bi-Racial Latina	1	2.2
European	4	8.9
Native American	1	2.2
Multi-Racial	1	2.2
Afro-Caribbean	1	2.2
New Zealand Maori	1	2.2
Other	1	2.2
Religious Identity or Spiritual Practice		
Quaker	2	4.4
Buddhist	6	13.3
Christian	6	13.3
Spiritually based mindfulness	14	31.1
Pagan	3	6.5
Jewish	4	8.9
Agnostic	3	6.5
Prayer	1	2.2
Atheism	1	2.2
Other	5	11.1
Annual Income of Respondents		
\$12,000-24,000	13	28.9
\$24,000-35,000	5	11.1
\$35,000-55,000	7	15.6
\$55,000-70,000	4	8.9
\$70,000 and above	10	22.2
Did not identify	6	13.3
Education Level		
High School diploma	2	4.4
Some college	6	13.3
4 years of college	13	28.9

Master's	15	33.3
PhD	7	15.6
Did not identify	2	4.4

Overall Sample Characteristics

The median age of respondents in the sample was forty-three with the maximum age being sixty-five and the minimum twenty-two years of age. Of the total number of respondents (n=45), 39 (86.7%) were female and 5(11.1%) were male, and 1 (2.2 %) intersexed. Respondents answered an open-ended question regarding ethnicity with 71.1% answering “White or “Caucasian”; 2.2%“African American” or “Black”; 4.4% “Jewish”; 2.2% “Bi-Racial Latina”; 8.9% “European”; 2.2% “Native American”; 2.2 % Multi-Racial”; 2.2% Afro-Caribbean”; 2.2% “New Zealand Maori”; and 2.2% as Other (see Table 1).

Respondents also answered a question regarding spiritual practice or religious identity with 4.4% answering “Quaker”; 13.3% “Buddhist”; 13.3% “Christian”; 31.1% spiritually based mindfulness practice including the Eight Limbs of Patanjali; 6.5% “Pagan”; 8.9% “Jewish”; 6.5% “Agnostic”; 2.2% “Prayer”; 2.2% “Atheism”; and 11.1% answered Other (see Table 1).

Interestingly, 28.9% of respondents seeking body-centered modalities involving therapeutic, direct touch were from lower income status ranging from \$12,000 to 24,000 annually, while only 22.2% reported annual incomes of \$70,000 or higher. The highest percentage of education achieved, 33.3% respondents, held a master’s degree, while 28.9% held a bachelor’s degree; 15.6 % held PhD’s; 13.3% had some college; 4.4% reported having a high school diploma, and 4.4% did not identify.

Characteristics of Trauma-Related Data

The sample was further analyzed related to respondents' traumatic experiences after having either (1) self-identified as having experienced a traumatic event(s), or (2) having a current or past diagnosis of PTSD. Of the total sample, 42.2% reported interpersonal trauma, 8.9 % reported accidental, and 24.4 % experienced both accidental and interpersonal trauma. Only 13.3% of respondents experienced a one time traumatic event, while 80% reported multiple traumatic episodes. Out of that 80%, 2.2% of respondents experienced events within one year; 8.9 % of respondents experienced multiple episodes lasting the course of three years; and 15.6% experienced traumatic events lasting five years. Participants answered an additional question related to the duration of trauma, if trauma persisted for more than ten years, in an attempt to identify respondents with possible complex PTSD: 55.6% of respondents reported on-going interpersonal trauma lasting ten years or more, while only 4.4% checked "not applicable" (see Table 2).

Table 2

Trauma Information

	Frequency	Percent
Accidental Trauma- including natural disasters, car accidents, plane crashes, and home accidents.	4	8.9
Interpersonal Trauma, including domestic violence, Physical and sexual abuse.	19	42.2

Both	11	24.4
One time event	6	13.3
Multiple traumatic events	36	80.0

Respondents were asked to identify trauma-related symptoms lasting more than three months post trauma. Among respondents (N= 45) high percentages were noted in symptoms of flashback/memory intrusion, hyperarousal, dissociation, and nightmares with infrequent patterns. Surveying the data, respondents who experienced trauma as a result of an accident or disaster reported less overall trauma-related symptoms compared to those who suffered from interpersonal trauma (see Table 3).

TABLE 3

Trauma-Related Symptoms

	Frequency	Percent
Flashbacks/memory intrusion	30	66.7
Hyperarousal	37	82.2
Spacey, disconnected	33	73.3
Difficulty concentrating	33	73.3
Nightmares	28	62.2
Sleep Disturbances	31	68.9
Accelerated heart rate	23	51.1
Loss of Appetite	11	24.4

The reported therapeutic modalities used varied across respondents (N= 45). The largest number of respondents used massage (N=30), followed by those who used Reiki (N=20). Other modalities reported were Bioenergetics (N=9); Rolfing and Rosen Method both reported (N=4); while some respondents (N=24) reported “other” modalities used

such as acupuncture (N=7), Cranio sacral therapy (N=3), Somatic Experiencing (N=4), and Hakomi (N=1). In the “Other” category, some respondents (N=10) reported using multiple modalities, such as massage and Reiki.

