

5-2013

The Well-Embodied Professional: Attitudes around Integrating Massage Therapy & Psychotherapy when Treating Trauma

Deborah S. Frank
St. Catherine University

Recommended Citation

Frank, Deborah S., "The Well-Embodied Professional: Attitudes around Integrating Massage Therapy & Psychotherapy when Treating Trauma" (2013). *Master of Social Work Clinical Research Papers*. Paper 177.
http://sophia.stkate.edu/msw_papers/177

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact ejasch@stkate.edu.

The Well-Embodied Professional: Attitudes around Integrating
Massage Therapy & Psychotherapy when Treating Trauma

by

Deborah Sue Frank, B.A., NCTMB

MSW Clinical Research Paper

Presented to the Faculty of the

School of Social Work

St. Catherine University and the University of St. Thomas

St. Paul, Minnesota

In Partial Fulfillment of the Requirements of the Degree of

Master of Social Work

Committee Members

Dr. Felicia Washington Sy, MSW, Ph.D., LICSW (Chair)

Kelly L.S. Cook, MSW, LICSW

Patricia L. Lawrence, MSW, HTSM-HP

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study.

This project is neither a Master's thesis nor a dissertation.

Abstract

The Well-Embodied Professional: Attitudes around Integrating Massage Therapy & Psychotherapy when Treating Trauma

By Deborah Sue Frank, B.A., NCTMB

Research Chair: Dr. Felicia Washington Sy, MSW, Ph.D., LICSW

Committee Members: Kelly L.S. Cook, MSW, LICSW; Patricia L. Lawrence, MSW,
HTSM-HP

Immediate and long-term effects of trauma result in mental, emotional, and physical symptoms that ultimately can inhibit normal daily functioning and cause dissociation and disorganized attachment. Previous studies highlight effective strategies in cognitive and physiological approaches to treating trauma. However, limited research has been found in the area of integrative approaches that include the use of touch. This qualitative study examines the professional attitudes around the integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma. Semi-structured interviews were conducted with five massage therapists and five licensed independent clinical social workers from Minnesota, all having clinical experience with trauma. Findings reveal that the multi-dimensional effects of trauma warrant a multi-dimensional approach. Therapeutically, benefits include providing comprehensive care, enhancing the therapeutic process, and saving time and money. This model would be professionally beneficial by promoting exceptional leadership in the healthcare industry and providing a sense of personal and professional gratification. However, therapeutic barriers include the client's ability to handle touch, the client's ability to understand the intent of treatment, and the potential for re-victimization. Professional barriers include personal and professional boundaries, professional identity related to scope of practice, fear of allegations, ambiguous laws and guidelines, and institutional resistance to change. These findings suggest a need for better advocacy, stronger laws and practicing guidelines, further research and practice models, continued dialogue among professions, and a shift in societal perspectives around the use of touch.

Keywords: trauma, integrative psychotherapy, massage therapy, touch

Acknowledgements

I would like to thank the massage therapists and social workers who participated in my research project. Without your wisdom, knowledge, passion, and willingness to participate, I would not have been able to complete this endeavor. Thank you for giving me the opportunity to listen to your inspiring stories, dialogue about the various challenges we face, and share in the moments of excitement for what is to come in our professions.

I am eternally grateful for the many teachable moments, wisdom, and support of my research committee: Dr. Felicia Washington Sy, Kelly Cook, and Tricia Lawrence. Without you, I would not have learned so much about myself as a student, as a professional, and as a human being. I am humbled to have had the opportunity to learn from each of you in so many different ways.

I would like to thank my fellow weekend cohort members for their professional perspectives, exceptional support, and endless amount of laughter during our journey together. Our synergistic connection exemplifies the true nature of what it means to be a team. I am grateful for the opportunity to have shared in this intimate experience with you.

Most importantly, I would like to thank my family for their understanding, encouragement, and moments of reality to keep me grounded during this process. Brian, thank you for being a partner who endured my many mood swings, was overloaded with extra household chores, and assumed the frustrating job of walking the dogs without a walking buddy. The dog walking alone is worth an endless amount of Canadian fishing trips! Nathan, thank you for being an independent, vocal, and humorous teenager; it has been quite stimulating for both of us to be in school at the same time. I am so very, very grateful for both of you!

Table of Contents

Abstract	Page 2
Acknowledgements	Page 3
List of Figures	Page 5
Introduction	Page 6
Key Concepts	Page 10
Literature Review	Page 11
Conceptual Framework	Page 18
Methodology	Page 21
Findings	Page 24
Discussion	Page 50
References	Page 57
Appendix A: Interview Questions	Page 60
Appendix B: Consent Form	Page 62
Appendix C: Approval Letter	Page 64

List of Figures

Figure 1. Theory of Successful Integration Logic Model Page 25

The impact of trauma is universal. Immediate and long-term effects can result in shock, denial, unpredictable emotions, flashbacks, strained relationships, and physical symptoms that ultimately can inhibit normal daily functioning (American Psychological Association, 2012). Prolonged exposure to trauma, as well as the severity of the traumatic event, can potentially lead to dissociation and disorganized attachment (Liotti, 2004). These profound and long-standing effects of trauma warrant additional research in the area of effective strategies and comprehensive approaches to treatment.

Various treatment approaches have been developed and recognized within the social work profession, such as pharmacological treatment measures, Exposure Therapy, Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), Hypnotherapy, Psychodynamic Therapy, and Group Therapy (Dillmann, 2011). Each treatment model focuses on a specific aspect of the traumatic experience. For example, pharmacological drugs are used to manage the physical symptoms associated with hyper-arousal, Exposure Therapy addresses the emotional response to the traumatic stimulus, and Cognitive Behavioral Therapy teaches individuals how to redirect negative thought patterns and behaviors (Dillmann, 2011). While each technique is effective in treating a particular element of the traumatic event within specific professional parameters, they seem to fall short of providing a deeper, innate experience to the healing process through the integration of touch. Human touch provides a sense of safety, support, spiritual nourishment, and self-awareness. This added element can be an important piece of the healing process for people who have experienced trauma (Fritz, 2000). Further examination into the use of touch within integrative techniques and modalities may shed light on more realistic approaches to a problem that has multiple components to it.

The perception and definition of integrative treatment approaches varies depending on the professional lens. Integrative psychotherapy “involves the integration of two or more therapies with an emphasis on integrating the underlying constructs associated with each therapeutic system” (Jones-Smith, 2012, p. 610). From this perspective, an eclectic theoretical approach to treatment is preferred. For example, an integrative psychotherapist may do CBT, EMDR, or psychoanalysis based on client needs. However, while the assimilation of these counseling approaches within the profession is integrative in theory, they do not address all aspects of the individual simultaneously. The medical model views integrative medicine as “a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine” (NCCAM, 2008, para. 2). Again, the collaboration of systems and practices are integrative in theory, but do not address the mental, physical, and emotional manifestations of trauma in one comprehensive treatment session. A truly integrative treatment model provides an individualized approach which addresses the physical, mental, and emotional components to healing simultaneously and includes the human element of touch. This approach is a part of an integral process that the aforementioned modalities do not address.

The therapeutic benefits of psychotherapy and massage therapy support an integrative approach to treating trauma. Since trauma affects the mind, body, and emotions, by combining the mental and emotional dynamics of psychotherapy with the physiological benefits of massage therapy, a sound clinical practice based on a truly integrative approach makes sense. However, professional and ethical standards relating to integrative treatment approaches are unclear. In regards to touch, the National Association of Social Workers’ (NASW) Code of Ethics states:

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact. (2008, section 1.10)

The definition of touch is not clearly defined in this section, nor is the topic of touch addressed again throughout the *Code of Ethics*. In addition, NASW does not discuss professional parameters for those who hold multiple degrees and practice under one umbrella. The American Massage Therapy Association (AMTA) addresses sexual misconduct and physical harm in the *Code of Ethics*, but does not specifically discuss guidelines for dually degreed professionals (2010). In fact, number one of the *Rules of Ethics* section mandates massage therapists to “conduct all business and professional activities within their scope of practice and all applicable legal and regulatory requirements” (AMTA, 2010). Even though scope of practice is mentioned, professional parameters for those with dual degrees are not clearly defined. Both entities’ *Code of Ethics* are ambiguous and do not provide enough support or guidance for dually degreed professionals to integrate their skills into one therapy session.

In order to gain more clarity into this puzzling display of ethics and guidelines, the researcher contacted the State of Minnesota Board of Social Work (BOSW), the National Association of Social Workers (NASW), and the American Massage Therapy Association (AMTA). The Staff Social Worker in the BOSW licensing unit said, “The board can’t make recommendations. We are bound by compliance laws (M. Kramer-Prevost, personal communication, March 18, 2013).” Yet, the BOSW Compliance Director responded by saying, “It is not permitted, nor prohibited. However, when a social worker engages in touch

there are potential boundary issues. Certainly this would increase reports (L. Hoffman, personal communication, March 28, 2013).” NASW Deputy Council Ann Kamper disclosed that after consulting with other legal representatives in her office and the Office of General Council, she would never advise a dually degreed professional to practice both modalities in a single session, much less see similar clients while maintaining separate practices. The reasons were related to “the intimate process of psychotherapy, boundary confusion, and the degree of sensitivity to touch (A. Kamper, personal communication, March 28, 2013).”

Since Minnesota is an unlicensed state, massage therapists are regulated by the Office of Unlicensed Complementary and Alternative Health Care Practice (OCAP). The OCAP is overseen by the Minnesota Department of Health and handles allegations of misconduct outlined in the statute (Office of Revisor of Statutes, 2013). However, practicing guidelines specific to the profession are not addressed. Gini Ohlson, Foundation Director for the AMTA’s Massage Therapy Foundation, admitted that to the best of her knowledge there are no states currently allowing this type of integrated model and therefore didn’t think it would be allowed in Minnesota (G. Ohlson, personal communication, March 22, 20113). Even though each of the accrediting and licensing guidelines appear vague, the message regarding the integration of massage therapy and psychotherapy is clear: Do not do it.

Little research has been done to reveal the therapeutic and professional implications of an integrative treatment approach, much less a model based on grounded theory and a conceptual framework that can be implemented into a sound clinical practice for dually degreed professionals. Furthermore, little research has been done to examine the professional attitudes and desires around implementing this particular treatment model, possibly due to the lack of clarity and potential barriers around touch and scope of practice.

The purpose of this study is to investigate the professional attitudes regarding the integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma. These issues will be explored using a qualitative research design in order to answer the research question: What are the professional attitudes around the integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma? In order to fully understand this research question, it would be important to define key concepts.

