MASSAGE AND BODY-WORK WITH SURVIVORS OF ABUSE

An article in five parts

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Although this material was developed for working with survivors of sexual abuse, it also provides a good framework for creating and maintaining professional boundaries and for doing effective massage and body-work with all clients.

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This is a series of five articles about massage and body-work with survivors of abuse.

Part I — Massage & Body-Work with Survivors of Abuse

How I Came to Work with Survivors

I first became aware of the prevalence of sexual abuse in the mid 1980s when a significant number of my students and clients began to disclose that they had been abused as children. Through my graduate work in 1984, I had already learned that early estimates of sexual abuse had been vastly underestimated. In the 1950s and 1960s it was commonly believed that one person in a million**1** in the United States had been the victim of incest. Research statistics in 1984 indicated that, in fact, 18% of the population in the United States had been victims of incest.**2**

The extent of sexual abuse was driven home to me during one of the classes I taught in which half of the students disclosed their experiences of abuse, and one disclosed being a perpetrator. During that same period in the clinic at the Muscular Therapy Institute, where we were treating two to three hundred clients each week, a pattern began to emerge. Students started to report that their clients were disclosing sexual abuse during treatment.

In 1989, the exposure of several well-known and respected physicians, in both the traditional and alternative health fields, as sexual abusers started me on a journey of investigation, research, and writing on the issues of sexual abuse within health care. In 1990 I decided to develop a workshop on working with survivors of abuse for hands-on professionals. I spent the next eight months researching various body-work approaches. I interviewed psychotherapists who specialized in working with survivors, massage therapists and body-workers who worked extensively with survivors, and survivors who had been helped in their healing process by practitioners of different forms of therapeutic touch. I also collaborated with Janet Yassen, the Crisis Services Co-ordinator of the Victims of Violence Program at Cambridge City Hospital, to develop the more psychological aspects of the workshop. In 1991 I began to teach the workshop, "Massage and Bodywork with Survivors of Abuse." Much of this article is based on the research, preparation, and experiences in teaching that workshop.

How This Article May Be Helpful

This article is intended as an introduction for massage therapists and body-workers who want to work with survivors. Many skills are needed, both technical and emotional, to work effectively with this population. Most of these skills are learned over time with training, ongoing supervision and increased self-knowledge.

This article by itself will not prepare a therapist to work with survivors. [*The term "therapist" in this article will refer to a massage therapist or body-worker.*] In fact, when I teach a workshop, I consider it a sign of success when a participant becomes aware enough to say "I realize that I'm not at all ready to work with survivors, I have a lot of work to do first." Some of the participants in most workshops decide not to work with survivors until they have a better understanding of their own histories and motivations.

The terms "massage therapy" and "body-work" will be used interchangeably and will include all touch therapies.

The article will be useful for:

* therapists who are working with survivors and those who would like to;
* therapists who discover that they are working with survivors and don't know what to do:
* therapists who wish to evaluate their own skills and motivations for working with survivors;
* survivors who are trying to decide whether to include massage therapy as part of their healing process and are wondering how to choose an appropriate therapist, and
* psychotherapists who are investigating whether or not to refer clients to a massage therapist or body-worker and thereby incorporate work with the body into the treatment process.

Although providing safety and clear boundaries is very important when working with survivors, it is also very important for the therapist working with all clients. In fact, we can thank survivors for forcing us to take a closer look at these issues.

In this series of five articles we will discuss:

a) the psychological underpinnings of abuse,
b) basic concepts in the treatment of survivors,
c) important prerequisites for working with survivors,
d) how to create an appropriate therapeutic environment,
e) ethical issues involved,
f) verbal and physical techniques used in treatment, including how to deal with flashbacks,
g) setting up an ongoing support system,
h) finding the appropriate supervisor, and

i) how to expand the therapist's educational base in preparation for working with survivors.

What Is Sexual Abuse?

Before we discuss how to work with clients who have been sexually abused, it is important to understand what sexual abuse is and the complexity of its effects. Janet Yassen**3** defines sexual abuse as "unwanted or inappropriate sexual contact, either verbal or physical, between two or more people that is intended as an act of control, power, rage, violence and intimidation with sex as a weapon." At its core, the intent of all abuse, whether sexual, emotional or physical, is the same: to dominate, humiliate, and gain control of another person. It is a traumatic event, perpetrated by another that violates the basic bodily and psychic integrity of the victim.

The Types of Abuse

Sexual abuse can range from inappropriate seductive behaviour and sexual touching to sexual intercourse. Sexual abuse includes rape, gang rape, date rape, partner or spouse rape, and incest.

Incest defines a specific kind of abuse which has particularly devastating effects. In its narrow, legal definition, incest is the sexual abuse of a person by a family member who is related by blood or marriage, such as a father, mother, uncle, sister, or brother. Within the psychological community, incest is more broadly defined to also include sexual violations by trusted individuals with regular access to a child or care giving responsibilities, such as family friends, child care providers, ministers, or psychotherapists.

Sexual abuse can also take the form of ritual and cult abuse. This is often a horrific and systematic form of sexual violation of children and teenagers, under which they are subjected to sadistic torture, drugged to become compliant, and forced to repeatedly perform sexual acts with adults and sometimes animals. This type of abuse has not been fully documented and accepted by all professionals in the field, but I have personally, interviewed people who have gone through some of these experiences.

Sexual abuse rarely occurs as an isolated event. It is often accompanied by other types of mental, physical and emotional abuse. Emotional abuse such as put-downs, insults, demeaning comments, and sudden irrational acts intended to instil fear are not unusual. In the case of incest, this may also include the withdrawal of love and affection or threats to hurt others as a weapon of control.

These are some of the things survivors have said to me:

"He told me if I told my mother he would kill me."

"My father told me if I let him do things to me he would leave my sister alone."

"He was usually drunk and would try to choke me or smother me with a pillow while he raped me. This went on weekly from the time I was eight till I was sixteen."

The Prevalence of Sexual Abuse

The statistics on sexual abuse are difficult for most people to take in. The numbers are staggering. In the United States alone, a woman is raped every six minutes.**4** One in three women and one in six or seven men have been sexually abused by the time they are 18 years old.**5** If these two figures are averaged, one in five people, or about 50 million people in the United States, have been sexually abused. Some professionals believe that this number is an exaggeration while others think it is low due to the under-reporting factor and those individuals who don't remember. If this number is hard to believe, reduce it by a factor of half, or even two thirds, and it is still a frightening number. Whether sexual abuse has always been that prevalent and is only now being more accurately reported, or whether it has increased due to the dissolution of the family and other social factors, is hard to determine.

There have been several periods over the last hundred years during which sexual abuse has been exposed, discussed and acknowledged,**6** but it has only been in the last ten or fifteen years that the social and political context has provided an ongoing, welcoming atmosphere for research and wide acceptance. According to Herman, the women's movement provided the political environment to support the ongoing research and recognition of the extensive existence of sexual abuse.

Although more girls than boys are sexually abused, one recent research study finds that the number of boys who have been sexually abused is greater than previously thought.**7** Most of the abuse is perpetrated by men,**8** although women can and do abuse both boy and girl children.

Thus, a therapist can generally expect that approximately one in five people who come for treatment is likely to be a survivor of sexual abuse, and many others will be survivors of other types of physical or psychological trauma.

The Effects of Abuse

Sexual abuse is a trauma that leaves profound and lasting effects on a person's psychological, cognitive, and emotional functioning. The impact and symptoms of trauma have become know as "post traumatic stress disorder" or PTSD.**9** According to dedicated researchers, including psychiatrist Judith Herman, who explored the effects of trauma in her groundbreaking 1992 book, *Trauma and Recovery*,**10** similar effects of trauma are experienced by survivors of sexual abuse, political prisoners, concentration camp survivors, and many men who have experienced combat in war.

In *Trauma and Recovery*, Herman summarises three major symptoms of post-traumatic stress disorder: hyperarousal, intrusion, and constriction. Hyperarousal is a state of constant alertness to danger experienced by the survivor of trauma. The survivor's senses and body are poised to respond to the slightest movements, noises, or provocations. A survivor may react with extreme irritation or alarm to situations that have little effect on others. Often, s/he sleeps poorly. To the person in this state, all situations carry potential re-enactment of past traumas.

Intrusion is experienced when past traumatic events recur as vivid memories, interrupting the course of life in the present. "The traumatic moment becomes encoded in an abnormal form of memory, which breaks spontaneously into consciousness, both as flashbacks during waking states and as traumatic nightmares during sleep," writes Herman.11

Constriction occurs when the intensity and pain of an event is so severe that the survivor becomes numb to it or removed psychologically. The survivor will register the event in his or her awareness, but in an altered state, where s/he does not experience pain, attachment, or emotion. The person may describe it as going numb, going deaf, or leaving the body. Also referred to as dissociation, this state helps the trauma victim survive unbearable conditions from which there was no actual escape. One incest survivor described her experience of dissociation during incest this way.**12**

> "After I knew what he was doing, I used to separate from him. I used to feel that if I could just get close enough to the wall, that he couldn't touch me (yet I knew he could), but I used to go inside the wall, and it was like he was touching someone else. I would just turn off and get cold."

Constriction can also be experienced as hypervigilance, an over-focused narrowing of attention onto one idea, one part of the body, or a particular sensation or feeling. The task in this case is expanding the focus, to begin to notice the forest and not just one tree. Constriction carries over to the experiences of the present, affecting the ability of the survivor to feel both positive and negative emotions, physical sensations, or attachments to others.

People experiencing post-traumatic stress disorder will often alternate between the opposing psychological states of hyper-awareness and numbness in an effort to gain balance. But until significant aspects of the traumatic memories can be explored and integrated, the survivor is caught between complete forgetting and the constant fear of reliving the traumatic experience.

Herman has proposed a new term, complex post-traumatic stress disorder (CPTSD),**13** for those subjected to prolonged, repeated trauma. Repeated traumatic abuse shatters a person's sense of self and relation to others. In an even more intense way, human contact, especially intimate contact, becomes associated with feelings of intimidation, pain, violence, rage, humiliation, disgust, shame, and betrayal.**14** Further, a person who has experienced prolonged abuse during childhood has no guideposts for judging who is worthy of trust or which situations are truly safe. As a result of the violation of physical, sexual and emotional boundaries, a survivor of sexual abuse often has difficulty defining his or her personal boundaries in relationship to people in the present, and is therefore at risk for further abuse.

The Three Stages of Recovery

Some clinicians have observed three distinct stages of recovery. Others believe that the stages of the healing process are less clearly defined and more fluid. While there may be a continuum of the healing process, I find the three stages described by Judith Herman very useful for massage therapists working with survivors. Herman's model gives the body-worker a clear way to think about a survivor's recovery, even though in the therapy process the survivor may move back and forth between stages two and three, or may experience two stages simultaneously.

Establishing Safety

The goal of the first stage of recovery is to establish physical and psychological safety.**15** The survivor learns how to take control of his or her body and to attend to his or her physical needs, i.e., eating well, sleeping, getting regular exercise, having a safe place to live. As the client establishes this immediate sense of safety, s/he can begin to exercise initiative and take charge of his or her recovery. Establishing safety may take as little as a few sessions or as long as a few years.