Characteristics of Trauma-Related Symptomatology

The sample was further analyzed according to the nature of symptomatology among respondents and whether the applied body-centered modality involving therapeutic, direct touch increased or decreased symptoms resulting from trauma. Of the total sample, 73.3% reported a decrease in overall symptoms, 6.7% of respondents reported an increase, and 6.7% were unchanged (see Table 4). Of the 6.7 % who reported an increase in symptoms, some stated that the increase of symptoms was due to an increase of affect experienced in the body. One respondent testified, “ When I first started body work, my symptoms did increase at times because I started to feel things. My life [post trauma but prior to treatment] was spent not feeling feelings or even being able to identify what feelings were.” The overall negative impact of therapeutic, direct touch seemed to be associated with “uncomfortable feelings,” which came to the surface as a result of the bodywork.

TABLE 4

Trauma-Related Symptoms Applied to Body-Centered Modalities Involving Therapeutic, Direct Touch.

	Increased	Decreased
Anxiety	13.3%	86.7%
Depression	11.1%	88.9%
Suicidal thoughts	6.7%	93.3%
Self-harming behaviors	6.7%	93.3%

Respondents who used a body-centered modality involving therapeutic, direct touch 66.7% reported no increase in symptomatology associated with traumatic experiences. As a result of having bodywork their symptoms were not increased, while 17.8% felt that their symptoms were increased.

Chi Square tests were run to examine the relationship between having a spiritual practice and symptoms increase or decrease reported by participants, compared with symptoms reported by those who did not identify having a spiritual practice. Of the total sample those who engaged in a spiritual practice, 83.3% experienced a decrease in their symptoms, while in the group that did not have a spiritual practice 88.9% experienced a lower rate (see Table 5).

TABLE 5

Chi Square Tests of Association Between Symptoms and Spiritual Practices

	Value	df	Asymp. Sig. (2 sided)
Pearson Chi-Square	1.103	2	.576
Continuity Correction			
Likelihood Ratio	1.762	2	.414
Linear-by-Linear Association	.915	1	.339
N= valid cases	39		

General Findings

The findings are grouped below in two primary areas: attitudes regarding respondents' experience with bodywork modalities involving therapeutic, direct touch and the awareness regarding the connection between physiological disturbances and psychological stress.

Attitudes Regarding the Use of Touch as a Modality

Attitudes associated with therapeutic, direct touch in various body-centered modalities were assessed through a subset of questions designed to understand how therapeutic touch is experienced by trauma survivors in this study. Likert scaled and open-ended questions focused on respondents' emotions, thoughts, or concerns about their chosen body-centered modality in the study.

Overall, 68.9% of respondents with a traumatic history reported a positive experience using therapeutic, direct touch modalities, 15.6% both positive and negative experience, and 2.2% were undecided. Touch in the context of body-centered therapy was helpful according to two respondents:

I found that touch in the context of therapy helped me to learn to get out of my head and feel my feelings. (I found most talk therapies to be rather cerebral and talked about my feelings, not actually processing them.) It also helped me to find where in my body the emotional holding was and how to release it. It was rather helpful to have somebody compassionately and skillfully facilitate a state of catharsis in a safe way.

Having my therapist place her hands on my heart, touching parts of my body that felt pain, holding my hands made me feel connected.

Another important component noted by respondents in the study was the “intentionality around the use of touch; discussing what touch will be used and why; discussing boundaries and saying no.” That is, respondents were helped by therapists' discussions about the use of touching in advance of beginning to touch, describing exactly what touch and boundaries around touch would be involved, and giving clients complete opportunity to say “no” to any given touch modality. Respondents described mindfulness of the therapist as an effective key to the successful use of touch mixed with psychotherapy.

Massage was the modality most utilized by respondents, which contributed to overall feelings of warmth and safety, leaving a calming influence and soothing an

overwhelmed, overworked nervous systems as a result of traumatic experience. Respondents reported receiving benefit from massage by working out tight muscles, relieving neck pain and stress associated with sleep disturbances, along with relieving “debilitating anxiety” and teaching muscles to relax. One respondent attested that “massage forced me to be in my body- that hadn’t happened anywhere in my life since the trauma.”