Key Concepts

Integrative therapy. Integrative Therapy is a dynamic and comprehensive treatment model that provides an individualized approach addressing the physical, mental, and emotional components to healing by incorporating the use of touch with multiple theories and practices from separate professional modalities simultaneously in order to achieve desired results.

Sound clinical practice. A sound clinical practice is an established, accepted, viable, and professional method of conducting an objective, consistent, thorough, and ethically solid approach to treatment (Mish, 1991, pp. 249, 923, 1127).

Massage therapy. Massage Therapy is “the scientific art and system of assessment and systematic, manual application of a technique to the superficial soft tissue of the skin, muscles, tendons, ligaments, and fascia, as well as to the structures that lie within the superficial tissue, by means of the hand, foot, knee, arm, elbow, and forearm. The manual technique involves systematic application of touch, stroking (effleurage), friction, vibration, percussion, kneading (petrissage), stretching, compression, or passive and active joint movements within the normal physiologic range of motion. Also included are adjunctive

external applications of water, heat, and cold for the purposes of establishing and maintaining good physical condition and health by normalizing and improving muscle tone, promoting relaxation, stimulating circulation, and producing therapeutic effects on the respiratory and nervous systems and the subtle interactions among all body systems. These intended effects are accomplished through the physiologic, energetic and mind/body connections in a safe, nonsexual environment that respects the client's self-determined outcome for the session" (Fritz, 2000, p.36).

Psychotherapy. "Psychotherapy, or 'talk therapy', is a way to treat people with a mental disorder by helping them understand their illness. It teaches people strategies and gives them tools to deal with stress and unhealthy thoughts and behaviors. Psychotherapy helps patients manage their symptoms better and function at their best in everyday life" (NIMH, 2012, para 1).

Grounded theory. Grounded Theory is "a research methodology for developing theory by letting the theory emerge from, or be 'grounded' in, the data" (Monette, Sullivan, & DeJong, 2011, p. 225).

Literature Review

Independent Treatment Approaches

Many studies have been done to research the effectiveness of cognitive and physiological approaches to treating trauma. However, the cognitive approaches neglect to address the physiological manifestations of trauma; and, the physiological approaches do not provide enough cognitive or behavioral support in order to prevent re-victimization. While

each has successful outcomes, they fail to provide a truly comprehensive approach to a multi-dimensional problem. A review of salient studies follows below.

Cognitive approaches. Traditional psychotherapy, also known as talk therapy, approaches to treating trauma have yielded positive outcomes and is highly regarded in the medical field. Pennebaker, Kiecolt-Glaser, and Glaser (1988) found a link between psychotherapy and reduced health problems after reviewing 28 studies conducted between 1965 and 1980. Psychotherapy was associated with a 13-20% drop in medical use. Another study (Pennebaker et al., 1988) found that college students who were asked to confront their trauma through written expression and verbal discussion visited the student health center significantly less than those who did not. Those who disclosed more about their trauma had a higher immune system stimulation response during the course of the study compared to those who disclosed very little (Pennebaker et al., 1988). This is significant because it suggests that physiological changes are taking place with the addition of psychotherapy resulting in effective cognitive treatment of trauma. However, nothing was noted in the study regarding the types of trauma experienced by the high disclosers versus the low disclosers. Knowing the type and duration of the trauma may be important when understanding one's ability to embody the experience. Quite possibly, those who disclosed the least may be unable to fully express how deeply the trauma had impacted them suggesting a greater need for an integrative therapy session. In addition, another drawback is the inability of replicating this study into a sound clinical practice with certain populations, such as children, English language learners, and people with developmental disabilities because of the potential lack of language development and inability to express themselves through written and oral communication.

Kubany, Hill, and Owens (2003) describe their Cognitive Trauma Therapy approach as one that is similar to Mowrer's (1960) conceptual framework of social learning through escape and avoidance conditioning and symbolic processes. According to Kubany, Hill, and Owen (2003), their randomized study design was tailored specifically for battered women and includes elements of psycho-education about PTSD, stress management, self-monitoring of maladaptive thoughts and speech, and talking about the trauma and exposure homework. The women who were in the delayed Cognitive Trauma Therapy (CTT) group, meaning they waited longer for CTT treatment intervention measures than those who started immediately, did not improve over the six weeks between their first and second pre-therapy assessments. However, 94% of all the women who completed CTT out of both study groups no longer met the requirements for a PTSD diagnosis (Kubany, Hill, & Owens, 2003). While these results are astonishing, cognitive treatment approaches do not treat the body. Memories of the traumatic experience can manifest in the physical body, resulting in re-victimization or resurfacing of trauma symptoms (Levine, 1997). An integrated approach would address all of the necessary components to healing.

Physiological approaches. As previously discussed, the effects of trauma induced stress can manifest in the physical body. According to Moraska, Pollini, Boulanger, Brooks, and Teitlebaum (2010) stressful events, as well as prolonged levels of stress, disrupt the body's natural state of homeostasis through the release of epinephrine and cortisol. The continued release of these hormones creates a different level of homeostasis, resulting in chronic, pathological consequences. Studies have found that massage therapy can interrupt this stress induced pattern of survival (Moraska et al., 2010).

A review of literature consisting of 18 randomized control trial study designs, two quasi-experimental designs, and five within-subjects designs (Moraska et al., 2010) was conducted in order to examine the effects of massage therapy with varying populations including those with a history of sexual abuse, eating disorders, pain conditions, HIV, cancer, critical care patients, and healthy adults. These studies revealed an 89% significant reduction in salivary cortisol immediately following a massage therapy session as well as a significant reduction in urinary cortisol from three of the nine published studies using this method of assessment. A reduction in heart rate immediately following a massage therapy session was also documented as being statistically significant. Even though the heart rates did eventually resume back to previous levels as noted prior to a massage therapy session, the reductions were again repeatable (Moraska et al., 2010). While limited research had been found regarding the effects of massage therapy on trauma survivors, the findings of this review capture the overall effects of physiological treatment approaches necessary for this project. It is evident that even though physiological approaches treat the effects of trauma, the cognitive piece is missing. Cognitive changes are crucial in order to prevent re-victimization by helping to change the behaviors associated with the traumatic event, such as a regression of developmental behaviors like thumb-sucking, a need for control, excessive shyness or withdrawal, and bed wetting (Levine, 1997) .

Integrated Treatment Approaches

The emergence of integrative treatment approaches, as previously defined in the *Key Concepts* section of this paper, is relatively new and is difficult to find within the literature. Many claim to be integrative, but did not meet the criteria of this study. It appears as if this concept is an “unchartered territory” as only one report was found that integrates massage

therapy and psychotherapy into a single, comprehensive session. Regardless of the lack of literature, the qualitative findings of the study were fascinating. In addition, it is a model that can be replicated into a sound clinical practice for treating trauma.

On the premise that recovery is related to the integration of self and a reduction of dissociation, Price (2005), a postdoctoral fellow in the School of Nursing at the University of Washington in Seattle, employed a randomized control group experimental design consisting of 24 adult female participants currently in psychotherapy for child sexual abuse. Group 1 was a *massage therapy only* control group; and Group 2 was an *integrated massage and psychotherapy* intervention group. Standardized measuring tools, questionnaires, and assessments were administered as a baseline as well as six times throughout the study. The bodywork practitioner who developed the systematic protocol for both groups had 17 years of experience as a bodywork practitioner and held a master's degree in counseling and psychology (Price, 2005).

Even though statistically significant data lacked between the two groups in the quantitative portion of the study, the qualitative findings revealed a much different outcome. Both groups expressed an increase of engagement in psychotherapy and a desire for body oriented connection to help heal trauma which confirms the efficacy of massage therapy. However, two different themes emerged which help to understand the impact of dissociation: (1) the somatic release of pain, and (2) the development of skills that help access inner wisdom and a sense of self. Group 1 expressed increased motivation toward self-care and adopted a behavioral perspective which helped to understand their dissociative behavior. Conversely, Group 2 experienced a somatic release of trauma, developed skills to access a sense of self, and increased an awareness of the mind/body/emotion connection. The

outcome difference was improved self-care for Group 1 versus a catalytic healing process for Group 2 (Price, 2005).

The obvious downside to this study is that it failed to compare a *psychotherapy only* session to a *massage therapy only* session and an *integrated psychotherapy and massage therapy* session. Quite possibly comparative research findings between these three distinct groups may be different to that of the two groups that were originally studied. Moreover, the significance of the study's findings may have been magnified with the addition of a *psychotherapy only* control group. Regardless, as this study suggests the profound differences in the quality and productivity between an integrated session and a separate massage only session provides enough evidence to warrant additional research around the professional and therapeutic implications of integrating the two approaches into a single session. In addition, all of the elements of a comprehensive approach to treating trauma are present, affirming the need for a sound clinical practice.

While this study revealed a deeper layer of healing with the integration of massage therapy and psychotherapy into a combined treatment session, there are still gaps which need to be filled. A review of literature revealed a lack of research regarding professional attitudes around this particular integrated treatment model. Likewise, literature reviewing the scope of practice for dually degreed professionals was not found either. Nonetheless, the controversy around professional touch has been thoroughly discussed in literature revealing the theories, misconceptions, and fears around the use of touch.

Professional Touch

Human touch is an essential part of development and assists the healing process (Young, 2005). Yet, the “slippery slope rhetoric” (p. 79) around the use of touch within a psychotherapy session has been the impetus for standardization and regulation around professional boundaries and physical contact (Zur, 2007). It is believed that (1) a psychotherapist’s misuse of power and authority could lead to sexual exploitation of the client, and (2) the professional use of touch by the therapist could be misinterpreted by the client as being sexual in nature (Zur, 2007). One author asserts that it is “worse in America as the levels of paranoia and concern about the use of touch seem to be much, much higher” (Young, 2005, para 8). This may be true as specific standards of care have been outlined within professional codes of ethics, licensing boards, and state and federal laws. Extreme error in judgment or deviation from these standards clearly warrants legal prosecution. However, the shades of grey within the interpretation of these standards or guidelines are cause for controversy. Psychologist Ofer Zur affirms that “translating most codes of ethics, licensing board regulations or using them to clarify the standard of care can be a complex and challenging task” (2007, p. 69). This results in a conscious disengagement of touch by the professional, regardless of the added therapeutic benefits. Given the ambiguity of professional guidelines around touch, it is clear why the use of touch is feared.

As indicated by the literature, the use of touch within a psychotherapy session encourages a deeper level of healing compared to other approaches for treating trauma. Yet, the elusiveness around the use of touch can pose a challenge for many professionals. The one thing that is clear is that further examination around the use of touch is needed.