Remembrance and Mourning

The second stage of recovery involves remembrance and mourning. In the presence of safety, formerly unconscious, often fragmented, disguised, and deeply buried memories become conscious so they can be reconstructed and transformed into an integral part of a life story. This stage of recovery can be profoundly painful and prolonged, as the person

experiences the pains and horror of the trauma, as well as the grief and loss that accompany it. "The telling of the trauma story inevitably plunges the survivor into profound grief," observes Herman. "The second stage of recovery has a timeless quality that is frightening. The descent into mourning feels like a surrender to tears that are endless. But it is by the remembering, telling of their story, and grieving that the survivor can move toward integration of their trauma and eventually reconnect with ordinary life."**16**

Reconnection

In the third stage of recovery, reconnection, the survivor begins to look to the future and imagine a whole, intact self. The survivor recognizes his or her

trauma but is not possessed by it. S/he begins to feel more confidence in his or her ability to connect with the outside world. The survivor also gains confidence in his or her ability to give and withhold trust appropriately, and to connect on his or her own terms. A survivor may turn his or her experience into social action having transforming effects on self and society.**17**

Recovery Criteria

In recent workshops I have taught, participants have found it useful to be familiar with the criteria developed to determine the benchmarks of recovery from sexual abuse. In a recent article by Lebowitz, Harvey and Herman,**18** seven criteria were identified to help clinicians define recovery from both chronic and acute trauma in more precise terms. Clients in psychotherapy may move through these stages sequentially, but more often the progression is not so orderly. Progress in different areas may vary. The criteria are as follows:

Memory

In recovery, the individual develops authority over the remembering process. He or she, can choose to recall or not to recall traumatic events that previously intruded unbidden into awareness. Critical memory gaps are filled in, and survivors have available a meaningful, coherent narrative of their lives that can be integrated with their ongoing life stories.

Affect Range and Tolerance

Many survivors live life in the affective extremes (numb and/or flooded). Affective recovery is achieved when emotional life is no longer experienced in the extremes, when emotions can be felt, named, and endured, and when the full complement of feelings, in a range of intensities, has become accessible to the survivor.

Memory and Affect Are Linked

Coping with trauma frequently necessitates the unlinking of phenomenological experience. In recovery, feelings and memories are joined. Memories are recalled with affect that is appropriate in content and intensity. The survivor is able to experience feelings in the here and now about what happened in the past and can access or imagine what he or she felt at the time of the trauma.

Symptom Mastery

Symptoms associated with chronic and acute PTSD, including psycho-physiologic ones, have receded or become manageable.

Self-Esteem

Over the course of recovery, feelings of self-hate, badness, and shame are replaced by more positive and realistic view of sex. Responsibility for the abuse is shifted from the victim to the perpetrator, adaptations needed for survival can be acknowledged without undue shame, and self-caring routines replace self-injurious ones.

Attachment

In recovery, disruptions in the survivor's ability to negotiate Psychologically safe relationships are developed or repaired. Feelings of isolation are replaced by an increased capacity to feet connected to others, and once polarised and distorted Perceptions of other people become more realistic.

Meaning

The survivor, through the recovery process, assigns a realistic meaning to the trauma and to the self as a survivor. Views of self, world, and others emerge that are complex and able to incorporate the contradictory and ambiguous nature of reality. The survivor is able to feet a realistic sense of hope and optimism about the future.**19**

The Benefits of Massage Therapy

As awareness of the prevalence of abuse has grown, an increasing number of survivors have sought massage and body therapy to help them reconnect with and reclaim their bodies. Psychiatrists, psychologists, social workers and counsellors are referring an increasing number of their clients for massage and body-work. The therapist who understands abuse and the healing process will be prepared and able to respond in a helpful and knowledgeable way.

Melissa Soalt, psychotherapist and founder of Model Mugging of Boston, a self-defence training, has worked with many survivors. She observes that:

> "For survivors of abuse, body-work can be a very powerful adjunct to psychotherapy. The trauma from abuse typically results in dissociative numbing or repressive mechanisms that can leave survivors feeling "empty" or vacant on the inside… With reconnection and integration (or a move towards wholeness) as primary therapeutic goals, working through the body can be a valuable tool towards this end. Because the body is such a direct medium, body-work can help facilitate this process of re-entry and one's ability to feel more present.
>
> Bodywork can help survivors develop a friendly and compassionate relationship with their body. Sexual or physical abuse often leaves survivors feeling disgusted, shameful or even violent towards their body, as though their body betrayed or turned against them. Bodywork can also help survivors experience his or her body as a source of groundedness and eventually as a source of strength and even pleasure—good things instead of a bad thing.

> Working with a compassionate and skilled body-worker can help rebuild a survivor's sense of trust and reconnect them with the possibility of genuine caring relationships."**20**

When performed responsibly, at the appropriate stage of the client's healing and with care and sensitivity, massage therapy can be an important healing force in a client's life. One psychotherapist observed that body-work offers survivors "a new and non-abusive way of being in touch with their bodies, to discover how their bodies feel and what their general level of health is. It may be their first experience of pain relief or nurturing they have had on the physical level. It may be the path home."

As these therapists have observed, skilful massage therapy can create a safe place for the experience of non-abusive, non-sexual touch, and can help survivors reconnect with their bodies. Massage can also help survivors regain control of their bodies as they practice setting limits and choosing where they wish to be touched.

Establishing a Place of Safety

When the survivor of sexual abuse enters psychotherapy, establishing personal and psychological safety with the psychotherapist is a crucial first step in the healing process. A massage therapy relationship can build on this experience. A healthy body-work environment creates another opportunity for the survivor to establish an environment where s/he can feel safe with emotions and the physical self. The massage therapy experience can offer a safe place to be touched with dignity and respect in a non-judgmental, non-sexual environment.

Regaining Body Control and Rebuilding Boundaries

Massage therapy can be helpful in the rebuilding of personal boundaries damaged by trauma and abuse. The client has the opportunity to construct new boundaries as the work together progresses. For example, by simply telling the therapist where to work and where not to work, the client sets important boundaries on a weekly basis. By being in charge of the session and the therapy, the survivor gains another piece of control of his or her life associated with the body. Each experience of inviting, choosing, and denying touch empowers the survivor.

A client described her experience of body-work, expressing both the benefits and cautions needed to guide therapy in relation to boundaries:

> "My "talk" therapist person suggested to me that I might want to start to draw some boundaries around places in my body where I just didn't feel that I wanted to be touched. That was the beginning of the physical healing part, to say, "No, I don't want you to massage below my waist and above my knees." I felt like such a baby having to draw those lines, but it was such an important part of my recovery… The more that I was empowered, the more I was able to say "Stop" and "No." To rebuild those boundaries was incredibly important to me… But there are still times when I roll over (onto my stomach) if I feel like my genitals are not covered up properly, it's like an alarm goes off somewhere in my head and I still have a lot of shame about saying what's going on for me in the moment."**21**

The Experience of Pleasure and Non-Sexual Touch

Touch that is neutral or pleasurable, and not sexual, provides building blocks for a changed experience of the body. After safety has been established through repeated positive physical contact, the survivor usually begins to perceive the practitioner's touch as neutral, and over time is able to experience touch without dissociation. Later on, pleasurable sensation which is not sexual is usually experienced by the client.

Another client describes her experience this way:**22**

> "Bodywork helped me learn how to be touched again - to relearn how to be touched. All the touch I had gotten was always abusive, sexually or physically abusive. I never knew that touch could be otherwise. Having a massage therapist helped me to trust again and eventually to relax. It was a wonderful way to learn how to go on to a normal life afterwards."

Re-integrating Body Memories into the Experience of Self

Working closely with a psychotherapist, massage therapy can assist the survivor in reaching hidden memories and integrating them into his or her present experience. Abusive traumas from the past cause the survivor to dissociate from the body and this experience often recurs when the body is touched. Massage may trigger the recall of memories to be processed in psychotherapy, as described below. Body therapy offers a pathway to integrate bodily sensations back into the client's life. Having positive body experiences helps to rebuild a sense of self where the body is connected with emotions and thoughts.

As clients begin to connect with their bodies in a more positive way, they experience improved body image and feel less shame. Therapists may find that these clients take care of their bodies more as therapy continues.

A Support to Psychotherapy

Psychotherapists who recommend massage therapy for their clients see massage/body-work therapists as

collaborators in the healing process. Many see it as a valuable adjunct for some of their patients. Some see it as a vital part of the task of reintegrating the body into the survivor's life.

In their collaborative book, *Embodying Healing,***23** Robert Timms, Ph.D. and Patrick Connors, C.M.T. write that "working with the body is a powerful means of side-stepping the conscious mind and gathering information directly from the unconscious fund of knowledge."**24** In their "psychophysical model," each professional brings separate skills and roles to the healing process. The psychotherapist helps the client integrate his or her emotional and cognitive insights, while the body-worker helps the client increase his or her self-awareness and gain access to emotions and less conscious memories through work with the body.

Timms, a psychotherapist, describes the benefits of his frequent collaboration with Connors, a massage therapist, in the following way: "Often I find clients are better able to make cognitive connections in psychotherapy sessions that follow body-work sessions. In most cases, the client's characteristic resistances are lowered and she or he is more available for therapeutic insight."**25**

Melissa Soalt writes:

> "In psychotherapy the therapist is often the one who holds the client's feelings until the client is more able or ready to have and own them. In this light, body-work can both elicit feelings/memories and help survivors contain (i.e., stay with but not become overwhelmed by) these feelings, thus aiding in the psychotherapeutic process."**26**

Psychotherapists and body-workers may collaborate in different ways. A psychotherapist and a body-worker may work together in a sequential mode, where the client has a massage session in the first hour and a psychotherapy session in the next hour. Another method is in a combined mode, where the psychotherapist and the body therapist work simultaneously with a client in one room, such as described by Timms. [*The combined mode, where psychotherapist and massage therapist work simultaneously, may present complex challenges, both rich in opportunity and possible difficulties.*]

Others work concurrently at separate locations seeing a client weekly at their offices and communicating by phone as needed. Most psychotherapists who regularly use massage therapy in support of their work first interview the therapists to whom they will refer their clients.

The Importance of Understanding Sexual Abuse

While massage therapy can provide an invaluable healing environment for the survivor of sexual abuse, the therapist must be sensitive to the experience of the survivor and its effect on their work together, in order to minimize the risks of retraumatization. Melissa Soalt again eloquently describes the dilemma that is faced by the survivor as s/he enters therapy:

> "Being present in one's body is a double-edged sword for survivors: on the one hand working through the body can stimulate the trauma and evoke confusing or frightening feelings; on the other hand, it is this very ability to be present and in one's body that ultimately allows one to feel more grounded and thus safer and more in control."**27**

When a massage therapist begins work with an abuse survivor, s/he may be the first person to touch the client's body since the abuse. Many responsibilities fall upon the therapist. Working to create a safe environment, as a first step, would be consistent with Herman's stages of recovery and minimize potential errors in the treatment process.

Flashbacks, intense memories, and unexpected reactions can result from the abuse experience. A therapist can be most helpful by understanding the origins of these reactions, how to recognize them, and understanding the contribution the massage therapist and body-worker can make.

Potential Harm

Several examples of the negative effects of body-work, when done without appropriate knowledge and training, emerged during my research interviews.

In one case, a massage therapist was approached by a client who was not in psychotherapy but wanted to work on her abuse issues through body-work. The therapist had very limited training in working with survivors, but felt she wanted to help the client in her healing process. In the course of their work together, the client began to have flashbacks during the massage sessions. The therapist felt she should let the client fully experience this memory experience and would then try to process what happened afterward. After several weeks the client began to experience more uncontrollable, intense and disabling flashbacks on buses, in the supermarket and frequently upon walking into the therapist's office. The therapist's lack of training in this area resulted in a damaging situation for the client and a lawsuit against the therapist. In this case the therapist did not understand the significance of the flashbacks and how to deal with them. She did not realize that the client needed to be in psychotherapy and to have other support systems in place; she herself lacked outside supervision to help guide her work when difficulties arose.