Massage and Reiki were credited with aiding in deep relaxation, and allowing the inner voice to emerge during bodywork sessions. Reiki was noted as “less invasive” of the body-centered modalities involving touch. Therapeutic, direct touch was associated with connection, trust and warmth; most importantly, touch used in massage was associated with creating a sense of safety and providing reparative issues through “boundaried, contained touch.” One respondent noted the curative effects of Rosen

Method bodywork:

Rosen Method touch helps access [emotions], at a client’s pace, traumatic material that is held in tight muscles. As unconscious material is brought to consciousness, and the feelings released, the muscle tension can let go. The result is a relief from symptoms of PTSD, as well as feeling at ease in my body and in the world.

When respondents were asked to identify aspects of therapeutic, direct touch that felt harmful during the process of working through traumatic material, 15.8% reported a mixed experience, both positive and negative. Issues surrounding the mixed response included the therapist not being mindful of using touch, perhaps the therapist’s own dissociation, as well as the therapist following a prescriptive protocol for applying touch, instead of a relational one where the respondent felt that the “touch was not placed directly on an area without any moving around of the hands.” Boundaries concerning the

implications of the therapeutic frame felt constricting to some respondents where one respondent comments:

Occasionally having to end the session precisely on time, right when something was about to come out/ wasn't done coming out yet, leaving me to be emotionally 'uncorked' after the session.

While there were a low number of males represented in the study, one female respondent with a sexual abuse history noted when choosing a body-centered practitioner, a male bodyworker would feel unsafe and trigger past traumatic experiences.

Awareness of Physiological Disturbances Connected to Psychological Stress

The sample was further analyzed to capture the application of therapeutic, direct touch modalities with respondents who experienced either one time or multiple traumatic episodes. Of the overall sample, 55.3% reported that bodywork received "helped a great deal" in processing traumatic experience; 34.2% said it "helped a little," and 10.5% "did not help at all". Respondents further noted when asked whether they had an awareness that physical symptoms may be related to psychological stress, 68.9% strongly agreed, 15.6% agreed, 2.2% were undecided and 0% disagreed. Previous descriptions above associated bodywork with allievating physical discomfort, such as neck pain, muscle tension, and with calming distressing bodily symptoms associated with trauma.

Respondents' attitudes concerning the use of therapeutic touch as a modality in the study point out an intrinsic connection between psychological and physiological process and how in describing those attitudes and experiences related to trauma, they also describe the body in process. Two respondents noted:

I had not connected the various physical symptoms that I've had to PTSD- although I had recognized that I am very somatic. Bodywork, although I feared it, in the end helped me bridge the gap between my physical experience and my psychological one.

Mind, body and spirit are all connected. Anything that affects one affects the other. To relieve the physical pain of body memory one needs to do bodywork. All human beings need to be touched and touched safely. I needed to learn about safe touch.

T-tests were also run to compare the mean responses of those who reported having a spiritual practice as well as overall decrease in symptoms and an awareness that their symptoms were connected to the original trauma. There was a significant difference in awareness for those who reported a spiritual practice compared to those without ($t(8.911)=2.340, p=.044$, two-tailed.) The group with a spiritual practice had a lower mean on the 1-5 awareness scale ($m=1.10$) than the no spiritual practice group ($m=1.67$). There was no 0% significant difference in overall decrease of symptoms.

Narrative Data

The general narrative themes that emerged in the answers from respondents in the study when they were asked how bodywork involving therapeutic, direct touch increased or decreased symptoms as a result of trauma, related to the predominant sense that bodywork with touch was helpful in decreasing symptoms. Other narrative themes included the impact of interpersonal relationships and sexual intimacy post trauma. The majority of respondents experienced a decrease in negative symptoms shown in Table 4: while an increase of symptoms was slightly indicated, some respondents described the increase in terms of a heightened sense of awareness; for some respondents, therapy

involving bodywork with direct touch was the first time feelings were experienced and felt as bodily affect. A respondent noted:

Some symptoms did spike at first- overall they decreased but when I first started with both Reiki and massage, the flashbacks increased and I was paralyzed with fear. It brought up more body memories but eventually [this] was what helped decrease my symptoms.

No boundary violations were reported among respondents; however one respondent reported an increase of symptoms due to a lack of information regarding treatment interventions for PTSD where a bodywork professional was uneducated about the sensitivities regarding touch in trauma therapy. This respondent wrote, “ I received inadequate and unscientific treatment while my symptoms worsened until I ended up in a psychiatric hospital.”

Respondents answered two open-ended questions related to how trauma impacted interpersonal relationships, and how trauma affected sexual intimacy. Of the total sample, 100% of respondents reported impaired interpersonal relationships and an impact on sexual intimacy. Seven respondents reported issues with trusting others and experiencing boundary violations within the context of interpersonal relationships, “choosing inappropriate partners,” and “feeling vulnerable.” Two respondents wrote:

The events made me wary of other people. Family found out about what happened and blamed me. The events had the effect of disconnecting me from others and of making me terrified of emotional intimacy. From shame, I avoided others and avoided talking about myself, being open.