However, before research can be done, it is important to understand the framework in which this study will be conducted.

Conceptual Framework

Theoretical Lens

This research project will be viewed through the lens of Trauma Theory developed by Peter Levine (1997). Trauma Theory is based in the belief that all mammals have a fluid and adaptive innate response for surviving trauma. Through an altered state of immobilization in which no pain is experienced, an animal has the ability to immediately freeze when the threat of a predator is imminent. Once the life-threatening situation is over, the animal will then discharge the compressed energy through movements, such as shaking or running, in order to regain equilibrium and restore the body to optimal functioning. This process is involuntary and affects all three integral parts of the brain: “the reptilian brain (instinctual), the mammalian or limbic brain (emotional), and the human brain or neo-cortex (rational)” (p.17). This response mechanism in animals is nearly identical in humans. However in humans, any residual energy that was not discharged can accumulate and persist in the body as symptoms of “anxiety, depression, and psychosomatic and behavioral problems” (p. 20). Levine believes that “when we are unable to liberate these powerful forces, we become victims of trauma” (p. 21). Trauma Theory supports the premise that the integration of massage therapy and psychotherapy into one session would help restore balance within all aspects of the affected brain cognitively while accessing the undispersed somatic energy that resides in the body physically. Additionally, the utilization of touch can add a deeper level of healing by

providing a safe, supportive, and appropriate environment for the somatic release of the traumatic experience.

Trauma Theory will be conceptually woven throughout this research project in the areas of data collection and interpretation. Specific interview questions will be asked regarding the respondents' perceived effects of trauma (physical, mental, emotional, and spiritual or energetic); the therapeutic advantages and disadvantages around the integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma; and, the relationship between the respondents' personal and professional experiences with trauma. These questions will inform the researcher if the respondents' perceptions around the manifestations of trauma and trauma treatment align with literature findings, theories, and treatment approaches.

Professional Lens

The researcher will compare the respondents' beliefs around touch, safety, scope of practice, and professional boundaries with those of the NASW and AMTA codes of ethics, mission statements, and standards of practice which serve to guide each profession. Interview questions will be asked regarding the professional standards of care, licensing regulations, laws, codes of ethics, mission statements and guidelines that the respondent adheres to as well as the professional advantages and disadvantages around the integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma. These questions will inform the researcher of the respondents' perceptions around their own scope of practice and their attitudes around the integration of touch into a psychotherapy session.

In addition, various demographic questions will be asked during the interview in order to compare and contrast respondents' answers to previous trauma related questions.

Personal Lens

In her twelve years of practice as a massage therapist, this researcher has seen the impact that trauma has on the body. The need for dually degreed massage therapy and psychotherapy professionals was realized after discovering that her scope of practice as a massage therapist was limiting the potential for healing her clients holistically. This research project's data collection instrument, sampling population, and data collection methods are biased due to this researcher's professional experience as a massage therapist working with trauma.

This researcher is also biased due to her own personal experiences with childhood trauma. Integrative therapy has been extremely successful in understanding and releasing somatic tissue memory as a result of a head injury at age nine. After dealing with chronic head and neck pain for most of her life, this researcher discovered that true healing had occurred after combining the benefits of massage therapy and psychotherapy into one session. The motivation behind this project is directly influenced by her own personal experiences as a trauma survivor. In order to reduce the effects of personal bias on this research project, findings will reflect the literature and not the researcher's experiences.

The combination of Levine's Trauma Theory, NASW and AMTA professional standards of practice, and the researcher's professional and personal experiences provide a platform for a successful research project. Each facet within this conceptual framework addresses the dynamic issues around touch and scope of practice in order to discover the

professional attitudes around the integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma.

Methodology

Research Study Purpose and Design

The purpose of this study was to examine the professional attitudes around integrating massage therapy and psychotherapy into a sound clinical practice for treating trauma; and, publish the findings. This study was a non-probability snowball sampling research design consisting of semi-structured qualitative interviews. The subjects interviewed for this study were licensed independent clinical social workers (LICSW) and massage therapists who work with trauma. Subjects were recruited from a list of approved clinical supervisors on the NASW website and a list of massage therapists from the AMTA website. They were also recruited from professional contacts in the community who were previously unknown to the researcher. From these initial lists, additional participants were recruited through a snowball sample.

Data Collection

Each semi-structured interview lasted approximately 30-60 minutes. A list of six open-ended questions and eight demographic questions were prepared ahead of time by the researcher. Additional questions were asked based on the responses to those questions. The open-ended questions consisted of the following: (1) the participant's background and exposure to trauma, (2) the participant's therapeutic style and treatment approach, (3) the

participant's perspective regarding the integration of massage therapy and psychotherapy when treating trauma, and (4) the participant's viewpoint regarding the use of touch and scope of practice for dually degreed professionals. Demographic questions were adapted from the *Student Attitudes, Attributions, and Responses regarding Poverty* (SAARP) survey (Toft, Brommel, Ferguson, Garrett, Hill, & Kuechler, 2010).

Interview questions were approved by Dr. Felicia Washington Sy, research professor at the University of St. Thomas, research committee members, and the University of St. Thomas Institutional Review Board prior to the onset of data collection. The interview questions were emailed to the participants prior to the interview in order to solicit further in-depth conversations that may have been overlooked by the researcher. The participants were interviewed at their work office, home office, or private meeting room in a public facility for convenience and data privacy reasons. The interview was recorded using a Motorola Tablet and was later transcribed by the researcher and prepared for coding. Appendix A outlines the interview questions.

Protection of Human Subjects

This research study had limited risks. Full disclosure of this research study was presented to the subjects prior to the interview. A consent form was reviewed and signed by the researcher and the participant detailing the purpose of the study, background information, procedures, risks and benefits, confidentiality, voluntary participation, and contact information. The letter of consent was approved by Dr. Felicia Washington Sy, research professor at the University of St. Thomas, research committee members, and the University of St. Thomas Institutional Review Board. The consent form is shown in Appendix B.

Transcripts, video recordings, and consent forms were kept confidential. Transcripts and video recordings were locked in a password protected document on the researcher's personal computer. Consent forms were stored in a locked cabinet at the researcher's home office. All confidential data was destroyed immediately following the final public presentation on May 20, 2013. Full approval was granted by the University of St. Thomas Institutional Review Board and can be found in Appendix C.

Analysis Techniques

Data analysis was conducted using Grounded Theory, defined by Monette, Sullivan, & DeJong as “a research methodology for developing theory by letting the theory emerge from the data, or be ‘grounded’ in the data.” (2011, p. 503). The researcher read the transcripts several times looking for open codes, thematic codes, axial codes, typology, and theory to emerge from the data. These codes, concepts, and themes were then written down next to the corresponding data. Codes that emerged several times were considered concepts, which in return formed the themes related to the research question. An unrestricted open coding process was conducted initially, followed by an intensive axial coding process of the themes that emerged. The researcher analyzed data through a concurrent interplay of inductive and deductive reasoning.

Ten participants were interviewed – five massage therapists and five licensed independent clinical social workers. Saturation was not achieved due to time and resource limitations. Validity, accuracy, and reliability were established through triangulation and a partner reliability check. During the partner reliability check, two additional research students reviewed the data, coded it, and discussed the concepts and themes with the

researcher. Guidelines for the overall coding process mirrored the methods discussed by Berg & Lune (2012) in which data was (1) coded for descriptive information; (2) coded for topic information; and (3) coded for concept development. The researcher and the additional coders followed the exact same three step coding process. This process was repeated until a theory of a successful integration of massage therapy and psychotherapy treatment approach emerged from the data.

Strengths and Limitations

The greatest strength of this study was the researcher's ability to personally interview each of the respondents. This allowed the participants to give detailed and complex responses instead of answering yes or no type questions. The semi-structured style allowed for further explanation and deeper meaning of participants' responses to the interview questions. In addition, validity was increased through the partner reliability check process.

The greatest weakness of this study was the lack of generalizability to a larger population. The small sample size only gave the view of ten people. The participants were recruited within the state of Minnesota and therefore lacked geographic variability. In addition, the study failed to provide the researcher an efficient means of instrument distribution, data collection, and data analysis.

Findings

The research findings developed into five main concepts: (1) multi-dimensional effects of trauma; (2) therapeutic benefits; (3) professional benefits; (4) overcoming therapeutic barriers; and, (5) overcoming professional barriers. From there, additional themes and sub-themes were identified. The codes, concepts, themes, and sub-themes stayed

congruent to the research question: What are the professional attitudes around the integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma? It was discovered that successful integration can be achieved if (1) the multi-dimensional effects of trauma warrant a multi-dimensional approach, (2) this particular treatment model proved to be therapeutically beneficial, (3) there were professional benefits toward integrating this model, (4) the therapeutic barriers were addressed, and (5) the professional barriers were overcome. This symbiotic concept is visually displayed in the *Theory of Successful Integration Logic Model* found in Figure 1.