This harmful situation occurred because the therapist did not understand that this client was in the first stage of recovery. The client needed to establish safety and a support network. She was not psychologically ready to

delve into her past.**28** The boundaries necessary for effective treatment were not in place.

Another therapist performed some deep and somewhat painful body-work on a woman who was an abuse survivor. Only months into the process did he discover that often, after sessions she had to go to bed for two or three days to recover from nightmares, light sensitivity, emotional pain, and turmoil.

Clients with a history of abuse may not be able to adequately protect themselves when a therapist errs. Treatment mistakes most often occur when a therapist works too deeply or inadvertently violates a boundary. Because survivors often have trouble recognizing their boundaries, they may sometimes ask for treatment that is inappropriate, or they may not be able to let the therapist know if they are feeling violated in some way. It is important for therapists to have an understanding of abuse when working with survivors in order to work at a level appropriate for the client's needs. This can determine how a therapist approaches a session. For example, as I've reported in a previous publication, a therapist I interviewed related a story**29** to me of a woman who came into a massage therapist's office and immediately began removing all of her clothing. The therapist quickly covered her with a blanket and gently asked her to dress again since they were going to start with an interview. During the interview and history, the woman reported that she was an abuse survivor and actually only felt comfortable removing her socks and shoes.

The therapist must have a gently enduring patience, for the pace of the body-work may be very slow. A therapist may literally work on a client's hands or feet for two or three months. Many clients report taking up to a year before they can have their backs and legs worked on without clothing.

Part II — Prerequisites for Working with Survivors

The undertaking of a course of massage therapy is a journey of courage for both the survivor and the therapist. It places many demands on both the client's and the therapist's resources. Certain prerequisites are essential and others very helpful in preparing the therapist and the client for their work together.

Prerequisites for the Therapist

The treatment of survivors requires a refined degree of self awareness, as well as practical training for the therapist. Education in preparation for this type of body-work should include training in psychology, communication, sexuality, ethics, trauma, and counselling, as well as actual hands-on techniques. The therapist will also benefit greatly from networks of support that include peer counselling and supervision.

Psychological Understanding

A baseline knowledge of human psychology and specialized knowledge of issues related to abuse are essential to the therapist who wishes to work with survivors. Fundamental psychological concepts relevant to the healing process include transference, countertransference, power differentials, body memory and boundary issues. The experiences of abuse survivors will intensify these aspects of the therapeutic relationship, and may have unexpected effects.

For the therapist working with abuse survivors, an understanding of the nature of abuse, a knowledge of the different types of abuse and the impact on an individual's life are essential. Learning to deal with flashbacks, body memories, and psychological symptoms, such as hyper-arousal, intrusion, and dissociation, are fundamental.

Workshops and Training

It's important for the therapist who works with a self-disclosed abuse survivor to be able to respond to a client's needs in a helpful and appropriate manner. The actual hands-on techniques for working with survivors are no more physically demanding or difficult than with any other client. But these clients can be more mentally and emotionally challenging because more focus and attention may be required. Training should prepare the therapist to set up an appropriate environment, establish safety and clear boundaries, and deal with symptoms such as flashbacks and dissociation.

Communications training can be very helpful in sensitizing the therapist to the messages a client sends, often without words, and enabling him or her to set up an empowering, non-hierarchical collaboration. For instance, how the therapist handles giving feedback and support to the client, and how the therapist receives feedback from the client, can be crucial In establishing and maintaining trust. The way the body therapist reacts to the client's memories, inadvertent boundary crossings, and anger at treatment errors can make or break the relationship. Making mistakes is not the issue because every therapist will definitely make mistakes. What's Important is how the therapist handles them. How the therapist deals with his or her own feelings of attraction or friendliness to the client, or discomfort with what is heard or experienced in the

session, will be keenly perceived by the client's radar and strongly affect the therapy relationship.

Understanding Your Own Issues and Motivations

It is important for the therapist who wants to work with survivors of abuse to understand his or her own issues and motivations. Taking a closer look at why one chooses to become a massage therapist or body-worker is an important step. We all choose careers for a reason. Becoming aware of conscious, as well as unconscious motives helps the therapist focus on what s/he needs to address in order to work effectively with a vulnerable clientele. Making friends with many clients, or talking about oneself and one's life with clients, or having difficulty telling h client that the therapist can't help, may all indicate a therapist's unresolved or neglected issues that will Interfere with the effectiveness of his or her work.

In one workshop a participant said he decided to work with the body because he was never touched in his family after he was about twelve, except when he was punished. And as an adult he was never touched unless It was sexual. He wanted to learn about touching that was not punitive or sexual. Another participant spoke of how she was never verbally intimate or physically close with anyone in her family and that her work satisfied her need for non-sexual intimacy. Through the course of the workshop the second therapist later realized she was using her work as a way to avoid developing intimate friendships.

A therapist participating in a recent workshop realized she needed to re-enter therapy, after learning she was over-stepping her clients' boundaries by asking invasive questions. In the workshop she realized that her questions related to her own intense curiosity and were not really relevant or useful to the therapy. In other words her Interventions with the client served her needs and not those of the client.

Being clear about where and how the therapist gets his or her personal needs met for touch, intimacy, and sexuality is an important aspect of preparing ourselves to work with survivors.

One good way for the therapist to explore his or her level of awareness about these issues, as well as the ability to communicate effectively, is to undergo personal psychotherapy. This is a good place to investigate and understand one's own unmet needs before and during the work with survivors because of the many strong feelings that may come up during this process.

Ethical Dimensions

The ethical dimensions**30** inherent in body-work are intensified in working with survivors. Having a clear ethical code that is thought through and adhered to is an important part of a therapist's commitment to the survivor and his or her healing. For example, it is important to have clarity about relationships with clients outside the treatment context, respect for the client's confidentiality, clarity in financial dealings, willingness to admit mistakes, and honesty if the situation goes beyond the therapist's expertise. The treatment must be truly client-centred.

Supervision and Support

Setting up solid support systems for oneself before working with survivors is essential. I recommend that therapists arrange for regular supervision with a psychotherapist who is an experienced supervisor and who has worked with abuse survivors. Ideally this person will have some familiarity with massage and body-work as well, but I have not found this to be essential. Meetings with a supervisor should be regularly scheduled, to deal with issues that inevitably come up when working with survivors. A description of how to find a supervisor will be suggested in Part V of this article.

Prerequisites for the Client

Clients need to be in a place in their therapeutic process where they will gain benefit from body-work. They should be in therapy and at an appropriate stage in their recovery. As body-work can intensify the psychotherapy process, clients must be ready and strong enough to deal with this.

In Psychotherapy

Before beginning body therapy with an abuse survivor, it is important to confirm that the person is working with a psychotherapist and the therapist has agreed that the inclusion of body-work at this time is a good idea. Psychotherapy is the primary therapeutic relationship for working through survivor issues. [*Survivor groups are also an essential part of the recovery and therapeutic process.*] Optimally the client is working with a psychotherapist who has had experience and training in working with survivors.

Appropriate Stage of Recovery

As described in Part I, the phase of the recovery process that the client is in is extremely relevant to the usefulness of body-work for the client. Bodywork is generally most helpful as part of the third stage**31** of recovery (reconnection), when the client is integrating his or her trauma experience, and when s/he is building connections with the outside world. Bodywork is sometimes helpful during the second stage of recovery (remembrance and mourning) as a means of making contact with the body, learning to like the body, and in some cases to help recover memories. The psychotherapist and client decide together if the time is right for a collaboration.

When body-work is undertaken too soon, it may trigger memories that the client is not prepared to handle. In these cases the client may actually, experience the

hands-on work as recreating the trauma experience. There may be episodes of escalating intrusive symptoms, crying, sleep disturbance and increased flashbacks.**32** Bodywork is generally inappropriate during the first stage of recovery (establishing safety) which requires very careful building of trust and safety between the client and psychotherapist.

Consent to Communicate

Ongoing contact between the client's psychotherapist and massage therapist may need to occur during the body therapy process. This may happen only at important junctures or once each month if the client is securely into the third stage of recovery. In other instances weekly contact may be important. When a client experiences a flashback or a very strong memory during a body-work session, It is usually useful for the therapist as well as the client to communicate this to the psychotherapist. The psychotherapist may also have helpful suggestions as to where the body-work might be concentrated at different points in the therapy. The client must be willing to give consent for this communication. This permission should be given in writing at the beginning of the first or second session and kept in the therapist's files for his or her protection.

Before the work begins, the client must understand that sessions are confidential, and that only the psychotherapist, body-worker, and supervisor(s) involved may discuss the client's sessions.

Important Psychological Concepts

To create and maintain an effective therapeutic alliance with the client, a massage therapist or body-worker needs to have a good grasp of seven important concepts as s/he approaches work with survivors. These are:

1. The nature of the therapeutic relationship
2. Transference and countertransference
3. Secondary traumatization
4. Projection
5. Power differentials
6. Dual relationships
7. Boundaries

It is important for therapists to understand these concepts in order to be effective in their work and avoid re-enacting the very traumas the client has come to body therapy for. Awareness and understanding alone will not insure a successful outcome, but it makes it more likely that the therapist will be in touch with the needs of his or her client. Although I will review these concepts in the context of working with survivors, they will be useful in working with all clients.

The Therapeutic Relationship

The massage therapist is in a therapeutic relationship. The therapeutic relationship is a special kind of relationship. It is client centred. The client has the right to expect that the practitioner will act in his or her best interest. The time spent together is limited and structured. The client comes for a session each week or at some other interval for a specific type of treatment. Each person has a clearly defined role. The client comes for help and the practitioner Is there to help the client. There is a power differential Inherent in the fact that one person comes to another for help and there is a payment for the service. Finally the client has the right to expect that the emotional and physical environment will be safe and never include a sexual relationship.

Transference

Transference is a normal psychological phenomenon that inevitably appears during the therapy process. All professional helping relationships usually have a strong transference element in which the parent-child relationship is unconsciously re-established. In transference, unresolved needs, feelings, and issues from childhood are transferred onto the helper. Transference also occurs in other relationships where there is a real or perceived power differential, such as with a boss, teacher or clergy. In the mature adult, these feelings are more likely to be recognized and dealt with and do not tend to control the person's behaviour. In individuals who are unaware of or not psychologically able to handle these feelings, transference may become the dominant reality,, causing frequent disappointment and rejection in many relationships, often followed by anger and withdrawal.

The power of touch in stimulating transference has not been formally, studied. But anecdotal evidence suggests that touch, especially when it is intentional and done with care, can quickly create transferential or regressive experiences. Comments by body-work clients confirm this reality daily. Clients frequently disclose very personal information in a first or second session, they often tell the therapist about their emotional problems, or forcefully demand special treatment. On an unconscious level, clients often expect body-workers to help them in emotional and other areas as well. These are transference reactions, and the massage therapist needs to be prepared to understand and deal with them in a gentle, appropriate manner.