I am pretty much agoraphobic now. There are days where I cannot leave the house or talk to roommates or even close friends without feeling anxious. These bouts of agoraphobia are directly related to my trauma (severe childhood hazing) where I viscerally associate having to socialize informally in/with groups of people with violence and being shamed.

Regarding the impact of the trauma associated with sexual intimacy, one respondent noted:

My past traumatic experience had impaired [my capacity for] sexual intimacy by [my] being overly sexual and with multiple partners. I was also unsafe. I was looking for intimacy and love. I now have learned to have a healthy sexual relationship.

Overview of Results

The results of this study reveal positive benefits regarding the use of therapeutic, direct touch with bodywork for relief of trauma-related symptoms. It was found that those who either (1) self-identified or (2) had a current or past diagnosis of PTSD found curative results from various hands-on therapeutic techniques. These results surfaced despite respondents' severe traumatic histories, especially those involving interpersonal trauma, suffering at the hands of another human being.

Overall, the professional, therapeutic relationship provided respondents the opportunity to develop and experience trust in the context of touch as a reparative means of healing past trauma. Body-centered therapy provided an opportunity for respondents in the study to use the body in psychological process and reflect on the innate connection between body/mind. Narrative themes from respondents showed that discussing the trauma while incorporating the bodily process facilitated their gaining a deeper understanding about the nature of traumatic material held in the body and the ways in which it can be released.

CHAPTER FIVE

DISCUSSION

A review of the literature revealed that the use of body-centered modalities involving therapeutic, direct touch as a treatment intervention for trauma-related symptoms is very much utilized in the field of Body Psychotherapy. Yet the literature also reflects ambivalence regarding the use of therapeutic touch when working with those who suffer from traumatic experience, especially interpersonal trauma. The use of therapeutic touch as a means to explore and abreact trauma remains a sensitive issue: Touching those who have experienced trauma at the hands of another human being can provide a cathartic, healing journey for both therapist and client when touch is applied from a relational, rather than a prescriptive perspective (Staunton, 2002). When modalities using therapeutic touch are used with trauma survivors, the therapist engages in a true use of self in order to rework maladaptive patterns of how survivors have previously experienced touch.

This study explored the effects of therapeutic, direct touch when working with those who either (1) self-identify as having experienced a traumatic event(s), or (2) have a current or past diagnosis of PTSD, and the use of the body in psychological process by surveying volunteer participants recruited in a purposive, convenience sample. This study explored two hypotheses: 1) body-centered techniques involving therapeutic, direct touch may have curative benefits for trauma survivors; and 2) therapeutic, direct touch may provide a means for rebuilding, restructuring maladaptive patterns held in the body to achieve healthy psychological functioning. Among those surveyed, this mixed method

study sought to understand how trauma survivors have experienced body-centered modalities and if the chosen modality was useful in processing psychological trauma.

Current Findings and Previous Literature

The findings show that the majority of those sampled who had a trauma history and used body-centered modalities involving therapeutic, direct touch, found curative benefits utilizing the body as a tool for integrating physical and psychological symptoms resulting from trauma. The negative bias surrounding the use of touch due to its being laden with sexual overtones (Milokovich, 1998; Zur, 2007, 2008) is unfounded in this study since 0% of respondents reported boundary violation during treatment interventions; moreover, respondents reported the opposite experience: therapeutic, direct touch provided soothing, calm qualities that alleviated anxiety, depression, suicidal thoughts and self-harming behaviors. Fully 69.9% of respondents reported a positive experience using therapeutic touch, while 15.6% reported mixed feelings and 2.2% were unsure. Although loss of trust in interpersonal relationships was an issue addressed by respondents (N=7) in the narratives, therapeutic touch in the context of a compassionate, caring professional provided restorative benefits for those surveyed. As discussed previously in the literature review above, there are clinicians whose professional opinion holds that touch may trigger reexperiencing of past trauma, especially those who have a history involving interpersonal trauma (Rothschild, 2000, 2002). However, results from this study suggest that those who had experienced interpersonal trauma (66.7%), and perhaps complex PTSD (55.6 % reported ongoing trauma lasting more than ten years),

benefitted from a therapeutic relationship incorporating touch in relearning, healthy, safe patterns associated with non-traumatic touch.

Self awareness and the use of bodily transference-countertransference are both thought to be critical components in ethical considerations when applying therapeutic touch to trauma survivors (Aposhyan, 2004; Matthew, 1998; Ogden, 1997; Totton, 2003). With regard to the importance of maintaining professional boundaries within the constraints of the therapeutic relationship when using touch, Smith (1998) reiterates the importance of informed consent-- meaning that the therapist needs to discuss the intention to touch, giving specific descriptions of how touch will be used in treatment so that the client will be truly informed and part of the process of deciding whether to use touch or not. Discussing the client's personal comfort with touch and how he/she feels the application will be curative allows for deeper connection between therapist and client. Therapeutic touch used in a relational context presents an opportunity for both therapist and client to explore client's sensitivities to touch based on religious, cultural, gender or personal preferences (Vargas, O'Rourke & Esfandiari, 2004). Gender implications when working with survivors of sexual abuse are imperative consideration for the success of therapeutic touch in the treatment room, and lack of sensitivity in this area may prove harmful to the client (Geib, 1982), shown earlier in the personal narratives of those surveyed.