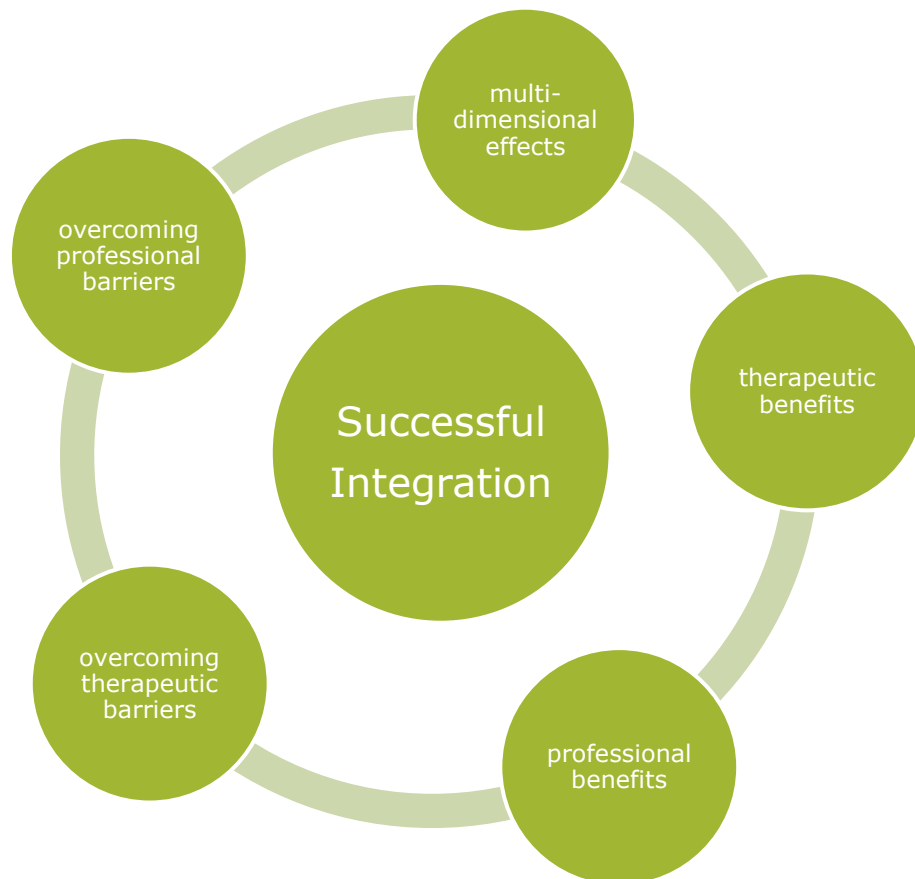


Figure 1: Theory of Successful Integration Logic Model. Frank, D.S. (2013)

Multi-Dimensional Effects

Types of trauma. Even though the primary intent for seeking out a massage therapist or a social worker differed, similarities existed regarding the types of trauma and the effects for their clients. Massage therapists tended to see clients primarily for physical complaints related to auto injuries, sports injuries, recoveries from surgeries, slips, trips, falls, and work related injuries. However, as treatment progressed, clients would disclose additional sources of trauma such as physical, sexual, and emotional abuse; childhood trauma; various types of addictions; abandonment; family issues; and relationship problems. One massage therapist described this process of working with trauma well:

I've worked with people who've experienced trauma, but that hasn't been the direct focus or intention to address that in any way in my sessions as a massage therapist. People hold experiences in their physical tissues from previous things like car accidents or other things that are physically traumatic and that has brought on relational or related emotional release.

Each of the massage therapists expressed similar outcomes with their clients, but did say that it doesn't necessarily happen to every client that they work with. However, it became clear that even though the primary intent of a massage therapy session is to address the physical complaints, massage therapists are discovering a much deeper level of pain associated with their client's trauma.

Conversely, the primary intent for social workers is to work with trauma directly. They work with many different populations and many different types of trauma like sexual, physical, and emotional abuse; domestic violence; veterans who were actively dealing with PTSD; natural disasters; apartment fires; death; and community-wide fear-based trauma related to violence. The difference that was evident between both professions had to do with

the intensity and frequency of trauma related issues that were present with their clients. One social worker shared what she often experienced at her previous employment as a hospital social worker:

So, a lot of times people are admitted for suicidality, but behind it and in addition to, the depression, the anxiety, or whatever is bringing them into the hospital for multiple trauma in their past. So, a lot of times the dilemma in that setting and often times in this setting, that is not what you can delve into at the time – the trauma; because, hospital stays are short and you're just trying to get a plan, a discharge plan, to help them be safe and help them to deal with that trauma eventually if they haven't already

Certainly, the role of a social worker varies; not all social workers experience high levels of intensity and frequency within their positions. Perceivably, the experiences that were shared by the social workers seemed far greater than those of their counterparts. In addition, from an ecological perspective it appeared that the social workers dealt with trauma on micro, mezzo, and macro levels; and, the massage therapists seemed to focus more on micro-level trauma issues (although it could be debated that their work affected mezzo-level trauma issues by indirectly influencing their clients' intimate relationships and family systems). While each profession attracted clients for different presenting issues, there were many similarities in the types of trauma they worked with.

Effects of trauma. Congruencies were also noted among both professions regarding the effects of trauma. Many of the exact same words were used several times by both, validating these findings even further. Some of these identical words were *worthless*, *body pains*, *headaches*, *anxiety*, *fear*, and *guarding*. Four sub-themes emerged when describing the effects of trauma: physical, mental, emotional, and spiritual or energetic. Both professions discussed a wide array of physical symptoms related to trauma such as varying

degrees of limited mobility, headaches, self-mutilation, anxiety, tension, body pains, physical guarding, and Fibromyalgia. Remarks were also made by both professions regarding mental health symptoms. They talked about how their clients just couldn't seem to function, clients had a limited level of understanding, some clients had a difficult time concentrating, their defenses were more primitive, and they showed signs of depression, fear, and regression. Both massage therapists and social workers have recognized emotional effects of trauma, such as anger, stress, denial, hate, self-loathing, low self-worth, and low self-esteem. Both professionals also added how their clients have had difficulty in their relationships, especially with their children and significant other. Social workers and massage therapists also reflected on symptoms affecting the spiritual or energetic level. They described seeing an inner conflict with their clients. Some described this conflict as a lack of worthiness to a higher power, while others felt a sense of being scattered or disconnected. One social worker was asked to describe the effects of trauma she sees with her clients. She replied:

Well, physically, I guess is more somatic symptoms. The stress comes out of the body....so headaches, body pains, fibromyalgia, um, any kind of body disability. Then, mentally and emotionally it's probably a very low self-worth, low self-esteem, feeling worthless, feeling like their bad. Really a lot of stuff...hate, self-loathing. Spiritually it's really not a whole lot of spiritual connection. And those that do have a spiritual connection, um, it's even a really much more in-depth inner conflict because they believe and want to have a higher power, but don't feel worthy to have that and that they're always betraying that higher power because their worthless.

Clearly, all of the research participants in this study agreed that trauma impacts all aspects of an individual. When describing these effects, a deeper meaning emerged regarding the overall connection of the body, mind, emotion, and spirit. This connection is described below as another theme within the conceptual category of multi-dimensional effects.

Body, mind, and spirit are inseparable. The “mind, body, spirit connection” was mentioned over and over among both professions. It was not merely a coined phrase describing how the various elements of trauma affect the specific components of an individual. It was deeper than that. Many of the massage therapists and social workers talked about how the body, mind, and spirit are one – how they are inseparable. Statements were made regarding tissue memory, trauma memory, and the mind/body/spirit. One massage therapist talked about how her work influences all aspects of a person: “It’s not just a separate thing that just happened on the table.” Another massage therapist used the word *story* to describe the trauma memories that are locked inside the body:

Oh, the body tells the story. The cells register the stress from the trauma. And, I observe the body to see, to help them understand where they are holding the stress of that trauma. And, once they discover the area, then I can help them get in touch with that story.

These statements were often times verbalized in either a casual way alluding to the assumption that the mind, body, and spirit are inseparable or emphasized in order to stress the importance of the mind/body/spirit connection when treating trauma.

Several research participants shared profound stories or statements emphasizing the need for a mind/body/spirit approach to healing. One social worker shared a touching story about a young girl who had been in and out of jail, probation and juvenile placements, and residential and mental health treatment programs for the past ten years. Recently, the social worker heard that she was prostituting. The young girl has learned that by assaulting people, primarily police officers, she will immediately be locked up. A jail cell has become a safe haven for her. She has all of the symptoms of trauma physically, mentally, emotionally, and

spiritually; but social workers and mental health professionals cannot figure out how to help her in the capacity that they are able to.

We can't get to the root. We know she's been traumatized. We know it, but we can't figure out what it was. She feels that unease inside her and she feels most safe when she is locked up in a cell. Um, we can't figure out what her trauma is and she shows all of the symptoms. She's just a puzzle. I definitely think that the benefits would be to symbolically help the child recognize that there is pain associated with what they experienced – possibly first to validate what happened to you should never have happened...it's painful...it's stored in your body. Let's use touch to lift it out so you can heal.

A massage therapist, who has a private practice in a massage therapy clinic, said that a lot of clients who have experienced trauma tend to search her out. She said, "It's sort of unusual I think, in a sense, for me to find that the people that come forth and search me out are the ones that have trauma." She has discovered throughout her 30 years of practice that the mind, body, and spirit are so intimately intertwined. After reflecting on the importance of this connection when treating trauma, she paused before adding, "We're just beginning to realize in this culture what it means to be a human being." She spoke with such a strong conviction and passion in her voice that literally brought tears to my eyes. Her story and others added to the depth in perception of mind/body/ spirit inseparability.

All of these responses support the first major concept in determining the outcome of a successful integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma: Multi-dimensional effects of trauma warrant multi-dimensional approaches. Social workers and massage therapists agree that the mind, body, and spirit are inseparable. Therefore, by focusing on each individual component of trauma, we are not treating the whole person.

Therapeutic Benefits

Comprehensive care. Both massage therapists and social workers felt that this type of treatment model was beneficial therapeutically, because it provided a well-rounded approach to treating trauma. Some research participants described it as blending; others talk about completeness. Both professions mentioned this concept of completeness indirectly by stating how it would help to fit the needs of their clients. A very lively massage therapist verbally stressed how amazing this approach would be:

A well-rounded, well-educated, dually degreed person could offer physical, emotional, chemical...all of that in one session. That is more completely treating the mental, the emotional, the physical, the spiritual. I think that would be an amazing benefit!

Several social workers shared similar beliefs. One social worker added how an integrated model may even speed up the healing process or attract those who may be less likely to get the help that they need:

You get the expertise of a massage therapist, what they can do with their treatment and their hands to help that moving forward, and the other therapist to help talk and guide and interpret, too and it would be beneficial to use two different approaches...there would be more healing – faster healing. You may have some clients who'd be more likely to get help, that that would be a way that would work for them.

While both professions conceived the concept of completeness differently, both agreed that the integration of massage therapy and psychotherapy into one treatment session would provide a more comprehensive care to meet individual client needs.

Therapeutic process. An interesting perception around intimacy and relationships emerged from the findings. Both professions discussed how this type of integrative model would provide an intimate space for healing to occur, establish trust, and enhance the therapeutic process. The words *moment*, *relationship*, and *healing* were coded multiple times within the context of therapeutic process and professional relationships. It was interpreted as something different than the theme of comprehensive care. One massage therapist said it directly, “It’s the connection and the relationship that heals.” Another massage therapist described it as a mutual process of observation, understanding, and discovery. She said, “I observe the body to see, to help them understand where they are holding the stress of that trauma. And, once they discover that area, then I can help them get in touch with that story.” That same therapist went even further to say how she felt as if the relationship between her and her clients took on a deeper, more spiritual meaning. She equated the therapeutic process to a spiritual journey: “Our journeys – we receive and we give...we give and we receive. I’m just a midwife to bring that forth for people.” Several social workers, on the other hand, used different language when describing an enhanced therapeutic process. They used terms like *attachment*, *professional relationship*, and *rapport* more often than their counterparts. The meaning derived from the different terminology was contextually related to this theme. For example, one social worker advocated for the use of touch in order to enhance a deeper connection since most of her clients have unmet attachment needs: “It’s the physical touch – that connection – that many of these people haven’t had. The attachment piece – being able to feel connected to someone.” Another social worker expanded even further: “Many have never been caressed, have never felt gentleness by touch – there’s always been hitting or slamming or kicking; lifting that barrier of fear between what

happened to them and what can be – accepting that touch as being good.” Regardless of semantics, both massage therapists and social workers believed that by integrating massage therapy and psychotherapy into one session, a certain level of trust, relaxation, intimacy, and rapport is added to the therapeutic process.