Countertransference

Countertransference is simply transference occurring in the opposite direction, from the therapist to the client. The therapist also carries unresolved needs, feelings and issues into the therapeutic relationship.**33** When these are unconsciously transferred onto the client, it is called countertransference. Countertransference is a strong force that can adversely affect the therapy

relationship -if not recognized and moderated. The results of unchecked countertransference will be less effective therapy, loss of clients, or actual psychological harm to the client. If the therapist is aware of the phenomenon of countertransference s/he is more likely to recognize it when it is occurring. This awareness can make the therapist's responses more appropriate and facilitate refocusing on the client. A therapist who is experiencing countertransference may experience some of the following:

1. More emotional charge, both positive and negative, toward a client. Distorted thinking, such as idealising the client or feeling very negatively toward them.
2. Feelings of irritability or anger with a client for not changing, getting better or co-operating with your prescribed treatment plan.
3. Thinking one's work is so much better than most therapists, or feeling one's work is totally ineffective and worthless.
4. A pattern of feeling exhausted, exhilarated, depressed, or uneasy when the therapist sees a particular client.
5. Recurring themes in one's practice, like frequent sexual attraction to clients, or the recurrent desire to make friends with clients.
6. The expectation of praise and resulting disappointment when clients do not praise the therapist's work.
7. Helping clients in matters outside the sessions, doing favours such as offering them a ride, frequently helping connect them to other people.**34**

What happens in countertransference is that the therapist begins to feel toward the client the same way the therapist felt toward someone in his or her past. Notice this as a signal of something that is happening on an unconscious level and get some help with it from a supervisor or psychotherapist.

*Secondary Traumatization **35***

It is commonly known that psychotherapists often experience secondary traumatization when they work with survivors of abuse or psychological terror. They may even take on some of the symptoms of post-traumatic stress disorder (FITSD). A body therapist may also experience, although probably to a lesser degree, the fear, outrage, and despair of the survivor client. S/he may feel suddenly helpless in the face of the client's pain and emotions.

While you are working with a survivor, s/he may choose to tell the therapist about some of his or her sexual abuse experiences. If this happens, it may stimulate uncomfortable feelings in the therapist, memories from the past, and possibly a stronger countertransference. It is important that the therapist deal with these feelings, memories or countertransference in a supervision session with a supervisor, in psychotherapy and/or with a colleague called on for peer supervision or support. It is inappropriate to share these kinds of feelings and thoughts with the client.

If a client says something that makes the therapist feel overwhelmed, a countertransference is probably occurring. One therapist might be able to contain the feeling, finish the session and get supervision afterwards. Another therapist might become too overwhelmed, and say, "I'm feeling strong empathy with what you've just said. Would it be alright if I took a break for a moment to gather my thoughts?"

Therapists need a place to work through the feelings stimulated by their clients' stories of abuse, or their unresolved feelings may get in the way of being an effective therapist.

Power Differentials

There is a natural power differential in many relationships, beginning with a parent and child, and moving on to teacher and student, boss and employee, and of course, therapist and client. Since a power differential exists in any therapy relationship, clients feel less important than the therapist,**36** and the therapist is accorded a great deal of power. From the parent-child relationship the client brings the hope that the therapist will always be able to help, and will only do what is best for the client. This power differential puts the client in a very vulnerable position and makes it difficult for the client to say "no", or to question the therapist's behaviour, even if the client feels uncomfortable or mistreated. The greater the power difference, the greater the potential for strong transference and countertransference.

It is the therapist's responsibility to use the power that has been conferred upon him or her only to foster the recovery of the client, resisting all temptations to abuse power.**37** This promise, which is central to the Integrity of any therapeutic relationship, is of special importance to patients who are already suffering as a result of another's arbitrary and exploitative exercise of power.**38**

Projection

Projection occurs when a person has a thought or feeling that s/he is not comfortable with and then projects it out and sees it in other people. For example, if a therapist feels sad, s/he may experience the client as feeling sad and ask about it. When a therapist is unaware of feeling angry, s/he may perceive the client as angry in general, or angry at the therapist. The primary danger of projection is that the therapist may not see the client where she or he **is** and will fail to help the client in an appropriate way. Instead, the therapist

tries to help the client with issues and in ways that the therapist needs help.

Dual Relationships

A dual relationship is one in which there are two overlapping roles. A multiple relationship is where three, four or more roles occur simultaneously. An example of a dual relationship might be if a person is a client and a friend, or a client and a boss. In a multiple relationship, the client may be a supervisor, a student, and an employee. The more overlapping the roles, the more complex the relationships become. For a therapist, having more than one relationship with a client carries certain risks. Some argue that most, or all, dual relationships are to be avoided because the client is in a less powerful position and always at a disadvantage. The client often ends up feeling hurt or disappointed. Others argue that in many cases dual and multiple relationships can provide a rich and useful experience. In the particular case of body-work with survivors, dual relationships tend to only complicate an already difficult task and are strongly discouraged.

Multiple and dual relationships differ from serial relationships, where one relationship is terminated before a new one begins. For example, a client stops being a client and becomes a student, graduates, then becomes a colleague, and later a friend. When the initial relationship was that of client and therapist, or student and teacher, the transference may have been quite strong. It is a good idea to let some time lapse before moving to a peer relationship. When dealing with clients who have had a sexual abuse history, extra care must be taken in making, these transitions. It **is** also important to recognize and consider that once this transition is made, it is very challenging to reverse the relationship without confusion and difficulty. If the client at some time in the future wishes to return for therapy, s/he will no longer be able to work with the therapist if they are peers.

Boundaries

An understanding of boundaries is crucial to the work of massage therapists and body-workers, especially those who choose to work with survivors. A boundary can be a perceptual line or zone that defines one's personal space In relation to others. It can be as literal as the skin that surrounds the body or the distance within which a person feels safe next to someone else. There are physical, sexual, intellectual, and emotional boundaries that define areas of privacy. Boundaries can be created through language, type of touch, clothing, money, time, the roles taken on at a given moment, and the attitude one presents. Non-verbal cues such as voice tone, facial expressions, certain eye movements or expressions, tilts of the head, sounds, breathing, and body postures or gestures can also signal change and create boundaries between people.

People have different kinds of boundaries depending on their personal histories, their own comfort zones, and their cultural context. Equally, a person creates and changes boundaries depending on the situations s/he is dealing with. For example, a person will have changeable boundaries in the course of a day, depending on whether the person is hugging someone s/he loves, nursing a baby, meeting with a boss, feeling under attack, or sharing an intimate moment with a friend.

Certain boundaries are built into the therapist-client relationship that are quite different from those between friends, colleagues, or family, members. How they are understood and applied has a profound effect on the quality of relationships with clients. This is particularly true for working with survivors of sexual abuse. Psychotherapist Melissa Soalt describes her observations from her work with survivors

> "*Because abuse disrespects and destroys one's boundaries, survivors typically have poorly developed boundaries. In order to feel "safe." many survivors resort to a familiar Isolation and erect dense protective barriers. Conversely, survivors often describe feelings of defencelessness and vulnerability that is equated with having "no skin" of one's own and therefore having no internal shock absorption. Everything feels "jarring" and triggering and personal. Creating flexible and appropriate boundaries can be extremely challenging for survivors.*"**39**

The boundaries of survivors have been crossed and broken repeatedly. Because of this past abuse, survivors are often unable to consciously recognize boundaries and protect themselves:

> "*I was not only molested by my father, but by my grandfather on my father's side. It was somehow accepted that my grandfather could put his arms around us, could pet our legs, could french-kiss us when he greeted us, you know… This would be in public, and yet, there was my mom smiling, there was my dad, smiling, and his french-kissing me in private was not far from that. Where did I draw the line? I didn't know.*"**40**

Therapists need to be very sensitive to the boundaries of touch both on and off the therapy table. For instance, when greeting or saying good-bye to a client do you shake hands, do you put your hand on the client's shoulder or back, or do you hug the client? These are all questions to be thought through and talked about when working with any client, but especially when working with a survivor. The boundaries of survivors have been so violated, that they may be consciously unaware of being violated, or may be unable to protect themselves by saying no to unwanted touch even if they are aware of it. With survivors, the range of physical contact on and off the table must be handled very carefully.

Careful attention to boundaries will help to empower the client and will also protect against excessive, unmanageable transference reactions. The therapist who works with survivors must have clear, consistent boundaries in order to both provide and model a relationship with good boundaries. An important part of the body therapy work is to help the client rebuild boundaries and thereby empower the survivor to protect himself or herself.

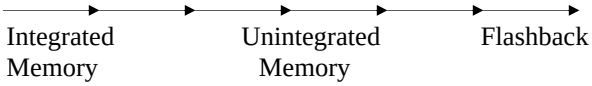
Part III — Physical and Emotional Boundaries

Body Memories and Flashbacks

It is important for the massage therapist and body-worker to have an understanding of memories, particularly the differences between flashbacks and integrated memories.

Any part of the body may hold a memory.41 When an emotionally charged area is touched, memories that have been repressed for a long time may be evoked.**42** Certain areas such as the mouth, throat, neck, chest, abdomen, buttock and inner thigh may be more likely to hold memories of traumatic sexual abuse than other areas. But this is not always the case. One survivor described getting very upset when her partner put an arm around her shoulder. She recalled her abuser putting his hand gently around her shoulder when the ritual of her abuse was about to begin in childhood.**43**

Memories appear along a continuum of consciousness, ranging from an integrated memory to a brief faint recollection that is gone in an instant (unintegrated memory), to a flashback which is out of the person's control.



A flashback is the experience of reliving or re-experiencing a traumatic event as if it is occurring in the present. When this occurs, "the individual is awake but appears to be in a state of altered consciousness and often has subsequent amnesia for what takes place. The experiences last from a few minutes to several hours..."**44** The person has regressed and believes the abuse is occurring or is about to occur.

A memory is a remembered event that may or may not be painful. When a memory is painful, it is often unintegrated. Parts of the memory may be blocked out and many of the details missing. If a memory is disturbing it may appear and then be lost for periods of time. One person recalled having a clear memory that was painful, and then totally forgetting it within seconds - as if it were in a fog. Memories can stir up unresolved feelings and may be quickly repressed.

An integrated memory is a memory that may have been painful but has been remembered, understood, and accepted. The person may not like the memory but doesn't fight remembering it and can cope with the details of the memory without being overwhelmed by it. An integrated memory doesn't consume the person or take the person over. It has an emotional charge that can be tolerated.

Along the continuum from integrated memory to flashback, there may be many variations. For instance, one can have a faint recall of an event triggered by a part of the body being touched or by a smell or a sound. But nothing of substance is recalled. A person can also have a very clear memory and find it so unacceptable that s/he re-represses it, and can't recall the memory later.

Here are some examples**45** of how touch triggered different memory experiences. One client described a memory of a very clear sexual encounter with her father while her mouth and jaw were being massaged. The client had no idea that she had been abused until that moment.

Another client always felt afraid whenever her left shoulder was worked on. She only recalled the details of her abuse after years of work in psychotherapy. A third client had a momentary flashback triggered by massage to the neck and went into a catatonic state for twenty minutes. This client was fully dissociated, not responding to verbal communication or touch. Some clients may feel indefinite, disturbing emotions when they are touched without any conscious memory at all. They feel uncomfortable, but do not know why. This can be the result of a painful memory that is triggered, but is not yet able to emerge into consciousness.

When a flashback is triggered, concrete, distinct memories suddenly surface and intrude on the present. They can be triggered by touching any part of the body or by a particular feeling, sensation, or experience. Sometimes the smell of an oil or the cologne the therapist is wearing is associated with a past event. A flashback may be experienced as a momentary flash of memory or a movie that the client is in. The flashback may pass quickly or be prolonged and last for an hour or more. During a very intense flashback, a person relives the traumatic event and believes that the abuse is actually occurring or is about to occur in the present moment. The client may have intense emotional reactions such as fear, sobbing, or feelings of rage with physical trembling. When the flashback is occurring the person is dissociated from the present. The client cannot tolerate the memory and splits off his or her consciousness and is no longer psychologically present.

When a flashback occurs the task of the therapist is to bring the client back to the present as quickly as possible. This will be covered in detail later.

Bodywork with survivors often unearths memories that are painful, unpleasant, or terrifying. When they occur at the appropriate stage of psychotherapy, this can be helpful to the survivor's process. To have a memory that is therapeutically useful (as opposed to a

flashback) requires that the client feels the environment is safe. In addition, the presence of the therapist as a witness can help the client integrate the memory into consciousness.