Krystal's (1988) observation that traumatic experience may lead to alexithymia and several respondents in the narratives reported dissociation: that as a result of trauma they lost the ability to feel and identify feelings. Bodywork modalities involving therapeutic touch allowed respondents to connect again with bodily sensations.

Interestingly, respondents who used body-centered modalities reported that their chosen intervention helped a great deal (48.9%), helped a little (28.9%), and did not help at all (8.9%), suggesting that while body-centered techniques help address somatizations, therapeutic touch may not be for everyone, depending upon personal preferences, cultural and religious ideas regarding touch in therapy. The original hypothesis that engaging the body in psychological process through therapeutic, direct touch encourages awareness and integration of traumatic memory was supported by 68.9% of respondents who strongly agreed that as a result of having bodywork they experienced an increase in awareness regarding symptoms being related to original traumatic experiences; 15.6% agreed and 2.2% were unsure. Since trauma-related symptoms are expressed as implicit, somatic memory held in the body, utilizing body-centered modalities discussed earlier in this study allows trauma survivors to access and address somatizations through therapeutic, direct touch. As a result of bodywork, 73.3% reported a decrease in trauma-related symptoms, while 6.7% identified an increase in symptoms, and 6.7% reported their symptoms unchanged.

Although touch is viewed as an intimate endeavor and should not be used as a prescriptive tool, it is interesting to note that the type of therapeutic, direct touch most utilized by respondents in this study was massage (N=30). One of the most intimate and physically revealing techniques, respondents chose this modality over other less intrusive interventions.

Strengths of the Study

This study consisted of a twenty-two question survey conducted online after this researcher established a URL traumaandthebody.net and proceeded to contact various

organizations to obtain permission to distribute the survey associated with this study to their list-serves, along with contacting various psychotherapists and bodywork practitioners. Quantitative and qualitative data were collected over a four month period. Collecting both quantitative and qualitative data allowed for using a Likert-type rating scale, thereby gathering numerical answers, as well as narrative responses. Giving voice to individual experiences through the narrative replies added a richness of personal experience and gave the data more depth and character.

The self-designed survey worked well with the exploratory/descriptive research question, addressing trauma-related symptoms and the use of bodywork modalities involving therapeutic, direct touch. The survey consisted of 1) demographic information; 2) a series of questions regarding a brief history of trauma information; and 3) a series of questions focused on therapeutic interventions. This approach was appropriate because it allowed for brief answers that provided boundary setting and containment, which may have otherwise been difficult to achieve in a strictly qualitative study. It may also have provided an opportunity for respondents to reflect upon treatments used and their process of recovery.

Use of an online survey guaranteed respondents anonymity and ensured confidentiality through SurveyMonkey.com's encrypted software. The anonymity assured by use of the encrypted software was helpful in that it provided absolute protection of their privacy, and allowed respondents to self disclose emotionally sensitive material at their own convenience and possibly in the comfort of their own homes. Lastly, an online survey was a cost-effective tool to gather data over a relatively short period of time and from a large geographical area.

Another strength of the study was derived from the qualitative responses received from the open-ended questions. Rich personal experiences with body-centered techniques illuminated what might have been only dry, numerical values in the study results, and gave further evidence and qualifications for the Likert scale questions as well. Respondents were able to share limited, brief histories of traumatic experiences thereby containing the possibility of reexperiencing further trauma. Because of the personal experiences shared, this researcher was able to further identify respondents who had complex PTSD and how it impacted relational functioning throughout their lives.

Limitations of the Study

Even though there are numerous strengths in the study, limitations exist as well. Most notable are the imbalance of gender and ethnicity. Caucasian women represented the vast majority of the sample. This is partially due to the researcher's focus in the recruitment process in seeking possible participants who used body-centered modalities involving direct touch in the recovery process. It was not within the parameters of this study to examine the gender implications of treatment interventions; the cause for this discrepancy in gender and ethnicity is unknown. Only 5 out of 45 respondents did not identify as being white or Caucasian. Similarly, only 5 out of 45 respondents were male.

As discussed in previous chapters, some respondents skipped various questions, or failed to complete the survey leaving out crucial data, so that 31 of the 76 surveys could not be used in the study. The sample of respondents was thus much smaller than would have been desirable. The absence of the researcher in-person while gathering data for this study may have impacted the lack of completed surveys, which might not have

occurred during a face-to face interview process. It remains unclear as to why surveys were not fully completed; however, given the nature of the target population, it is possible that survey questions triggered reexperiencing symptoms causing respondents to exit the survey.