Timely response. The sub-theme of *timely response* evolved from the previous theme of *therapeutic process*. As each of the massage therapists talked about the therapeutic process, they also mentioned that if they were able to work through the traumatic issues at the moment of physical release, their work would be more effective. One massage therapist stated, “You’d be right there with the person at the moment of the trauma coming out and then you could work with that right at the present moment.” Many had shared stories about missed opportunities with several of their clients because of a lack of psychotherapeutic knowledge and a limited scope of practice. One massage therapist suggested, “I do feel like there is a potential to go deeper or go further when things come up. Even just to debrief afterwards would be a very supportive thing in the process.” Social workers did not mention anything about being in the moment or a timely response. However, due to the fear around touch in the social work profession, it would only make sense that they would not share similar experiences.

Saves time and money. While the added benefit of saving time and money was only mentioned by two massage therapists, the researcher felt it was worth noting due to the degree in which each participant discussed the topic. One massage therapist stressed how financial benefits would be the number one reason to have an integrated session: “The benefits would be #1 financial because you’d have a single session instead of paying for two sessions.” While discussing the benefits of an integrative treatment model, a massage

therapist emphasized her viewpoint non-verbally by rolling her eyes in frustration. She asserted, “A benefit would be that you’re not seeing 15 professionals for the same thing – you have 15 different opinions on how to help you.” She continued to talk about how an integrated session may have the potential to be covered by health insurance, making it more affordable. This participant went on to explain that massage therapy is currently not covered by health insurance companies. In her opinion, the lack of health insurance coverage equates to a lack of recognition as a medical modality: “Right now, you can’t find health care coverage that will accept it. But, I really think it’s on the forefront of being recognized...as a medical modality.” This secondary theme expands into a greater concept of *professional benefits*.

Professional Benefits

Professional status. The theme of professional status was pieced together using several matching codes. Both massage therapists and social workers mentioned one’s expertise, knowledge, and education in a particular field of study if they were dually degreed. One massage therapist said that a dually degreed professional would “be a leader in the healthcare industry.” She went on to explain that being “a well-rounded” and “well-educated” dually degreed practitioner would promote a higher level of expertise in both fields, especially in trauma treatment. Another massage therapist talked about the benefits of networking between both professions. She explained how the connection to both fields would provide additional resources that could potentially demonstrate higher results, setting a professional standard above the rest. Social workers felt the same. Three of the five social workers acknowledged that a dually degreed professional would assert a higher level of expertise in dealing with situations specific to trauma patients that massage therapists

currently deal with in their own practices. In regards to instances of dissociation, one social worker stated this well:

If they were to be touched and they dissociate...well, most people aren't even going to know what that is. So, if you have a licensed clinician that's doing both, they're going to know what to look for – they're going to know how to reground somebody – and, because potentially they're triggering that and somebody dissociates and they leave from that situation they could be really disoriented.

As a whole, both professions felt that this distinct model would be beneficial for both professions as it would establish a higher level of expertise, knowledge, and professional status as opposed to each profession independent of the other.

Professional gratification. All of the research participants had numerous things to say about the therapeutic benefits of an integrated treatment model. They expressed a strong desire in helping their clients heal from trauma. Each individual was able to relate to a particular client, share their story, or express an interest in their overall well-being. Many were quoted saying: “what is going to help the client the most”, “to more fully meet the needs of my client”, and “I work with people to fit their needs.” These statements reflect a sense of personal and professional gratification aimed at meeting specific client needs, resulting in successful outcomes. One social worker said, “I like what I do. It's been a wonderful career for me.” He went on to say that his wife, daughter, and son are social workers, too. They find a sense of satisfaction together as a family, knowing how they are all making a difference.

Another component to this theme involves the practitioner's ability to incorporate their own interests and abilities into their work. One social worker talked about her passion for holistic therapies such as yoga, hypnosis, and psychodynamic therapy. Another social

worker moved her practice to her hobby farm so she could integrate the animals into therapy. Horses and dogs are certified to do therapy with her; and, she incorporates elements of nature into each session. She shared incredible stories of how healing would occur while walking through her gardens or brushing the horses. Her farm is her passion and feels like the transition was well worth it. Several massage therapists used the words *important*, *reward* and *gift* when describing their work. Each of the massage therapists had specialty areas like Structural Energetic Therapy, Reiki, Integrated Neuromuscular Re-education, Positional Release, Healing Touch, Polarity Therapy, David Gorman's Learning Methods, and William Glasser's Choice Theory Reality Therapy. Additional therapies allow professionals to integrate their interests and passions into their work, can be very rewarding, reflect a dedication toward their professional practice, and allude to a sense of personal and professional gratification.

Overcoming Therapeutic Barriers

Client's inability to handle touch. One area of great concern for both massage therapists and social workers was a client's inability to handle touch. Some participants felt a therapeutic barrier might be a client's overall willingness or desire to be touched. Others thought that tactile issues and physical disabilities were other barriers. Many participants acknowledged that touch may not be appropriate for everyone based on their situation or level of healing. In reference to people with Autism, one massage therapist pointed out, "I think it would be beneficial, but I think it would be a large barrier to determine how that disability would affect your outcome." Quite frankly, clients who fall into this category may not benefit from this type of therapy at all. Overall though, an inability to handle touch, a

decreased willingness or desire to be touched, and a certain level of healing are obstacles that need to be overcome prior to the implementation of an integrated treatment model.

Client's inability to understand intent. A client's ability or capacity to perceive correctly due to mental health issues is of great concern for both professions. One massage therapist discussed how she will often get referrals for auto related injuries and discover that they have a mental illness or disability as well. She said that it is important to "make sure that their perception is the same as yours." She went on to say, "When you touch that person, that they're not considering it something abusive or attacking or uncomfortable or even sexual." Four of the social workers shared their concerns regarding mental illness. One of them addressed personality disorders in particular:

At the hospital in the mental health unit, we also work with a lot of personality disorders. So, then you run into the issue of...they may have read all that, they may have agreed to all that and they know the boundaries and the guidelines and everything, but at some point they turn and they accuse you of doing something inappropriate. And then how do you defend that?

Another social worker shared a story about a girl who accused her adoptive father of sexually offending her when there was a witness to testify against the allegation. The child was mentally unstable – recalling the sexual abuse from her past. However, she was not able to discern her offender from her adoptive father: "There was a witness that it didn't happen, but she *knows* that it happened. Her trauma is preventing her from knowing who it was." Both professions agreed that a client's inability to understand intent is a precarious obstacle to overcome.

Cultural barriers. While it was not discussed in great detail, participants from both professions referenced the term *culture* several times. Many of them directly stated how they

work with immigrant populations who have limited English speaking skills and have clients from different religious backgrounds. These factors influence an integrated model as many cultures and religions have differing beliefs around the use of touch. One massage therapist talked about getting referrals to work with Muslim women, primarily because she was a female therapist. She had to research specific Muslim customs in order to accommodate their cultural needs. Her story is just one example of how understanding cultural norms around the use of touch is important to consider when creating an integrated practice.

Appropriate assessment. All of the social workers felt that proper assessment prior to an integrated session would need to take place first. They believed that in their experience, not everyone would benefit or be appropriate for this type of treatment model. Four of the social workers were really hesitant about even attempting this type of approach mainly due to the lack of appropriate assessment tools. However, one seemed more optimistic. Along with all five of the massage therapists, this particular social worker commented on the importance of scope of practice and what to expect during an integrated session, but felt positive that proper assessment was attainable. Despite the differing attitudes around proper assessment, all believed that the intent to integrate would have to be explained ahead of time and that appropriate assessment tools would have to be used in order to discern who was ready for this type of treatment model.

Re-traumatization. Several social workers brought up the issue of re-victimization related to the unearthing of trauma memories during an integrated session. One social worker who works with children talked about her experience with a young boy and his adoptive mother. His birth mother severely neglected him as he spent his first year and a half

in a crib without stimulation or touch. Now, the boy has difficulty accepting appropriate touch. She shared his response:

And, his adoptive mom is so gentle and nurturing...you couldn't ask for a better person to now step in and take that role. But, the minute she steps in and touches him he flinches and he doesn't understand where that comes from.

Another social worker had concerns about some of the people she works with. She thought that people who have PTSD may have a very difficult time dealing with the flood of emotions and stimulation that potentially could come as a result of this type of treatment:

People are going to be triggered and then not know what to do with that, or not like it, or not maybe ready to go there, or not expecting what happens or what comes up and not wanting to deal with that even if there is a professional guiding them through that...that they might not be ready to go there. And then, if they're actively having PTSD, the touch might be too much, it might just be a little overwhelming for them if they're not ready for it.

Many other examples were given that reflect a similar degree of concern regarding the re-traumatization of clients. Even though the idea of an integrated model for treating trauma makes sense, both professions agree that therapeutic barriers related to re-traumatization stand in the way of implementation.

Overcoming Professional Barriers

Professional boundaries. The practitioner's personal and professional boundaries were addressed multiple times by both massage therapists and social workers. Specific words such as *dual relationships*, *non-sexual relationships*, and *confidentiality*, were coded multiple times in reference to personal and professional boundaries. Social workers seemed to have more concerns than massage therapists. Four of the five social workers perceived the

integration of touch leading to allegations of sexual misconduct, so therefore maintaining a certain physical distance from their clients will help to establish healthy professional boundaries. They believed this physical distance would also help to prevent dual relationships with their clients. However, one social worker talked about how she relies on touch in her practice with her animals. She uses hand over hand positions to demonstrate how to brush the horses, for instance. She also mentioned that a gentle touch on the shoulder of her grieving client or a hug after an intense session helps with the healing process. She did admit that she must make a conscious effort to keep certain areas of her property off limits to her clients for safety and personal reasons, and states that she is very clear about her boundaries with each client ahead of time. She was the only social worker who did not present an overall fear or hesitation around maintaining healthy boundaries.