When aware of the dynamics of body memory, the body-worker can help the client remember while remaining present and in his or her body. A skilled therapist learns how to avoid inducing flashbacks and how to move the client back to the present if flashbacks occur. Much of this is covered in Part V of this series of articles, but nothing can replace in person training, including boundary setting and flashback role plays with a skilled teacher or coach.

Body Therapy in Practice

We have discussed the nature of abuse, critical psychological concepts, and a number of prerequisites to working with survivors. Now let's turn from theory to practical application.

A therapist may begin work with a survivor in a number of ways. A client may be referred by his or her psychotherapist as part of the psychotherapy process. The therapist may be contacted by a survivor who has heard about the therapist's work through a friend, or who has read about the benefits of massage therapy. Also a current client may disclose being a survivor of abuse. Let's begin with the first contact when we talk with a client who has disclosed on the phone that s/he is a survivor of abuse and how the first session might be set up.

Initial Contact — The Phone Interview

The treatment relationship usually begins on the phone. After getting the person's name and the name of the referring person or psychotherapist, an opportunity exists to create an appropriate context. The therapeutic relationship starts here by establishing some boundaries, structure and an initial sense of safety. There are many ways to structure an initial session, and a potential client will benefit from knowing the therapist's approach. Ask the person if he or she would like a brief description of an initial session. The following is a suggested structure and initial description that may work well. The therapist might say something like:

> "My first session is an hour and a half long. For the first half of the session I will ask you for some information and give you a chance to ask me as many questions as you would like. I see the first session as an exploration of whether we would like to work together. After 30-40 minutes of conversation you can decide if you would like to try a short hands-on session."

Let the client know right from the start that s/he is in charge. The therapist might also say, "If you are not sure, or if you want to think about it for a week or if the match doesn't feel right to you, we can stop to give you time to decide."

My policy if the session stops at this point is not to charge anything. My personal philosophy is that the person should not pay me to see if I feel safe enough to work with. At this point I would say something like, "My fee for the first hour and a half session is $75.00 and for subsequent hour-long sessions it is $50.00. If you decide not to continue the session I do not charge anything for the initial 40 minutes. If we do decide to work together and continue, I will charge you for the session." Always establish financial arrangements on the phone to minimize the possibility of misunderstanding.

Some therapists also include additional information on the phone. For some clients it may be important to know that s/he is in charge of where on the body the therapist works, or that the client may leave most of his or her clothes on during treatment. If you have a sliding fee scale it might be important to mention that and how it is negotiated.

What you have done during this initial phone conversation is begin the relationship. The client knows that s/he is free to interview you and shares the control of the process. During the phone conversation also ask the client if there is anything s/he would like to ask you before coming. This invitation opens the door if there is something the client really wants to ask you, but feels hesitant.

Everything you discuss on the phone will be repeated at the beginning of the first session. It is best to have everything in writing also, for clarity, and especially if the person's primary mode of processing information is visual. Sometimes the client is experiencing fear and anxiety just making the phone call, and most of what is discussed will be forgotten.

Conducting phone interviews along these lines gives a feeling of mutuality, and respect, no matter what the specific arrangements are.

The Physical Environment

The physical environment of the therapist's office should create a sense of safety and comfort. Some suggest making the office colours soft and neutral. If the therapist works in a professional office, s/he might make changes to create a more homelike and warm feeling. Have some personal effects in the office to make it look less sterile. If the therapist works in an office in the home, make it very separate from living space if at all possible, and decorate it in a way that makes it feel more clinical and professional. There should be a minimum of clutter in the waiting area and office space. Be sure the windows are covered, and there is a smock and/or a sheet laid out for the client. If possible have a separate bathroom without your personal things in it.

Be sure the office is reasonably soundproof. Use a sleep sound (a small machine which produces a background noise), or quiet music, if the soundproofing is not as good as you would like it to be. Literature in the waiting room can create a sense of safety. For instance, books, brochures and articles that deal with abuse may be helpful. The therapist might have a statement of policies in a small binder for clients to read. This may also be sent to the client prior to the first session. When the client enters the office or treatment room have the curtains or blinds drawn, so there is no possibility of being viewed by a stranger.

One survivor related an upsetting experience of visiting a practitioner whose office was disorderly and obviously not soundproof. She described feeling unsafe and unable to relax and decided not to work with this particular therapist.

The First Session

As the client enters the treatment room or waiting area, greet the client in a friendly but professional way. Shake hands only if the client extends a hand toward you first. If the client has to wait before you begin together, it may be useful to give them relevant literature to read or the written history form to fill out, which we will review later in this section.

The Pre-Treatment Mutual Interview

After a client is settled in a chair, always restate what was discussed on the telephone. As was previously noted, it is very likely that the client was anxious during the initial phone conversation and doesn't remember everything that was said. Let the client know that the first half of the session will be spent in conversation, during which the client will have an opportunity to ask questions. Then proceed to the hands-on phase of the session only if the client wishes to.

Reviewing Policies

After reviewing the structure of the first session, outline the policies for the client. It is good to make sure that everything is understood. Have a standard set of policies made available to the client in writing and go over it as part of the first interview. Writing up guidelines helps the therapist fully think through and be clear about his or her policies.

These are suggested guidelines to set up a therapeutic relationship, and to establish good boundaries. Create your own or feel free to use these if you wish.

Appointments
The first session is an hour and a half, appointments after that are one hour. If the client is late, work for the remaining time of the session. If the therapist is late, the client gets a full hour.

Cancellation Policy
When working with a survivor, as with any client, be clear about the cancellation policy. Some therapists have a two, five, or twenty-four hour cancellation policy. Whatever your policy is, make the boundary clear and stick to it, allowing for the same flexibility you would give to any client if a situation arises where there is unusual distress or extraordinary circumstances. It is important not to make special exceptions or do special favours for any client, survivor or non-survivor.

Fees
State your fees, whether you have a sliding scale or not, how payment is handled, how often you raise fees, etc.

Professional qualifications
Briefly describe your training. Include the training you have that qualifies you to work with survivors. Describe the work you do and how it differs from, but is supportive of, psychotherapy. Encourage the client to ask questions all along the way by periodically asking if what you have said is clear and if they would like to know more.

Supervision
Inform the client of the kind of professional supervision you receive on all your clients and its function.

Code of Ethics
Tell the client that you have a professional code of ethics developed by your profession and/or yourself and that they may have a copy if they wish. Clearly state that you do not have social, intimate, sexual or business relationships with your clients.

Confidentiality
Speak about the confidential nature of the therapeutic relationship. Also let the client know that you will not ask for any details about his or her abuse history, but are interested in hearing anything that s/he feels will be helpful to your work together.

Collaborative Nature of Your Work
Stress the importance of working in a collaborative relationship with the client and his or her psychotherapist. Let the client know that you don't work with anyone who has an abuse history unless s/he is currently working with a psychotherapist, preferably one who has knowledge and training in working with that issue. If not in therapy, let the client know why it is important to consider. Describe the possibility of opening up areas of memory, experience and feelings, and the need to have a place to share and explore those experiences.

Delayed Discovery of Sexual Abuse
Sometimes, a person comes for massage and body-work and doesn't know s/he is a survivor, but figures it out after a period of treatment. In the author's experience, this occurs with some frequency. If the

client is not in psychotherapy or is working with someone not specifically trained to work with survivors, it may be wise to discuss your work with the client. In some cases it may be important to delay the body-work until the person gets settled into a more supportive psychotherapy situation. It is good to have a list of referrals for such situations.

Level of Therapy

After establishing that the client is in psychotherapy, ask the client if his or her psychotherapist agrees that s/he is in an appropriate stage of recovery for body therapy. Where the client is referred by a psychotherapist, the appropriateness of body therapy has probably been previously established.

Informed Consent

As an addendum to the confidentiality agreement, it is important for the client to know that the only other persons who will know about your work together will be your supervisor, who will not know the client's name and identity, and the client's psychotherapist.

Disrobing

A clear statement about disrobing is very important when working with survivors. Stress the importance of comfort for the client. Let the client know that s/he will dress and undress in private. Make it clear that the client can wear whatever s/he feels comfortable wearing. The client can wear all of his or her clothes, take off shoes and socks only, wear a smock, wear some of his or her clothing, whatever is most comfortable. Let the client know that it is not at all unusual to leave clothes on for some time. It is recommended that a survivor not completely disrobe, including underwear, even if completely covered under a sheet. Leaving this article of clothing on helps to create a safe boundary for the genital area.

Tell clients that they will always be covered with a sheet or towel except for the area you are working on. Explain that the therapist leaves the room for the clients to change in private. Once the client has had time to change, get on the table and cover him or herself, the therapist knocks on the door before coming in and asks if the client is ready

Give the client opportunities to ask questions about the therapist's policies, so that mutuality can be established. S/he has the right to ask questions about the therapist's approach, ethical dimensions of the work, and any other questions that come up about the therapist's work.

Taking the Client History

After the mutual interview, a review of the client's history will enable the therapist to build further rapport and gain valuable knowledge about the client's situation. Through the history taking, it is also important to establish the survivor's strengths in creating strategies for his or her survival. Therapists need to identify and build on those capacities and skills that helped the survivor get to where s/he is now. The history will also help the body therapist find out whether it is appropriate for the client to undertake body-work at this time.

When the client comes in, some therapists have clients fill out a brief history form in the outer office before entering the treatment room, while others just ask the questions verbally. The history form, in addition to the normal details, will typically include questions like this:

* Is there any pain problem or injury that you currently have?
* Have you had any significant medical condition in the past?
* Are you currently taking any medications? If so which?
* Do you exercise?
  ___ Regularly ___ Occasionally ___ Rarely
* What kinds of exercise?
* Describe your diet.
* Where in your body do you feel you carry stress and tension?
* Are you seeing any other health care practitioners regularly? (medical doctor, psychotherapist)
* What things do you enjoy doing?
* Have you had body-work or massage before?
* If yes, was it a positive, negative, or neutral experience?
* What strategies have you used to cope with and manage some of the symptoms and stresses you have worked through?
* How are you feeling now, in anticipation of this session?
* What would you like to get out of our working together?

At the end of the history form or on a separate form include the following statement:

> I hereby give permission to (body therapist's name) and my psychotherapist (the psychotherapist's name) to exchange relevant information to help me in my healing process.
>
> Signature _____
> Date _____

At the bottom of the history form, you might add, "Please feel free to add additional comments below that might be helpful in our working together."

Follow-Up Questions

EVEN IF FILLED OUT WHILE WAITING, reviewing the client's history together helps to build a connection in addition to gaining some relevant new information. When reviewing the history, ask the client about:

Pains, injuries, or medical conditions. This lets you know what to be careful of. You do not want to cause the client any pain in the treatment.

Medications and drugs. Certain medications, like thorazine, elavil, zoloft, and others will affect the client's ability to feel sensations in the skin. Ask about the use of alcohol, recreational drugs and smoking. These questions will give the therapist some idea if substance dependency is an issue for the client.

Personal care. This gives an indication of how much the client takes care of himself or herself physically, i.e., exercise, diet, and health care. Answers to these questions will tell the therapist the degree to which the client is taking care of or abusing his or her body.

Body Awareness. By asking where the client carries stress and tension, the therapist gets an idea of how in touch with his or her body the client is. The therapist compares the client's assessment with his or her own after working on the client. If the client is fairly unaware, the therapist may approach working with this client somewhat differently than if the client were more aware. For example, if a person thinks that his or her body is very relaxed but in fact is very tense, the therapist would move very gently and slowly in bringing that awareness to the client. The therapist would not say, "Your back is really tense, like a rock." On the other hand, if a client demonstrates keen awareness when telling the therapist where s/he feels tension or deadness, the therapist might speak with the client more directly about it.