Based on the small sample surveyed, there is enough evidence to suggest that trauma survivors are using body-centered techniques as a means of healing trauma. Overall, trauma survivors surveyed found positive results using therapeutic, direct touch. In several instances, respondents reported success using multiple modalities to address trauma suggesting the importance of varied usage, coupled with relational component of the therapist's listening to, and remaining mindful of client's needs. Although the number of respondents (N=45) is relatively small in the study, the high percentages regarding (a) overall positive experience with the chosen therapeutic touch technique; (b) the awareness that physical symptoms were related to the original trauma suggest a strong need for further research regarding body-centered modalities involving therapeutic, direct touch. Moreover, the overall low percentages of respondents who reported concerning increases in trauma-related symptoms as a result of using therapeutic, direct touch modalities again suggest there would be benefits to be realized from future research.

Researcher bias is also a component to this study insofar as the impetus for this topic rests in the researcher's own belief in the curative aspects of body-centered therapies involving therapeutic, direct touch with trauma-related symptoms. Furthermore, the researcher is a certified Level II Usui Reiki practitioner who incorporates body awareness and psychological process into treatment interventions. The researcher's prior clinical knowledge and experience has shown that trauma survivors felt benefit from

professional bodywork such as massage and Reiki, and in many cases, is the only time in which a survivor can experience touch safely.

In addition, the use of the Internet survey presented some drawbacks, the major one being the limitation addressed previously regarding unanswered or incomplete questions. An online survey question can only be answered once and if the question is vague or unclear to the participant, the question may not be answered. Unlike quantitative data collection, qualitative research allows the researcher to be an active member of the interviewing process guiding and structuring questions for clarification, which ensures that questions will be answered fully. Nonetheless, another drawback to the Internet survey was that there was not a relational component to the data collection process whereby questions could be skipped without a human appeal or intervention.

Implications for Future Research

Some specific implications for future work have already been discussed above, but the major ones to be stressed are as follows. The results of this study support Vargas, O'Rourke and Esfandiari's (2004) observation that body-centered therapies "advance the psychological and physical healing process" (p.129). It is clear from this study that participants suffering from traumatic experience benefitted from using the body as a tool in psychological processing as a means of integrating traumatic memory and resolving symptoms as a result of trauma. Yet careful thought and consideration should be given when working with those who have experienced trauma bodywork involving touch and should be applied as in a relational, therapeutic context and not as a prescriptive protocol.

The findings of this study suggest that further exploration is needed examining effective body-centered treatment interventions for trauma survivors using therapeutic, direct touch. In an effort to extend the findings of this study, it might be interesting to investigate further the relationship between trauma-informed interventions and various therapeutic, direct touch techniques with a one year study where potential participants work with a primary therapist in order to navigate experimental learning. Possible participants would be prescreened for PTSD using a diagnostic assessment tool, such as the *Trauma Symptom Inventory* (TSI) in order to qualify for the study. Participants would then be grouped into two categories, each with a separate control group. Each control group would consist of individuals who do not have a diagnosis of PTSD and have used body-centered therapies to alleviate generalized depression and/or anxiety but *have not experienced* a traumatic episode. Group 1 would consist of participants who have a diagnosis of PTSD and use body-centered therapies involving direct touch as a primary treatment. Group 2 would be comprised of participants who have a diagnosis of PTSD and use only traditional psychotherapy. This one year study would allow the researcher to examine the efficacious component in direct touch techniques compared to healing benefits of those using only talk therapy. The control groups for each group will further measure the benefits and risks of using therapeutic, direct touch with trauma survivors compared with those who do not suffer from PTS.

Pre and post treatment measurements would be evaluated for fluctuations in neurobiological structure and functions through the use of neuroimaging scans, PET and functional magnetic resonance imaging (fMRI) testing. Blood tests would monitor stress hormones, such as cortisol, along with measuring cardiovascular structure and functions

(e.g. resting heart rate, blood pressure). Body posturing, facial expressions, skin tone and body temperature would also be considered in observing the physiological aspects of treatment.

The use of therapeutic, direct touch is a complicated topic when applied to trauma-related symptoms. Touch modalities may be beneficial to some, and less helpful to others depending on the range of experience and clinical presentation. The spectrum of human experience is varied and what one client may have experienced as helpful may not be as useful to another. Yet some theorist believe that “touch is so important that *not* using it in therapy may hinder clients” (Strozier, Randall & Kuhn, 2008, p. 247). Touch is a necessary, life giving source but should be used with thoughtfulness, especially when working with trauma survivors. If touch is used within the relational framework of a trauma-informed body-centered therapist, unconscious body memory may be expressed and released in the body and brought into consciousness to be examined furthering exploration in the understanding of traumatic memory.