Conversely, massage therapists in general felt comfortable with establishing personal and professional boundaries, but admitted that they must work at it every day. They adhere to professional draping methods, maintain a professional business-like atmosphere, and are very clear about client/therapist boundaries with their clients. They have even had to end sessions when boundaries have been violated by the client. Even though the massage therapists felt comfortable with maintaining healthy boundaries, they were definitely aware of the professional and ethical implications related to boundary issues. Certainly, professional and personal boundaries create barriers that inhibit the implementation of an integrated practice for treating trauma. However, the massage therapists felt as if these barriers can be overcome by staying grounded, remaining focused, and being in a “very good spiritual place”, as one therapist suggested. This tied into what some of the social workers

alluded to when discussing their own personal boundaries with clients. This idea of self-care shed light on yet another sub-theme in relation to overcoming professional barriers.

Self-care. Several participants talked about their ability to stay grounded, maintaining their own personal space, and needing to work through their own trauma while discussing professional boundaries. Based on the level of importance and high level of repetitive coding regarding this topic, it evolved into an independent sub-theme. Several participants in each profession revealed how they have worked through their own personal trauma, often times going into detail on the types of trauma, effects of trauma, and overall healing process. One massage therapist in particular shared how her own personal experiences have impacted her own work with her clients. She began the interview by setting the stage for further inquiry:

I have worked through my own personal trauma, first of all. I've had my own wounds and I've had to do my own process... So, the more I've done my own inner work, from my own physical, mental, emotional traumas, then the more peaceful I am, the more accepting I am.

She went on to explain how she attracts clients who have experienced trauma because of the personal healing work she has done with her own past. She believes that part of her healing is also being a model for others. This is an extremely important issue that cannot be overlooked. In order for dually degreed practitioners to be able to function in their positions, they must take care of themselves physically, mentally, emotionally, and spiritually. The potential for re-triggering the practitioner's trauma must be minimized in order for this work to be effective. Quite possibly, many social workers and massage therapists may not be the best professional for this treatment model. For example, a county social worker expressed

her own concerns about transference and counter-transference with the children she works with. She admits to crying when she listens to some of the horrendous situations that her clients endure. She knows that she is a sensitive person and feels as if adding touch into her practice wouldn't allow her to be as effective in her position. Her hesitation and fear around boundaries not only supports the need for continued self-care, but strengthens the need for on-going supervision.

Supervision. The need for on-going supervision and consultation was specifically mentioned by only one social worker. The sub-theme contextually emerged from conversations about referrals, advice from other professionals, agency hierarchies, and experts in the field. The concept of supervision is not new to the social work field. However, due to the lack of licensing in the state of Minnesota for massage therapists and the potential for isolation among independent practitioners, regular consultation is minimal or non-existent. Supervision and consultation is a crucial piece that cannot be overlooked.

Professional identity and scope of practice. One area which seemed to lack clarity and vision by many participants is the area of professional identity and scope of practice. Social workers and massage therapists equally questioned the role of each profession when integrating them into a single session. Most thought that each professional lens would conflict or interfere with the other. Several participants from each profession used the word *tricky* when asked to elaborate on the potential professional barriers related to scope of practice and professional identity. One of them felt that adding touch to her current practice would be tricky, primarily because social work is considered a “hands off” profession and massage therapy is a “hands on” profession. She used those exact words repeatedly, shaking her head in disbelief that this type of professional integration was even possible. A massage

therapist added that potentially a new professional group would have to evolve in order to integrate both professions if collaboration is unattainable.

Professionally, I kind of touched on the fact that these different licensing organizations that there would be some sort of high level conversations between these different groups or the formation of a new group of the sort of blend or something. They usually describe their own as a way of saying that *we are not this...we are not this....we are not this...* so if you are bringing in one of these things that have been a *not* then that becomes the challenge.

This massage therapist also talks about the need for “high level conversations” between the licensing and accrediting agencies. This idea can also be perceived as an institutional resistance to change and is discussed below. Whether professional identities change or a new identity emerges, professional scope of practice must be addressed in order for this barrier to be overcome.

Ambiguous laws, code of ethics, and guidelines. Massage therapists and social workers agreed that laws, codes of ethics, and professional guidelines were too ambiguous, especially regarding the use of touch and scope of practice. When asked about current regulations and how they may affect an integrated treatment model, massage therapists were uncertain because the state of Minnesota does not have licensing requirements. This posed a serious concern for one massage therapist who said, “Right now there aren’t any rules or regulations so I can pretty much do whatever.” She admitted that the looser regulations made it easier for her to practice, but was not beneficial for the profession as a whole. If a city does not have an ordinance governing massage therapists, then anyone can establish a practice, regardless of their training and background. Several practitioners stated their city ordinances required criminal background checks, as well as regular monitoring by the health

department and city building inspectors. Even though practicing guidelines and regulations are ambiguous, all of the massage therapists interviewed chose to be members of the AMTA and expressed pride in upholding professional standards of practice, maintaining continuing education, and following ethical guidelines. In addition, four of the massage therapists became nationally certified by the National Certification Board of Therapeutic Massage and Bodywork (NCBTMB). The national certification exam, administered by NCBTMB, is highly regarded in the massage therapy profession and is a requirement for licensing by many states, including the neighboring state of Wisconsin (Wisconsin Department of Safety and Professional Services, 2012). Coincidentally, one of the massage therapists is also a Registered Nurse (RN). She has dealt with this type of ambiguity most of her career. She expressed her frustrations around variations in professional guidelines, the city ordinance, and her malpractice insurance.

Scope of practice...boy I would come under that label of *RN* first then *CMT*. I can do nursing measures and assessments and then follow under AMTA guidelines. I don't have to have a criminal background check because of that with the city. I have malpractice insurance, but I used to have insurance through a nursing organization until 2 years ago when I talked to somebody about that and they told me that they wouldn't cover me under massage, nursing massage. So why do I even pay money for that every year? So, I don't have that coverage anymore. To me, I have my own code of practice, my own standards of practice, which is probably stricter.

She went on to say that because she is an RN, she is exempt from most of the regulations outlined in the city ordinance – criminal background checks in particular. She believed it was related to a “taboo around touch” and a lack of state licensing for massage therapists. Even so, her unique situation as a dually degreed professional yields yet another sub-theme that will be addressed in the next section: conflicting laws, code of ethics, and guidelines.

Social workers also felt that laws and guidelines are ambiguous. Their attitude in general was to avoid any potential risks and conflict in order to navigate the gray areas more effectively. Since ambiguity does exist, social workers rely on supervisors, consultants, and discussion panels to help interpret those gray areas. Remarkably, only one social worker felt comfortable with an integrated model and felt as if each profession's laws and guidelines would support the other. The discussion around ambiguity prompted a county social worker to express her frustration with contradictory rules, laws, and practice guidelines that she faces every day. Her statement reflects a need to address not only the ambiguity within the social work profession, but the conflicts that arise between each regulatory and licensing agency.

Conflicting laws, code of ethics, and guidelines. Not only are the laws and guidelines difficult to interpret, they sometimes conflict as well. The county social worker mentioned above asked the interviewer to record her statement about the conflicts she currently faces in her role as a county social worker even though the interview had ended. She felt compelled to expose the contradictions and how they affect the quality of her work:

As a licensed social worker, I abide by the code of ethics of social work; but also find that it is contradictory of what is expected and policy wise from the Department of Human Services, state requirements and working for the government, and also county policy. So, sometimes there are...this terrible grey area between what the code of ethics say what is ok and what the state says we should do and also what the county practice is. And, a lot of it stems around relationships with clients. To be an effective social worker, you could easily look at the code of ethics and be a lot more to people than what the county wants us to be. Even simple things like attending a graduation of a child you worked with for 10 years, attending a funeral of a family member or an actual client. Those are things that we are not encouraged to do and be a part of and it totally contradicts what I believe the code of ethics in social work would allow us and expect us to do. So, there are those things that contradict. Personally, it depends on the situation of what comes first. I feel it's neglectful to not celebrate a graduation or something enormous in a child's life when they are asking you to be there to be a part of it.

This statement not only reflects the ambiguity and contradiction between licensing agencies, it also reflects an overall contradiction to the purpose and mission of the social work profession. Although not as profoundly stated, the dually degreed massage therapist had similar frustrations. She was unsure if she should practice as an RN or a massage therapist or both. The advantage of labeling herself an RN allowed her to be exempt from some of the mandates, but would detract from appropriately defining the work that she does as a massage therapist. Her solution was to call herself a “nursing massage therapist” in order to clearly define her expertise, maintain ethical guidelines and standards of both professions, and weave through the regulations effortlessly. Findings from both massage therapists and social workers confirm that this ambiguity and conflict is a huge obstacle to overcome if a dually degreed professional were to create a sound clinical practice by integrating the two professions.

Fear of allegations. The fear around allegations was extremely strong, especially among social workers. Phrases like *allegations, protection, malpractice insurance, background checks, liability, and witness* were used quite frequently among both professions. One social worker directly stated, “The fear of touch is the fear of allegations...the fear of losing your license.” Another social worker, who previously worked in the mental health department at a hospital, expressed grave concerns about working with people who have been diagnosed with serious mental health issues. She would not feel well-protected in defending herself against false allegations, and therefore would not attempt integration.

At some point they turn and they accuse you of doing something inappropriate...and then how do you defend that? You'd be in a closed door room like this...would that be a barrier as a part of your practice? Would you want to video everything for your own protection? And, then confidentiality comes into play or some clients don't want

a video. You'd have some screening, some pretty serious screening for who you'd want to do that.

A county social worker, who works with children, had similar concerns. Although, she brought up the idea of having a second person in the treatment room, but questioned the therapeutic effects:

You'd almost need a witness of some sort, yet would that dilute the therapeutic process? Would that be fearful for the child to be in the presence of two adults and ask to be vulnerable? Two adults that are well known to that child? So, I don't know if the therapeutic process will be diluted because of that and not as effective...

Massage therapists did talk about allegations, but felt as if they maintain professional boundaries well and have adequate liability insurance. They did not express any fear around allegations for themselves. However, they were more concerned about psychotherapists and male practitioners because of societal stigma. This point of interest will be discussed below as it reflects a much deeper sub-theme of stigma and institutional resistance. Strong emotions surfaced when discussing the fear around allegations, especially for social workers. Findings have concluded that massage therapists in general do not have a fear of allegations around touch, as opposed to their counterparts.

Institutional resistance to change. The theme of systematic and societal resistance to change emerged when interviewing both massage therapists and social workers. Many participants from both professions felt that society wasn't ready for this kind of treatment model. Three main reasons transpired: stigma around touch, lack of empirical evidence, and insufficient training.