Previous Bodywork. This can be an important question if the client has had a bad experience or has never had body-work before. It lets the therapist know what to be careful of or what needs more preparation. If the previous body-work was a good experience, ask why the client didn't go back to that therapist. This will give you information as to what the client is hoping to get from working with a new therapist.

Asking a few open-ended questions after the history and follow-up gives the client an opportunity to offer additional, information. At this time, it might be appropriate to ask if the client has ever experienced flashbacks. If so, ask what has been helpful in those experiences. The therapist may ask, "Is there anything else you would like me to know?" but not "Have you had any particular abuse experiences that might impact our work?" In the second instance the client might experience the therapist as intrusive, putting pressure on the client to reveal more than s/he initially wants to.

Asking the questions in a neutral manner shows care and interest. When clients feel comfortable and have a need to tell the therapist about some aspect of their experience, they will. During one such open-ended conversation, a client described being sexually molested and tortured around her face and neck. She let me know when she was ready that I needed to be very careful when working near or on her face and neck. Another client revealed that a therapist had sexually abused her and that she was very anxious about our session. Others will respond simply by saying "No." Never push to get information from a client. When a client is ready, s/he will tell the therapist what s/he wants the therapist to know.

Let the client know that sometimes survivors experience difficult emotional feelings and/or bodily sensations during or after a massage session, like a tingling feeling in the hands or feet, intense heat, or momentary dizziness. The therapist might say, "If that happens, I will do my best to help you understand what is happening and refer you to additional sources of support if that appears necessary or appropriate."

Part IV — Moving To Body-Work

The previous discussion described the therapist's first session with a potential client. In the first session, the initial contact, mutual interview and history-taking requires about thirty to forty minutes. It is now time to ask the client, "Do you have a sense of whether or not you would like to continue the session and have a hands-on treatment today, or would it be a good idea to stop now and think about whether or not you would like to work with me." If the client isn't sure, suggest that s/he think about it and call to schedule a hands-on session, if it feels right. It is important for the therapist not to let anxiety or the desire to work with a particular client allow him or her to apply any pressure for the client to continue. Allowing the client to be in charge will make the therapy more effective.

If the person decides that s/he would like to continue the session and try the hands-on work, move to the next phase, which involves the specific work that the client and therapist are going to undertake together.

Setting Goals Together

Ask the client what goals and expectations s/he has for the massage and body-work. Discuss long-term goals and set short-term goals for the first session together. If the client has difficulty with this, give some examples of realistic goals. A long-term goal might be something like: "To help me reduce the tension in my body so I can feel positive or enjoyable sensations when touched." or "To be present and not disappear (or dissociate) when being touched." or "To not be afraid

when being touched," or simply "To connect with my body," or "Be more aware of how my body feels."

A short-term goal for the session might be to see if massage is something s/he wants to do. Another might be to remain present while having his or her feet worked on, or to learn how to relax when touched on the foot or to have the lower legs worked on. Having the client establish a goal that the therapist agrees can be accomplished in a session or two places a manageable limit or boundary on the session and puts the client in charge of the treatment options.

Empowering the Client

While preparing for body-work together, emphasize that you will be working as a team, and that the client knows more about what s/he needs than the therapist does. The therapist might say, "I may make certain suggestions which you can decide to try or reject." Invite the client to make suggestions that the therapist can try. If the therapist is uncertain about the appropriateness of the requests, s/he may want to discuss these with a supervisor or personal psychotherapist.

Tell the client, "You will determine where on your body I will work, how deeply I work, and how long I will work in certain areas." Some clients like to use a body chart to identify zones where it is OK to be touched and zones where it is NOT OK to be touched. Let the client know that s/he is free to stop the session at any point. To make the client comfortable, the therapist might give examples of things other clients have said that relate to his or her situation. For example, the therapist might say, "One client asked me (or a colleague of mine) to work on her head and neck the first three months, and added the feet during the next two months." It is reassuring for a person to know, for example, that it took someone else three months to have anything but the head and neck worked on. The example given must be real and truthful. To safeguard confidentiality when discussing another client's experience, be careful to change details to protect the person's identity. If the therapist has no professional examples at the time, s/he can say it is common for people to... and cite this article as an example.

Remember that the purpose of the body-work is not the massage *per se*. It is to reconnect the person with his or her body and to give control of that process to the client. When the body is touched, many survivors will dissociate, and a major part of treatment is working with the client to stay with his or her body sensations while being touched. A client may show signs of dissociation when on the table by not responding when spoken to, by experiencing a loss of sensation (especially in the legs), appearing to have a vacant expression in the eyes, staring pointedly into space, or fluttering the eyelids. The person may also report a sensation of leaving their body.

In addition to dissociation other survivors may become hyper-vigilant, or over-focus on the specifics of what is being done, and consequently be unable to relax. For these clients, the task may be to defuse the narrowed concentration and to learn how to focus on a wide area or on the entire body at once.

Creating Emotional Safety

To learn what degree of safety has been established so far, ask the client how s/he feels in anticipation of the physical part of the session.

The therapist might ask the client, "How would you like me to respond if you become upset — for instance if you feel sad and begin to cry." One client might ask that the therapist leave the room for a few minutes, while others may ask that the therapist just sit quietly for a moment and wait for him or her to finish. It is important to remember that even though a client has expressed a preference beforehand, the therapist still needs to check with the client at the time the feelings come up. If something unexpected happens the client may have a different need that has not been expressed previously.

During the initial discussion, a client might request that the therapist try to induce memories. If this happens, explain that memories come when the person feels safe enough to remember**46** and that forcing memories to surface is not useful. In fact this can often be detrimental or harmful to the process and can derail your work together. The therapist might share an example of this happening in an instance when a client was not ready. If the therapist doesn't have one, he or she might quote this article, saying something like, "*Many clients have got into emotional difficulty when trying to induce memories. Several clients have been overwhelmed by memories that were forcefully induced in this way. One had to go to bed for weeks, another started a cycle of frequent uncontrollable flashbacks that took months of therapy to stabilize.*"

Preparing for Flashbacks and Memories

Ask if the client has ever had a flashback where s/he actually experienced being regressed into a frightening situation. If the client has had body-work, ask if this has ever occurred during a body therapy session. Inquire as to what would be useful if a flashback occurred in a session. For instance, one client might want the therapist to immediately take his or her hands off the body and try to make eye contact: another would feel more comfortable if the therapist kept his or her hand on the person's arm or shoulder, or held their hand. Other clients might recommend that the therapist cover them with a blanket and ask them to sit up or stand up to bring them back from the flashback.

A Helpful Exercise to Try

Sometimes it is useful to employ exercises to help decide where to work and to support the client in taking control of the body-work.

First Touch Exercise **47**

1. Tell the client, "You will have control of the treatment process with regard to what parts of the body I work on, the amount of pressure used, the types of strokes performed, and so forth. I would like to do something **if** you are willing." Then explain 2, 3 and 4.
2. With the client clothed and sitting in a chair say, "I would like you to tell me a part of your body where it would be comfortable to be touched while sitting here, for example your shoulder, hand, back."
3. Say to the client, "Tell me when it's okay to touch you." When the client signals it is okay, touch firmly but gently.
4. Now tell the client, "Let me know when you would like me to remove my hand with a nod or a few words."

This exercise gives the client the experience of being in control. Some clients find the exercise helpful and others do not. After describing it, ask the client if s/he would be willing to try it.

The Body-work

When beginning the hands-on work, it is important the therapist demonstrate to the client that s/he intends to follow through in allowing the client to take the lead in the process. Begin working on the area that the client requests.

Pace and Predictability of Touch

Always move slowly from one part of the body to another. Before moving to the next part of the body to be touched, tell the client what will be done there, especially if it is very different from the kinds of strokes or touch done just previously. For instance, when moving from the hand to the upper arm, or from the neck to the lower back, tell the client this is about to happen. Then ask if that feels OK. After weeks of doing this it may be unnecessary to constantly ask, but never assume if it was OK this week that it will be fine the next. Check with the client if s/he wants less "checking in" on the actual movements.

Voice Quality

The tone of voice can carry messages of warmth, kindness, professional distance, boredom, impatience, condescension, etc. Be conscious of the messages that your voice, as well as non-verbal cues, are creating. The quality and presence of voice is important. When the therapist is feeling empathic, accepting and positively disposed toward the client, s/he will be gentle, genuine, concerned, and present in the feeling tone of the voice. When this is not occurring (it is not easy to recognize in oneself), the therapist may want to work with a teacher, supervisor or colleague to get some feedback on his or her empathic abilities and what is coming through in the quality of the voice.

Be aware that some clients may react to a hypnotic voice by going into a trance state which may encourage dissociation. Check out how your voice is being received by the client.

It is important for the therapist to have a feel for appropriate language when working with survivor clients. Language should be warm but professional, not intimate, but also not so formal as to be distancing. Therapists who use language that is too familiar, too critical, or contains a sexual overtone will inevitably violate a client's boundary. For instance, making unsolicited comments about the person's body (i.e., not in the treatment contract) is a violation of a client's boundary, if the client has not asked for this feedback. Comments like, "Boy, your spine is kind of twisted, it needs some work" or, "Was it hard for you to lose weight." are inappropriate boundary crossings unless these issues were part of why, the client came to see the therapist.

Being Present

Being present as a therapist is the most important factor in treating survivors. What this means is that the practitioner needs to be attentive moment by moment to where the client is in relation to the work being done.

Because it is common for survivors to dissociate or become hyper-vigilant, the therapist needs to find ways to frequently check in to see if the client is present, and if not, to help bring them more into contact with themselves. The therapist can explore creative ways to help the client remain present to his or her experience of touch as it occurs. If the client is dissociating, one helpful technique is to have the client focus attention on the point being worked on, or have him or her imagine breathing into that part of the body. If the person becomes hyper-vigilant and over-focused, suggest s/he release that focus onto a broader, more general area, or, if this is a problem, try to switch the area of the body being worked on more frequently.

You can suggest visual images, or have a client bring a favourite piece of music to listen to during the session. Sometimes having the eyes open allows the client to be more present, while others feel more present with the eyes closed. Actively working together to find what assists the client in his or her experience continues to build trust and a sense of safety.

The most helpful tool the therapist possesses is his or her own ability to be really present in the moment. The

more present the therapist is, the more possible it will be for the client to be present as well.

Continuous Communications

Unlike most massage clients, working with survivors of abuse requires a special type of communication during the treatment. You will need to actively track the client as the session proceeds in order to keep him or her from dissociating. For instance, it is helpful if you regularly ask, "How are you doing?" or "Where are you?" This brings the client's attention and awareness into the body. Another possibility is to say something like, "I am focusing on your foot." and then begin to make positive affirming statements from time to time, like "Are you experiencing your foot relaxing." or "I think your foot is letting go, but I'm not sure. Can you tell me what you feel?"

Clients will frequently withdraw or lose connection to their experience and have no idea how or why this happened. It can be very helpful if together the therapist and client can discover why. Was the therapist touching a particular part of the client's body? Was it a phrase the therapist used or a sound the therapist made? Over time an awareness can develop that helps a client begin to understand his or her own reactions. These kinds of interactions encourage the client's collaboration with the therapist in the exploration of his or her body.

Hands-On Techniques

The first few times you initiate a new movement, check in with the client and ask if what you are doing is all right. Do the same massage movement over and over again instead of moving from one to another quickly. When beginning to work with survivors, massage or any other hands-on technique is best done slowly.