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Appendix A
Human Subjects Approval Letter

December 5, 2008

Sunshine Finneran

Dear Sunshine,

Your new revisions have been reviewed and all is now in order. We are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your interesting project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

APPENDIX B
RECRUITMENT LETTER

Hello,

My name is Sunshine Finneran and I am a graduate student at Smith College School for Social Work. I am working on my master's thesis on trauma and body-centered psychotherapy. I am a Level II Reiki practitioner in Connecticut- New England area and would greatly appreciate if you could help me recruit participants for my study titled- Trauma and the Body: A Survey Examining the Use of Therapeutic Touch. I am seeking participants to help me understand the nature of trauma in the body and the outcome of using therapeutic touch as a method of healing trauma.

Participants must be between 25-65 years of age, have a past diagnosis of Post Traumatic Stress Disorder, or self identify as having experienced a traumatic event, used bodywork involving direct touch as a healing modality, along with one year of psychotherapy. If you know of anyone that might fit these criteria, please direct them to my link:

<http://www.traumaandthebody.net/>

Please feel free to contact me at sfinnera@smith.edu you have any questions or concerns. If your organization has a means for me to advertise my recruitment, I would greatly appreciate the information.

Thank you so much for helping me distribute this important study.

Sunshine Finneran
Candidate for Master's in Clinical Social work

APPENDIX C

INFORMED CONSENT FORM

December 7, 2008

Dear Participant:

My name is Sunshine Finneran. I am conducting a study on the uses of physical touch in body-centered therapies and its effect on symptoms resulting from trauma. This research study for my thesis is being conducted as part of the requirements for the Master of Social Work degree at Smith College School for Social Work and may be used in future professional presentations and publications.

Your participation is requested if you are a person who has experienced past trauma for which you sought individual psychotherapy for a minimum of one year; and whose body-centered therapy involved touch as a primary modality -- such as massage, Reiki, Rosen Method, Bioenergetics, or other non-specific hands-on bodywork not mentioned here. The survey will briefly cover your demographic information, such as age, gender, occupation, level of education, your socio-economic status, brief circumstances of your therapy experience, the therapeutic methods you chose, and your thoughts on the outcome. It should be noted that the emphasis of the survey lies in the interventions used and not on the traumatic experiences themselves. The survey will be conducted electronically and will take approximately 25 minutes to 35 minutes to complete. The survey requires that participants read and write English and have Internet access.

The potential risk of participating in this study may be that some survey questions may trigger uncomfortable thoughts and feelings, although the focus of the survey will be on methods used in your therapy rather than on the events that were traumatic and led you to seek treatment. In the event you feel the need for additional support after participating in this study, you will be given a list of online resources to locate mental health services in your area.

Benefits of participating in this study afford you a unique opportunity to reflect on your own healing process, what was effective and what was not effective for you. You will also have the opportunity to reflect on how touch impacted your healing process and the connections associated with the particular therapeutic interventions.

You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to new information regarding effective treatment for trauma. It is my hope that this study will help therapists and bodywork practitioners better understand how trauma held in the body may be helped with body centered methods, as well as the specifically most helpful ways to serve clients.

You must read and electronically sign the informed consent by checking "yes" at the bottom of this page. By checking "yes" you have indicated your consent and will be automatically sent to the survey. If you chose to participate, please print this page and keep it for your records. If you click "no" below you will immediately exit the survey.

Strict confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. Your identity will be protected, as the survey remains anonymous and no potential identifying information will be used in reporting of the data. The data may be used in other educational activities as well as in the preparation for my Master's thesis. I will then store the data in a locked file for a minimum of three years, consistent with federal requirements, and after three years all data will be destroyed unless I continue to need it, in which case it will remain in a secure, locked location.

Your participation is completely voluntary. You are free to refuse to answer specific questions and to withdraw from the survey at any time by clicking “exit this survey” located at the top right hand side of the page. However, once the completed questionnaire is submitted, a participant will not be able to withdraw from the study since there is no identifying information on the completed survey that would connect a particular survey to a particular participant -- rendering it impossible to selectively delete the intended information.

If you have additional questions about the study, please feel free to contact me at the contact information below. Thank you for participation in this study. If you have any concerns about your rights or about any aspect of the study, please contact me via email sfinnera@smith.edu or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR CLICKING “YES” BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

- YES
- NO

Date: _____

Please print a copy of this page for your records by going to file at the top of this browser page and selecting “print” so you can contact me or use the referral resources.

Thank you for your time, and I greatly look forward to having you as a participant in my study.

APPENDIX D

Trauma Survivors

Have you experienced a Traumatic event in your life?

I am a graduate student seeking participants to help me understand the effects of trauma and the use of therapeutic touch.