Stigma around touch. The words *taboo* and *skepticism* were coded multiple times by both professions. The perceptions around touch supported a negative belief system that touch equates to sexual misconduct and regulatory violations. This was very evident among social workers. Their attitudes around touch were biased by their professional lens. Massage therapists discussed two separate barriers to this societal stigma: Psychotherapists touching their clients and gender inequality within the massage therapy profession. First, a massage therapist used the word *sad* to describe the unthinkable notion of being touched by a psychotherapist, citing enormous legal and boundary issues. Second, another massage therapist discussed the disenfranchisement of men related to the societal stigma around touch. She asserted:

I have found that male massage therapists have a hard time breaking that gender barrier. They're not perceived as trustworthy, as caring, as comforting as a female massage therapist. And, there's always the concern for sexual misconduct between a male massage therapist and his clients. I think that will be a hard barrier to really break through, especially if you have a male social worker who's doing touch.

The male social worker, who happened to be the only male research participant, shared a similar belief of gender inequality. He revealed that he was involved in a very serious incident involving a false sexual misconduct allegation toward him by a jealous husband of a female client, which caused an enormous amount of distress. He had to present his case to the state of Minnesota social work licensing board, resulting in lost time and money. Fortunately, the jealous husband later recanted his claims after learning about the legal repercussions of making a false report, and admitted that he was lying. This social worker also explained that it can be the same for women social workers who work primarily with male populations. As a supervisor, he had to have difficult conversations about safety and

effectiveness with some of the women he supervised. He would ask, “How are you going to overcome that when they just look at you and just melt? How are you going to demonstrate your effectiveness as a therapist and as a woman?” The societal stigma around touch is clearly a giant obstacle to overcome. However, in order for an integrated model to be accepted, it at least must be addressed.

Lack of empirical evidence. The need for research was suggested by both professions. One social worker admitted that despite the therapeutic and professional benefits, if a model is not supported by evidence based practices then it will not be considered a viable treatment option. She explained:

I think it could be a piloted program and see what the results are – that would be my thought is to pilot it as a program and see what comes up for research. If it isn't an evidence based practice they're not going to use it anyway. You'd have to start there I guess.

She did go on to say that in her opinion therapies are “moving along holistically”, but in regards to an integrated model, she added that “society may not be ready for that shift yet.” Along those same lines, a massage therapist suggested the skepticism or resistance may be a result of an inability to quantify holistic treatment measures, making it difficult to market as a valid treatment option.

I think there's going to be a lot of skepticism and I think it'll be hard to market to the hard-nosed people who don't see holistic treatment as valid. I think finding supporters to continue to fund it or fund the research because it hasn't – it's hard to quantify.

Clearly the lack of research warrants the need for piloted programs and treatment models, which is discussed below.

Insufficient training. As previously suggested by a social worker, piloted programs and additional training is needed for a paradigm shift to occur; massage therapists agree. In fact, one verbalized her search for adequate trauma training and professional modeling in order to meet the needs of her clients. She sighed, “We don’t have the models – I didn’t have the models. I had to go look for them.” She explained that she had to search out trauma coursework at a local university and a spirituality center, but admits it was a piecemeal approach to her education. Even though this particular research participant appeared to have a strong desire to seek out adequate resources to meet her professional needs, she may be an exception. Whether the resistance to change is related to stigma around touch, lack of empirical evidence, or insufficient training, both professions agree that in order for a dually degreed professional to establish this type of integrated practice model, societal barriers must be overcome first. These, and other themes previously illustrated, provide adequate data for a thorough discussion.

Discussion

The qualitative findings which emerged were rich with information. The participants were thorough, gave many examples, shared real-life stories, and expanded on their thoughts and ideas well. Both professions agreed that the multi-dimensional effects of trauma warrant a multi-dimensional treatment approach. Many believed that an integrated treatment model would be beneficial therapeutically by providing comprehensive care, enhancing the therapeutic process, yielding a timely response, and saving time and money. Professionally, this particular model would be beneficial by enhancing professional status and providing a sense of personal and professional gratification. However, in order to implement this particular type of practice, many therapeutic and professional barriers must be overcome.

Therapeutic obstacles include the client's ability to handle touch, the client's ability to understand the intent of treatment, cultural barriers, appropriate assessment, and the re-victimization of the client. Professional barriers include the therapist's personal and professional boundaries; the need for self-care and supervision; professional identity and scope of practice; ambiguous and conflicting laws, code of ethics, and guidelines; fear of allegations; and institutional resistance to change, such as the stigma around touch, a lack of empirical evidence, and insufficient training. The findings reveal that the integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma cannot be achieved until each of these factors are synergistically in place. Key differences between massage therapists and social workers were noted regarding the use of touch within a psychotherapy session. Social workers were very apprehensive and cited fears of allegations, adequate liability, and the potential to lose their license. Conversely, massage therapists did not personally or professionally attach themselves to the fear around touch, as one might expect. Massage therapists had a clear understanding of the potential risks due to institutional and societal barriers, yet felt that adding psychotherapy to their existing practice would be advantageous. Still, the overall challenges and fears seemed to outweigh the potential benefits.

The findings related to the multi-dimensional effects of trauma are consistent with the literature (Kubany, Hill, & Owens, 2003; Levine, 1997; Moraska et al., 2010; Pennebaker et al., 1988). All of the research participants observed similar symptoms with their clients. In addition, the participants' opinions regarding the need for a multi-dimensional treatment approach is congruent with Levine's theory (1997). This similarity further validates the findings and affirms the need for a multi-faceted treatment model.

Several of the research participants discussed how an integrated approach would benefit the therapeutic process by building upon the existing environment of trust, relaxation, intimacy, and rapport. They believed that the incorporation of touch would enhance the healing process by adding a spiritual component as well. These assumptions are supported by the findings of the Price study (2005). The outcome of *Group 2* in the Price study revealed that a deeper level of healing had occurred by integrating the two modalities. *Group 2's* reports of experiencing a somatic release of trauma, increased self-awareness, and an increased mind/body/spirit connection are synonymous to the research participants' perceived therapeutic outcomes; thus, supporting the findings of this study.

Probably the most glaring assertions from the literature that support this study are from Young (2005) and Zur (2007). Their positions regarding the fear around touch (Young, 2005) and ambiguous practice guidelines (Zur, 2007) are consistent with the research findings. Both professions expressed a strong need to implement an integrative practice, yet social workers were fearful around the use of touch and massage therapists did not have clarity around scope of practice. Regrettably, communication efforts with the various licensing and accrediting agencies fell short of providing adequate information or suggestions to overcoming these barriers. Moreover, many did not encourage continued dialogue or support for dually degreed professionals. Unfortunately, their narrowed scope of practice and fear around touch seemed to limit the possibilities in the realm of trauma treatment.

Limitations

There were several limitations which presented prior to and during the interviews. The snowball sampling method proved to limit the diversity of the research pool. All the participants were Caucasian, nine of the ten were females, and all of them practiced within 90 miles of the researcher. These factors may have contributed to a narrow viewpoint and may not represent each profession as a whole. Ideally, a more diverse population would have enriched the data including practitioners of color and men.

Another drawback to the research findings involved the data collection instrument. An unfortunate malfunction with the videotaping device occurred during three of the interviews. Almost 90 minutes of conversation was not recorded and was not discovered until a week later. It was determined by the researcher not to schedule second interviews due to time constraints. Even though enough data was collected to capture the essence of each interview, the researcher recalls many undocumented themes and stories from the interviews that may have supported the findings.

Future Research

Many of the research participants were adamant about the need for future research. One social worker stressed the importance of an evidence-based practice models and suggested a pilot program. Others expressed a lack of vision or guidance due to non-existing treatment models. These findings reflect the lack of integrated massage therapy and psychotherapy treatment research currently in the literature. It would be ideal to replicate the Price (2005) study with different populations, types of trauma, and levels of trauma exposure in order to examine treatment outcomes. By adding a third *psychotherapy only* comparison

group, researchers may find even more amazing results compared to the original study. Certainly, any amount of research would be beneficial since current literature is lacking.

As the findings suggest, professional trends tend to be moving in a direction toward integrative approaches to treating trauma. Social workers incorporated yoga, hypnosis, meditation, and other body-centering techniques into their professional practices; and massage therapists added elements of emotional coaching and behavioral modification. The therapeutic and professional benefits found in this study indicate early and successful intervention is substantiated. Findings suggest that both professions are mutually beneficial as well. It would be ideal for social workers to be able to provide a more comprehensive treatment approach that could potentially decrease long-term effects of trauma, reduce expenditures, and diminish the cyclical patterns of trauma for future generations. Additionally, massage therapists would have the skills and expertise to handle underlying trauma issues that surface while addressing physical complaints instead of allowing the therapeutic moment to pass. Further exploration is needed in order to understand the deep, intrinsic fears that prevent successful integration for treating trauma.

Professional Implications

Massage therapy. The research findings suggest a strong need and desire for some type of licensing or regulation for massage therapists in the state of Minnesota. While OCAP may provide an avenue for public reporting of misconduct, it fails to enrich professional standards, monitor continuing education, and uphold the integrity of the profession. More research, advocacy, and lobbying must be done on state and national levels in order for change to occur. Undoubtedly, the AMTA and the Massage Therapy Foundation together

foster the advancement of the profession through awareness, research, education, philanthropy, and practice management. However, findings suggest that a societal shift in perspective regarding the professional use of touch still has yet to emerge. Massage therapy must be valued and recognized as a viable therapeutic intervention worthy of professional status similar to other professions, instead of being feared for something it is not. If this change does not occur, massage therapists will continue to be ill-equipped to handle trauma effectively and appropriately within their scope of practice; and, dually degreed professionals will not be able to integrate their work into a sound clinical practice for treating the multi-dimensional effects of trauma.

Social work. The inherent fear around the use of touch is cause for concern for the social work profession. The NASW Code of Ethics specifies that social workers are responsible for setting clear, healthy boundaries when involved in appropriate touch, provided it is in the best interest of the client (NASW, 2008). Therefore, it would only make sense that dually degreed professionals would have the appropriate skills, knowledge, ethical training, and discernment needed to engage in therapeutic touch. In fact, as the research participants admitted, incorporating touch into a psychotherapy session would enhance the overall session. Yet, the lack of openness and willingness of accrediting and licensing entities to explore the possibility of achieving successful integration is disheartening. Perhaps the need for self-preservation and protection has caused our profession to veer from our roots a bit. In moving forward, additional research, discussion panels, and pilot programs would be highly recommended, as mentioned by several of the research participants. Hopefully, as more evidence-based practice models emerge, the fear around touch within the social work field will fade.