To see if the movement being used is working for the client, the therapist might create a kind of shorthand communication. If what the therapist is doing is fine with the client, it may be suggested that the client say "okay" when asked. If not, s/he might say "no", which signals the therapist to move on and try another movement. This again puts direct control in the hands of the client. Every time the client says "okay" or "no." s/he is setting the boundaries, not the therapist. At first, the therapist may ask rather frequently, "How's this? Is this movement all right?" As the work on a particular body part progresses over time, the frequency with which the therapist asks may diminish. But as the work moves to another body part, the therapist starts the question process over again. If it becomes obvious that all the moves are okay, the therapist might ask if the client wants him or her to stop asking.

The responses to this OK / NO technique can vary. Some find it very empowering, but after a while, it might become irritating.

Closure

As the therapist moves towards the last two or three minutes of the hands-on portion of the session, s/he tells the client that the body-work part of the session is close to finishing. As the body-work segment ends, the therapist always fully re-drapes the client (this may seem obvious, but many therapists forget this simple act). The therapist tells the client that the body-work portion of the session is over and then s/he leaves the room. After the therapist has left, the client dresses (or rests awhile before dressing). The therapist can knock before returning or the client can indicate s/he is ready by opening the door.

The therapist leaves time to talk with the client at the end of the session. After returning to the room s/he asks how the client is, how the session went, and how s/he is feeling now. The therapist asks if the client wants to talk about anything specific that happened during the session and checks to see if anything could have been done differently which would be helpful in the future.

It is important to give the client room and encouragement to tell the therapist if any boundaries were inadvertently crossed. Because this will be difficult for the client, the therapist might give an opening like: "Did I work too hard on any part of your body?" or "Did I move too quickly?" The therapist will need to use his or her own judgement as to when such questions are appropriate. Often, the first or second session is too soon.

Structure

Repetitive structures create safety. A particular structure is suggested here, but it doesn't really matter what the structure is, as long as it is clear and establishes some kind of routine that the client can count on. Try to do certain things the same way each week at each session. Pay special attention to being on time for the appointment. Have the same appointment time each week, if possible. Always ask the same one or two questions at the beginning of each treatment, for instance, "Is there anything about the last session or how you felt afterward that you want to tell me?" Then ask the client what s/he would like you to do today and where s/he would like you to work. If the therapist wants to alter the routine, remember to include the client in the process of making the change.

It is good to have goals for each session and to give the client a chance to talk about the goals at the beginning of the session. At each session, also repeat the statement that the client leave on or take off whatever clothing s/he is comfortable with. Of course, take no phone calls and have no interruptions during the session. Distractions interrupt attention and focus. To help maintain clear boundaries, be careful not to touch the client's body casually when s/he is not on the table.

Support Material

Feelings may surface after massage therapy or body-work. At the end of the first session you will want to discuss this with your client. You might give the client the following list that briefly describes some common after effects that may be experienced after the session.

After Effects of Massage **48**

There are some feelings that may come up following a massage therapy session. The following is a list of guideposts to use - there is no "right" way to feel. Listen to your body. Feel your own experience - that's what is right for you.

1. A sense of aliveness or pleasure in your body or a feeling of physical well-being. This may specifically include a sense of connectedness in your whole body, awareness of sexual energy and/or feelings, and a sense of deep relaxation. You may find that you sleep more restfully that evening.

2. Less numbness in specific areas of your body. In those areas that may have felt "frozen" you may experience a sense of "letting go," "thawing" or "melting." Those areas may actually become warmer to the touch. On the other hand, you may experience trembling or shakiness. Staying warm, using a warm blanket, heating pad or wearing more layers of clothing can be helpful.

3. Awareness of more tension in parts of your body. This may be in areas that you are aware of that hold stress, or it may be in other areas. If this occurs you might want to think of things that have helped you in the past. Some people find it helpful to imagine breathing into those areas to relax them and give your attention to any feelings that may have been held in those muscles and now may be more accessible.

4. Increased emotional awareness. Being more in touch with your body, can bring awareness of new and different emotions. You may start to feel things that you knew about before but were disconnected from emotionally. Unexpected memories may surface, you might feel fear or sadness or a sense of emptiness. For instance, you may experience feelings of deprivation, stimulated by the nurturing touch that you didn't get enough of as a child. Grieving for the nurturing touch you never received, or never received enough of, is appropriate. Feelings of anger about your deprivation may also be part of your experience.

5. Apprehension about returning. It is not uncommon to feel apprehensive about returning for another massage session. Part of that may be from feelings of exposure and vulnerability with the massage therapist. It is important to realize that this experience is different from your past experiences with touch. If the session feels good, you don't have to feel guilty for wanting, even longing, for safe nurturing touch. It is what you always deserved—even when you didn't get it. Let yourself take it in now.

6. Shutting down. Another natural reaction to experiencing more sensation in your body is for your organism to contract and shut down temporarily. If this happens, be patient with yourself and ask your massage therapist to go slower with you. Everybody needs to move at their own pace. Respect your own body's rhythm.

Giving the client this information, either verbally or in writing (or both), is very useful to the survivor, especially in the first few weeks of body-work. Many of these sensations and feelings may occur. Knowledge of these possible responses helps create client safety and comfort.

Part V — Dealing with Flashbacks and Memories

Recognizing a Flashback

Touch can trigger a flashback. Sometimes it's easy, and at other times very difficult to recognize whether a client is experiencing a flashback. On one end of the continuum, the out-of-control flashback can be frightening to experience and easy to recognize. Other flashbacks can be quieter and be over fairly quickly. Recognizing these more subtle flashbacks requires a practiced eye.

One of the keys to identifying a flashback is by looking at the client's eyes.**49** The pupils will often be dilated, and the person will have a far away look, as if s/he is "out of it", very tired, or using drugs. The person has left the body, either literally as in out-of-body experiences, or s/he is out of touch with feelings, thoughts and sensations. S/he may stare into space, curl up in a ball on the table, not answer when asked a question, begin to cry, or talk incoherently. Phrases like "No, no, what are you doing?", "Who are you?," or "Don't touch me, I'm scared!" may be said. The body may suddenly tighten, stiffen up, or shake uncontrollably.

Physical touch to particular areas of the body is more likely to stimulate a flashback than others:

* The "safest" areas to work are the hands, feet, legs below the knee, arms, gently on the scalp and forehead, the middle and lower neck, shoulders,

upper back area, and the mid-back. The lower back in certain individuals will hold a high emotional charge. The lower back muscles help to control pelvic motion and the inhibition of movement during unwanted sexual contact.

* Be very cautious in working with the following areas until a certain degree of integration has occurred: the deep, sub-occipital muscles at the back of the head, the buttocks, the front and back thighs. With some clients, I may never work on some of these areas.

* It is suggested that the therapist never work on the following areas, except in consultation with the client's psychotherapist: in the mouth, the front of the neck, the throat, the abdomen, and the upper portion of the inner thigh.

* Never work on these areas: a woman's chest, the breast tissue, and the front of the pelvis Oust above and to the side of the genitals). And of course, never work in or around the genital itself.

No matter how careful you are, sometimes flashbacks will occur. Certain hand techniques or past associations with specific types of touch, like a gentle touch on the shoulder, will trigger a flashback. In working with a client over a period of time, the therapist may be able to help minimize the likelihood of flashbacks.

Remember, when the client is reliving a flashback s/he may believe that abuse may be about to occur or is occurring. The person may feel s/he is actually back in childhood re-experiencing the trauma. The therapist, alert and conscious about his or her role in this situation, will facilitate the client's awareness of the present and immediate surroundings. "Reliving" flashbacks does not offer the opportunity to learn from earlier experiences in a way that is useful.**50**

How to Bring a Client Back

When you realize a flashback may be occurring:

* Break contact with your hands and acknowledge that a flashback is happening before you do anything else. Say the person's name, e.g., "Rochelle, are you here with me?," and wait for a reply. If the person is in a flashback, there is usually no reply or a vague one that is uncharacteristic of the client's communication with you.

* Cover the client with a blanket to create a safer, thicker physical boundary around the body. Stand to the side of the table, and try to make eye contact. The client will usually have eyes closed, or will be staring into space, not seeing you. S/he may also cover the eyes with his or her hands.

* Make voice contact. Using the client's name every time, say in a very calm, unagitated voice, "Jane, This is Ben, we are here together." Or say, "Ralph, where are you right now? Are you here with me? This is Ben, I am here with you. We are having a body-work session." Ask questions like "Do you know where you are? Do you know who I am?" If the eyes are closed, say, "Ann, can you open your eyes and look at me?" or direct him or her to look at an object in the room, "Let me know that you can hear me," is another phrase to bring a client back.-

Encourage the client to try to open their eyes and to focus on something. It is a very good way to bring them back to the present. If the eyes are open, make eye contact, if at all possible.

* Be sure to follow any instructions that the client may have given you about how to respond if s/he goes into a flashback.

* Encourage the client to sit up. This often helps to re-establish an adult reality. Ask if the client would like to sit up. If the client is not sure, encourage her/him to do so. If s/he says "no," go with the client's preference. If you have the impulse to help the person sit up, ask if it is okay. Do not touch a client in that state without permission. Either have the client sit on the table or move to a chair. Pull up a chair yourself and sit so you are neither above the client looking down, nor too close. Some clients are very specific, and ask the therapist to sit off to the side, not directly in front.

* Take some time to talk about what happened, not probing for any details of the flashback. First, ask if the client feels able to talk about the process of what happened, and what might be important from this experience to discuss with the psychotherapist. Then talk together about what you are going to do next, whether you are going to continue the hands-on session, or stop. If this is a first time occurrence for the two of you, it is usually a good idea to stop the hands-on portion of the treatment.

Understanding Why the Flashback Occurred

Once the client has sufficiently recovered from the flashback, together see if you can determine if anything you did triggered the flashback. Was it something you said, or a specific part of the body you were working on? Gather as much information as you can in a gentle, non-invasive way. Ask if s/he felt or feels numbness in any part of the body, especially the legs. If numbing occurs, the effects of the flashback were very strong and are still occurring. This information may influence your decision whether to continue or stop the body-work part of your work together during this session.

If you choose to continue the hands-on session, check in with the person frequently to see if s/he is present. Notice if the client becomes spacey and ask if s/he is beginning to feel numb physically, particularly in the legs.

If you choose to stop, leave the room and have the client get dressed before talking further. Moving into the routine of dressing and preparing to leave will help bring the person more strongly into the present. It is a good idea to call through the door once to make sure s/he is okay. I have had the experience of leaving the treatment room, and then discovering the client has not moved during my absence. When the client is finished dressing, sit down and have a more complete closure than usual.

Ask what was helpful and what was not helpful when you were trying to bring the client back to the present. Ask what you could have done differently, if anything, to be more supportive.

Making Sure the Client is Safe

Ask if the client has plans after leaving the session. It is important that the client has a specific plan after leaving your office. The client should be with people with whom s/he feels safe. Sometimes the client may be too disoriented or dizzy to drive or travel alone. Take the time to arrange for a taxi or for someone to pick the client up, to ensure her/his physical safety. Most people will recover within a half-hour but others may take longer. Help the client make emergency plans in case another flashback begins to occur. Talk about whom they will call, whether a friend, partner, family member, their psychotherapist, you, or a hospital emergency room.

Adjusting Your Schedule

If a flashback occurs, particularly toward the end of the session, you may have to run overtime. This is not a practice to get into the habit of, but it may happen in an unusual situation. If this occurs and another client is waiting, take the first opportunity that feels appropriate to tell your client that you are leaving for just a moment to tell the next client that you are running a little late. This lets the client know that you are conscious of the extra time needed, but want to respect the person who is waiting. It sets a professional tone and helps the person feel comfortable at the same time. Don't take but a few moments to do it, lest the person feel abandoned.