If you are:

- Between the ages of 25 and 65 years of age,
- Self identify as having experienced a traumatic event or have a diagnosis of Post Traumatic Stress Disorder ,
- Involved in psychotherapy for a minimum of one year,
- Used bodywork - massage, Reiki, Rosen Method, Rolfing, Bioenergetics or non-specific hands-on energy work

I would like to invite you to take a survey for my thesis research.

For more information – contact: sfinnera@smith.edu

Please use the link below to connect to the survey:

APPENDIX E
INSTRUMENT GUIDE

[If you are completing this Survey, you are indicating that you have read and understood the purposes of this study, are between the ages of 25-65 years old; have experienced post-traumatic stress symptoms for which you sought and received treatment lasting at least one year, and that this treatment involved direct touch as a primary modality from your therapist during its course.]

Age in years: _____

Self-identified ethnicity: _____

Religious/spiritual preference, if any: _____

Highest years of education: _____

Occupation:

Gender: _____

Socio-Economic Status: Annual Income-

- \$12,000-24,000
- \$24,000- 35,000
- \$35,000- 55,000
- \$55,000 and above

Relationship status: (e.g., single, married, separated/divorced, widowed, in committed relationship): _____

1) What category of Post Traumatic Stress Disorder best describes your circumstances?

Please check only one response.

- One time event
- More than one event

2) If more than one event occurred, please specify the appropriate time period in which the events occurred:

- Events occurred within three years
- Events occurred over five years
- Events occurred over ten or more years
- Not applicable

3) What type of traumatic event (s) best describe your circumstances:

- Accidental Trauma, which includes natural disasters, car accidents, human error, plane crashes or home accidents.
- Interpersonal Trauma, which includes domestic violence, physical or sexual abuse.

4) Please check the appropriate box that describes your past symptoms associated with the traumatic stress. Please check all that apply:

- Flashbacks/memory intrusion
 - Auditory
 - Visual

- Hyperarousal- meaning you have a heightened sense of awareness, moments when you fear for your safety, feelings of intense alertness accompanied by feelings of anxiety.
- Feeling disconnected, spacey where memory can be impaired
- Difficulty concentrating

5) Physical symptoms included: Please check all boxes that apply to you

- Accelerated heart rate
- Sweating
- Loss of appetite
- Loss of sleep/sleep disturbances
- Nightmares

6) If you checked nightmares, how often did nightmares occur:

1. Nightly
2. Once a week
3. Once a month
4. Infrequently, with no typical pattern
5. Not applicable

7) Impaired relationships (Dialogue box) Please briefly describe your experience in the box provided before:

8) Impaired sexual intimacy (Dialogue box) please briefly describe your experience in the box provided before:

9) Please check the appropriate box to more adequately describe the treatments

you have experienced:

- Massage
- Reiki
- Biofeedback or Bioenergetics
- Hands-on Energy work, non-specific
- Rolfing
- Rosen Method
- Other: Please Specify:

10) In which of the following settings did you receive bodywork:

Please check all that apply.

- Professional Office
- Home Office
- Your home
- Retreat Center
- Other

11) As a result of the body-centered work, please indicate what happened to your symptoms:

- Increased
- Decreased
- Remained unchanged

12) To what degree did body-centered work you received help you process your traumatic experience:

- did not help at all
- helped a little
- helped a great deal

13) Please check the appropriate box(es) to describe the symptoms that were alleviated:

- Anxiety
- Depression
- Suicidal thoughts and/or behaviors
- Self-harming behaviors, eating disorders, cutting.
- Please briefly describe your decrease in symptoms in the dialogue box provided below:

14) Did body-centered work you received increase your symptoms?

- Yes
- No

15) Which symptoms, if any, were increased:

- Anxiety
- Depression
- Suicidal thoughts and/or behaviors
- Self-harming behaviors, eating disorders, cutting.

- None

Please briefly describe your increase in symptoms in the dialogue box provided below:

16) Please add other information about your experiences in the dialogue boxes provided below:

17) What specific aspects of touch in the context of the therapy you experienced, if any, were helpful?

18) What specific aspects of touch felt harmful?

19) Briefly describe in the space below why you chosen the body-centered intervention (i.e. massage, Reiki etc)

20) Was your overall experience with therapeutic touch?

- Positive
- Negative
- Mixed both positive and negative
- Unsure/Undecided

21) During either psychotherapy or body-centered work you had an awareness that your physical symptoms may be related to your traumatic experience:

- Strongly Agree

- Agree
- Not Sure/Undecided
- Disagree
- Strongly Disagree

22) Do you know of anyone who fits the participating criteria who would like to participate in the survey? If so, please offer this survey link in order for others to participate.

THANK YOU MOST SINCERELY FOR YOUR PARTICIPATION IN THIS SURVEY!