This study explored the professional attitudes around integrating massage therapy and psychotherapy into a sound clinical practice for treating trauma. Findings revealed a mutual agreement among professions regarding the need for this particular treatment model, as well as the therapeutic and professional benefits. Additionally, both professions concur that several therapeutic and professional barriers must be overcome in order for successful integration to occur. However, key differences between massage therapists and social workers were noted regarding the use of touch and scope of practice within a therapeutic session. In order to transcend these barriers, we must continue to strive toward a higher level of consciousness resulting in a shift of the current attitudes around scope of practice and the use of touch by fully embracing the notion that the mind, body, and spirit are inseparable. We must also come to the realization that we are an integral part of this dynamic process. Successful integration is dependent upon us: The well-embodied professionals who desire to embrace, give meaning, and exemplify a truly integrative approach to healing trauma.

References

- American Massage Therapy Association (AMTA) (Revised May 1, 2010). *Code of Ethics*. Retrieved from <http://www.amtamassage.org/About-AMTA/Core-Documents/Code-of-Ethics.html>
- American Psychological Association (2012). *Trauma*. Retrieved from <http://www.apa.org/topics/trauma/index.aspx>.
- Berg, B.L., & Lune, H. (2012). *Qualitative research methods for the social sciences* (8th ed). Pearson Education, Inc.: Upper Saddle River, NJ.
- Dillmann, S. M. (2011). *Common therapy approaches to help you heal from trauma*. Retrieved from: <http://www.goodtherapy.org/blog/common-trauma-therapy-approaches/>.
- Fritz, S. (2000). *Mosby's fundamentals of therapeutic massage* (2nd ed.). St. Louis, MO: Mosby's, Inc.
- Jones-Smith, E. (2012). *Theories of counseling and psychotherapy: An integrative approach*. Thousand Oaks, CA: SAGE Publications, Inc.
- Kubany, E.S., Hill, E.E., & Owens, J.A. (2003). Cognitive trauma therapy for battered women with PTSD: Preliminary findings. *Journal of traumatic stress*. Vol. 16, No. 1, pp. 81-91
- Levine, P.A. (1997). *Waking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Books.

- Liotti, G. (2004). Trauma, dissociation, and disorganized attachment: Three strands of a single braid. *Psychotherapy: Theory, research, practice, training*. Vol. 41, pp. 472-486.
- Mish, F.C. (Ed). (1991). *Webster's Ninth New Collegiate Dictionary*. Springfield, MA: Merriam-Webster, Inc.
- Monette, D.R., Sullivan, T.J., & DeJong, C.R. (2011). *Applied social research: A tool for the human services* (8th ed.). Belmont, CA: Brooks/Cole Cengage Learning.
- Moraska, A., Pollini, R.A., Boulanger, K., Brooks, M. Z., & Teitlebaum, L. (2010). Physiological adjustments to stress measures following massage therapy: A review of the literature. *eCAM*. Vol. 7, Issue 4, pp. 409-418. Doi: 10.1093/ecam/nen029.
- Mowrer, O.H. (1960). *Learning theory and symbolic processes*. New York, NY: John Wiley & Sons.
- National Association of Social Workers (NASW) (Revised 2008). *Code of Ethics: 1.10 Physical Contact*. Retrieved from <https://www.socialworkers.org/pubs/code/code.asp>.
- National Center for Complementary and Alternative Medicine (NCCAM) (2008). *What is complementary and alternative medicine?* Retrieved from <http://nccam.nih.gov/health/whatiscom>.
- National Institute for Mental Health (NIMH) (2012). *Psychotherapies*. Retrieved from <http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml>.

- The Office of Revisor of Statutes. (2012). *2012 Minnesota statutes: Chapter 146A. complementary and alternative health care practices*. Retrieved April 24, 2013. Retrieved from <https://www.revisor.mn.gov/statutes/?id=146A&view=chapter>
- Pennebaker, J.W., Kiecolt-Glaser, J.K., & Glaser, R. (1988). Disclosure of traumas and immune function: Health implications for psychotherapy. *Journal of consulting and clinical psychology*. Vol. 56 (2), pp.239-245.
- Price, C. (2005). Body-oriented therapy in recovery from child sexual abuse: An efficacy study. *Alternative Therapies*. Vol. 11(5), pp. 46-57.
- Toft, J., Brommel, S., Ferguson, S., Garrett, K., Hill, K., & Kuechler, C. (2010). *Student attitudes, attributions, and responses regarding poverty (SAARP) survey*. St. Paul, MN: University of St. Thomas & St. Catherine University.
- Wisconsin Department of Safety and Professional Services. (2012). *Massage therapist and bodywork therapist: License information*. Retrieved May, 16, 2013. Retrieved from: <http://dsps.wi.gov/Default.aspx?Page=014ac1de-1329-4f2d-b4c9-50bd3771442e>
- Young, C. (2005). About the ethics of professional touch. *International journal of psychotherapy*. Vol. 9, No. 1. Retrieved from: <http://www.eabp.org/pdf/TheEthicsofTouch.pdf>
- Zur, O. (2007). Touch in therapy and the standard of care in psychotherapy and counseling: Bringing clarity to illusive relationships. *United States association of body psychotherapists journal*. Vol. 6, No. 2, pp. 61-93.

Appendix A

The Professional Attitudes around Integrative Therapy Interview Questions

Part 1: Pre-qualification Interview Questions

1. Have you ever worked with or currently work with a client who has experienced trauma?
2. Are you currently working as a massage therapist or an LICSW psychotherapist?
3. Would you be willing to set up an interview with me as part of my research project?
4. Do you know three other professionals who fit the previous qualifications for this survey?

Part 2: Interview Questions

1. What kinds of trauma have you worked with?
 - a. Describe the populations, settings, treatment protocols, etc.
2. What are some of the effects of trauma that you have seen with your clients...
 - a. Physically?
 - b. Mentally?
 - c. Emotionally?
 - d. Spiritually/Energetically?
3. Describe how effective your approaches are at addressing the various symptoms of trauma.
4. If a dually degreed massage therapy and psychotherapy professional were to work with a client who has experienced trauma....
 - a. What would the treatment benefits be?

- b. What would the treatment barriers be?
 - c. What would the professional benefits be?
 - d. What would the professional barriers be?
5. Describe the professional standards of care, licensing regulations, laws, codes of ethics, mission statements and guidelines that you adhere to either with NASW, AMTA, or any other governing body regarding your scope of practice around touch and/or psychotherapy.
6. If you were able to establish a sound clinical practice for treating trauma by integrating massage therapy and psychotherapy into one treatment session, would you become dually degreed? Why or why not?

Part 3: Demographic Questions

1. How many years have you been practicing massage therapy or social work?
2. What type of practice setting do you work in?
3. Is that setting in a rural or small town, mid-sized town, suburban, urban or metropolitan area?
4. What is your highest degree attained?
5. What other degrees or certifications do you have?
6. What is your cultural or ethnic background?
7. What is your gender?
8. What is your age?

Appendix B
CONSENT FORM
UNIVERSITY OF ST. THOMAS
GRSW682 RESEARCH PROJECT

**The Well-Embodied Professional: Attitudes around the Integration of
Massage Therapy & Psychotherapy into a Sound Clinical Practice for
Treating Trauma**

I am conducting a study about the professional attitudes around combining a massage therapy and psychotherapy session when working with people who have experienced trauma. I invite you to participate in this research. You were selected as a possible participant because of your area of expertise and as a recommendation by a colleague. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Deborah S Frank, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Dr. Felicia Washington Sy.

Background Information:

The purpose of this study is to examine the professional attitudes around the integration of massage therapy and psychotherapy into a sound clinical practice for treating trauma. This qualitative study will be analyzed through the conceptual framework of Levine's Trauma Theory, National Association of Social Workers (NASW) and American Massage Therapy Association (AMTA) Code of Ethics, and the researcher's personal viewpoint.

Procedures:

If you agree to be in this study, I will ask you to respond openly and honestly to approximately twenty questions. The interview will take about one hour and will be videotaped using an electronic tablet. The interview will be transcribed and coded by myself, and two fellow students will review the data as a reliability check. This data will eventually be presented to the public in May, 2013.

Risks and Benefits of Being in the Study:

This study has limited risks. Participants may object to answering any of the interview questions by stating their decision to the researcher. The participant may choose to stop the interview at any time. Their decision to stop the interview will not affect their current or future relations with the researcher or the University of St. Thomas/St. Catherine University.

This study has no direct benefits.

Confidentiality:

The records of this study will be kept confidential. As a classroom protocol, I will not publish any of this material. Research records will be kept in a locked file at my home office. I will also keep the electronic copy of the transcript in a password protected file on my computer. The research

committee members and the research coding partners will see a transcript of the interview, but will not know who you are. I will delete any identifying information from the transcript. Findings from the transcript will be presented to my research committee, research class, and the public during an open presentation in May, 2013. The videotape and transcript will be destroyed by May 31, 2012.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will still be used as evidence that an interview attempt had been made.

Contacts and Questions

My name is Deb Frank. You may ask any questions you have now. If you have questions later, you may contact me at 320-255-0543 or Dr. Felicia Washington Sy at 651-962-5803. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix C

Institutional Review Board



Institutional Review Board - University of St. Thomas
 2115 Summit Ave. - Mail #AQU319
 St. Paul, MN 55105-1078
 Phone: 651-962-5341 - Email: irb@stthomas.edu

DATE: February 3, 2013

TO: Deborah Frank, B.A., NCTMB
 FROM: University of St. Thomas Institutional Review Board

PROJECT TITLE: [394682-1] The Well-Embodied Professional: Attitudes around Integrating
 Massage Therapy & Psychotherapy into a Sound Clinical Practice for Treating
 Trauma

REFERENCE #:
 SUBMISSION TYPE: New Project

ACTION: APPROVED
 APPROVAL DATE: February 3, 2013
 EXPIRATION DATE: February 3, 2014
 REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # [enter category, or delete line]

Thank you for your submission of New Project materials for this project. The University of St. Thomas Institutional Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of February 3, 2014.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Eleni Roulis at 651-962-5341 or e9roulis@stthomas.edu. Please include your project title and reference number in all correspondence with this committee.

Best wishes as you begin your research.

Thank you for your work.

Eleni Roulis, Ph.D.
AVP Academic Affairs/IRB Administrator

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of St. Thomas Institutional Review Board's records.