Follow-Up with Psychotherapist

Tell the client that at the end of the day you will be talking to her or his psychotherapist about what happened during the session. Suggest that the client may want to call and talk with the therapist the same day as well.

Follow-Up at the Next Session

At the beginning of the next session, again ask the client what was helpful and what was not. You may get very different information.

Supervision

The importance of having good clinical supervision when working with survivors of abuse can not be stressed enough. Many issues and difficulties will arise for the experienced therapist as well as the novice. Issues of transference and countertransference will frequently come up, Feelings of vicarious traumatization of the therapist will occur, and tricky situations will arise in which the client may unconsciously try to re-enact the abuse.

In a previous article,**51** supervision was discussed extensively. The following is a brief review of that information.

When a therapist touches a client, cares for a client, and helps a client, the client will inevitably have a transference response. Transference occurs even if care has been taken to minimize the power differential that exists by stressing collaboration between client and therapist.

As a result of this process, the client may behave in ways that cross the boundaries of the relationship. The client may test the therapist's boundaries with some frequency, depending on how far along s/he is in recovery. As a result, the therapist may be in situations that are difficult to handle. For instance, the client might ask the therapist to work on a part of the body that the therapist feels the client is not ready for. How does the therapist deal with that? A client may want to come more frequently than the therapist thinks is useful. If the therapist says no, the client may feel rejected. How can this be accomplished in a constructive way? Suppose the client is an artist and invites the therapist to an opening: the therapist feels that s/he should probably decline, but isn't sure how. The client may tell a therapist things about his/her psychotherapist, and once the therapist is drawn in, ask that it not be repeated. These and many other situations will arise for which the therapist will need help.

The therapist may also experience strong reactions based on his or her own past. S/he will want to explore and talk about these situations with another professional. When a client experiences a flashback, followed by a difficult few days, a therapist may feel guilty. A therapist may feel sexually attracted to a client, and not know what to do with these feelings, or a therapist may become emotionally attached to a client in a way that is not useful. Anger may arise at a client for crossing boundaries, questioning the therapist's competence, or pushing his or her "buttons" in some way. If a therapist sees no visible change after working three months on a client's feet or hands, s/he -may experience feelings of discouragement and/or frustration. In other instances a therapist may be privy to painful and graphic stories of abuse; secondary traumatization can arise in the therapist by hearing about a client's trauma.

These are all feelings of countertransference that the therapist will need help with, either from a supervisor or a psychotherapist. Practitioners need a place to explore, talk about and work through these experiences. If not dealt with successfully, their efforts to work effectively with clients can be jeopardized.

Finally, an unconscious pull into a countertransference situation may re-enact the abuse that the client experienced in the past. For example, in a desire to help a client, the therapist may offer too much, for instance, by, cutting fees excessively. This might make the client feel dis-empowered or devalued. S/he may have a negative reaction and blame the therapist for being patronising or irresponsible. Cutting fees might also make the client feel special, which might repeat a similar dynamic s/he experienced with the abuser. The question in the client's mind might be, "What do you want back from me?"

Supervision can be done on a one-on-one basis or in a group. It is often more useful to have supervision in a small group of body-workers who are doing the same kind of work as you. This broadens the base of beaming and creates an additional support system for each member. If the therapist is in a group situation where s/he can learn from other therapists' difficulties or errors, it is possible the same mistakes can be avoided. The group can also be a support system. Hearing the fears and doubts of other practitioners who are feeling challenged by unusual client situations can help one to feel less isolated and alone. If a therapist has a lot of cases to discuss, s/he may want to have private supervision sessions twice a month.

A good supervisor is like a guide in unfamiliar territory. S/he can enhance understanding and help direct the therapist toward constructive answers, if necessary. A supervisor will often help by asking a variety of questions about what **is** needed and what the therapist was thinking/feeling during the time s/he didn't know what to do. In appropriate situations, advice can be offered as to what to do with a client. The most important aspect of supervision, however, is the opportunity to explore and work through a problem. In a group setting the supervisor will often invite other members to help navigate a colleague towards the core issue which may be underlying the problem. Supervision also creates a setting for self-care, support and nurturance. It is the right place to receive appreciation for the good and useful work a therapist is doing.

Finding a Supervisor

Finding a good supervisor is often not an easy task, particularly in small, out of the way places where there are few therapists familiar with cases of abuse or various forms of massage and body-work. There is a long tradition of supervision in psychotherapy and there are many experienced supervisors throughout the country. The most ideal supervisor would be experienced in supervision, experienced in working with cases of abuse and would have some familiarity with body-work. But a good supervisor with only the first qualification could navigate a body-worker very effectively through most of the difficulties s/he will encounter.

To find a supervisor, look for psychologists, psychiatrists and social workers who have supervised other psychotherapists for at least five years. Rape crisis centres or incest survivor groups may lead to experienced, available therapists interested in doing supervision. If a small group does this, it can be fairly inexpensive. I personally know of groups of five therapists who hire a supervisor for an hour and a half twice a month, and pay $25 each per session. They also meet and talk by phone individually to receive support, when needed.

In Conclusion

Every therapist will work with survivors. At least one in five clients will be a survivor of some form of abuse. Working responsibly with survivors involves understanding the effects of abuse and the many complex psychological issues that influence the practitioner as well as the client. Anyone who chooses to undertake this type of work must have awareness and understanding of his or her own limitations and boundary issues. Knowledge and training that includes role-playing client flashback situations and recognizing dissociation will be helpful to the practitioner preparing to work with survivors. Just as important as having knowledge and training in this area is ongoing supervision and support.

Remember that it is crucial that the client be ready to begin body-work as part of his or her ongoing recovery. The client should be in psychotherapy and at the appropriate stage of recovery. With the right combination of psychotherapy and survivor groups, massage therapy can be an important adjunctive treatment for many survivors.

Each individual client's journey is unique and different, calling on the practitioner's combined talents of knowledge, skill and intuition. If all of these converge with compassion, the massage therapist/body-worker's contribution can be vital to the client's recovery.

Along with wider realization and acceptance of the prevalence of sexual abuse, valuable resources are now available to the therapist who chooses to undertake work with survivors. Numerous trainings and workshops, as well as a growing body of literature, are accessible. A few of these are listed below.

Sources of Education and Training:

The following individuals and organizations offer workshops and training in working with survivors:

1. Ben E. Benjamin Ph.D., or teaching staff, "Massage and Bodywork with Survivors of Abuse."
   Contact Dr. Benjamin at 508-369-3150 or 508-3690514..
2. Peter Levine, Ph.D.. Director. The Ergos Institute for Somatic Education,
   P.O. Box 1730. Lyons, CO. 80540. Contact 303-823-9524.
3. Sharon A. Piantedosi. RN, LMT. "Safe Touch® Seminars."
   Contact Aleka Munroe at 603-749-4780.
4. Carol Osborne Sheets and Kate Jordan.
   Contact Carol Osborne Sheets at 619-748-8827.
5. Chris Smith, Colorado School of Healing Arts, Trauma Touch Therapy™ Program, 7655 W. Mississippi, Suite 100. Lakewood, CO. 80226.
   Contact Chris Smith at 303-986-2320.
6. Robert Timms, Ph.D. and Patrick Connors. C.M.T.. "*Bodywork and Psychotherapy for Abuse Survivors.*"
   Contact Robert Timms at The Atlanta Center for Integrative Therapy. 404-321-5533.
7. Suzanne Torrenzano, Ph.D., "*Incest: Insults to the Body-Mind. Bodywork with Adult Survivors.*"
   Contact Suzanne Torrenzano at 21104 Crocus Terrace, Ashburn, VA. 22011. 703-536-5012.

Further Readings:

Books:

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2. Pope, Ken, "*Sexual Feelings in Psychotherapy*", American Psychological Association, 1993.

3. Timms, Robert Ph.D., and Connors, Patrick, C.M.T., "*Embodying Healing*", The Safer Society Press, 1992.

4. Ford, Clyde, DC, "*Compassionate Touch*", Simon and Schuster, 1993.

5. Herman, Judith, "*Father Daughter Incest*", Harvard University Press, 1982.

6. Rush, Florence, "*The Best Kept Secret*", Human Services Institute, 1992.

7. Lew, Mike, "*Victims No Longer*", Harper Collins Publishers, 1990.

8. Katherine, Anne, "*Boundaries: Where You End and I Begin*", Fireside Parkside Books, 1993.

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9. Rutter, Peter, "*Sex in the Forbidden Zone*", Mandala (Harper Collins Publishers, Inc.), 1990

Articles:

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Benjamin, Ben and Chellos, Dual Role Relationships, *Massage Therapy* Journal, Spring 1992.

Disch, Estelle, "*Discovering your Boundary Issues*", Massage Therapy Journal, Summer, 1992.

Benjamin, Ben, "*Sexuality and Boundary Issues*", Massage Therapy Journal, Fall, 1990.

Endnotes:

1 Judith L. Herman, M.D.. Lecture at the Bunting Institute of Radcliffe College, May 1994.

2 D.E.H. Russell, "*Sexual Exploitation: Rape, Child Sexual Abuse, and Sexual Harassment*" (Beverly Hills, CA: Sage. 1984).

3 Interview, Janet Yassen, 1991.

4 Boston Women's Health Book Collective, "*The New Our Bodies Ourselves*" (New York: Simon and Schuster. 1984).

5 Ibid.

6 Judith L. Herman. "*Trauma and Recovery*" (New York: Basic Books, 1992). p. 6-32.

7 Boston Women's Health Book Collective.

8 Ibid.

9 *DSM IV*.

10 J. L. Herman. "*Trauma and Recovery*".

11 Ibid.. p. 37.

12 Motorola Teleprogram Information (MTI). DeerfieId, IL. "*Incest: The Victim No One Believes*." Film. 1978.

13 Ibid. p. 121.

14 Ibid. p. 121.

15 Ibid. p. 168.

16 Ibid. p. 195.

17 Ibid. p. 207.

18 L. Lebowitz. M.R. Harvey. J.L. Herman. "*A Stage-by-Dimension Model of Recovery From Sexual Trauma.*" Journal of Interpersonal Violence. Vol. 8. No. 3. September 1993. Sage Publications.

19 Ibid.

20 Melissa Soalt. personal communication. 1994.

21 Survivor Interview, videotape. 1992.

22 Ibid.

23 R. Timms and P. Connors, "*Embodying Healing*". (The Safer Society Press. 1992).

24 Ibid. p. 24.

25 Ibid. p. 38.

26 M. Soalt. personal communication. 1994.

27 Ibid.

28 Interview, J. Yassen. 1994.

29 B. Benjamin. "*Sexual Abuse within the Health Care Field*." Massage Therapy Journal. Spring 1990. p. 13.

30 B. Benjamin. "*Sexuality and Boundary Issues.*" Massage Therapy Journal, Fall. 1990.

31 J. L. Herman. "*Trauma and Recovery*". (New York: Basic Books. 1992). p. 196.

32 Ibid.

33 Daphne Chellos. "*Creating Boundaries Handbook*". 1992.

34 Ibid.

35 Interview. J. Yassen. 1991.

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38 Ibid.

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41 C. Pert.. "*Neuropeptides: The Emotions and Bodymind*". Massage Therapy Journal. Fall 1987, p. 39.

42 Wilhelm Reich. "*Character Analysis*". (Vision Press, London, 1950), pp. 55. 357-365.

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44 Perterson, Prout and Schwartz. *PTSD, A Clinical Guide.*

45 Client Sessions. B. Benjamin.

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