

Shiatsu and trauma therapy

- The recognition and management of chronic shock

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These days, at the beginning of the twenty-first century, civilised society is more apt and more able to respond with sensitivity and skill to traumatic and shocking events, whether they involve one individual, a limited group of people, larger communities or even the whole of society itself.

I think this statement is one that can justifiably be made in the light of progress in the fields of medicine, psychology and sociology, and the general improvements in education, services and social awareness during the twentieth century, but only tentatively. It was a hard century and perhaps we are still in shock.

I have come to understand the depth and breadth of this topic only gradually, in a process that not only involved my work as a clinical practitioner but which deeply touched my personal life and development as well.

In order to cover the difficult subject of chronic shock, it seems worthwhile to briefly review the various types of trauma, and the treatment of injury and shock in general, from both Traditional Eastern and Modern Medical perspectives.

Clinical sketches -
traditional and modern
views of trauma, injury and
shock

In Traditional Chinese Medicine, the Nine Principle Causes of Disease include the category: "Trauma and Injury", without distinction between the physical, emotional, and mental aspects and without elaborating further on the varying degrees of injury that might be experienced. Each must be diagnosed and treated as encountered, using surgery and bone-setting, herbal salves, acupuncture or manual therapy as necessary. We must look deeper into the tradition for guidance on emotional and mental issues

and, where that is deficient, we must find other ways to understand and help.

In practice we might encounter minor degrees of trauma with various clinical conditions from localised swellings, cuts, bruises and pain, through to dislocations and broken bones. After emergency and first line treatment, all these would be seen traditionally as "channel problems" and treated according to meridians with shiatsu and moxibustion to "move the Qi" where it is blocked. *Equally, however, such injuries may only be a part of more serious trauma with deeper effects on the entire system and the integrity of the person concerned.*

Such trauma frequently manifests with symptoms that include palpitations, dizziness, fainting, trembling and shivering, disorientation and loss of memory, or even more extreme states of collapse and unconsciousness. Some of these symptoms can also recur during the recovery phase, compounding the patterns of existing disease, just as there can be recurring or prolonged symptoms of tension and pain (blockage of Qi), even after initial treatment and apparent recovery. N.B. some acute traumatic illnesses can have similarities with acute episodes of chronic disease, e.g. cardiac and diabetic emergencies or stroke.

In reacting to emergencies, the body reaches and surpasses certain limits as it attempts to protect our most vital functions. If we survive, there are many, often delayed, effects to the system. The most obvious of these relate to the Heart and Blood. From the viewpoint of Traditional Eastern Medicine, haemorrhage damages the Blood directly and also depletes Body Fluids. Conversely, severe diseases with vomiting or diarrhoea rapidly exhaust the body-fluids and so damage the Blood. Exposure to "Summer Heat" is a classic example; heat or fire attacks the Yin and fever with profuse sweating further reduces the fluids. There is rapid heartbeat, palpitations, delirious hallucinations and,

finally, chilliness and loss of consciousness. In such extremes we can see that the Shen is also disturbed because it is housed in the Heart and rooted in the Blood.

Apart from the range of injuries commonly associated with accidents and emergencies, which are treated in familiar ways in a modern hospital, the symptom pictures cited above include variants that modern medicine would term "clinical shock". This is normally associated with extreme stress and loss of blood or fluids. Defined by cardiac stress (instability) with lowered blood pressure it is regarded as a situation of medical emergency. There are established medical routines to stabilise the heart and bring blood-pressure back to normal, including drugs, administration of fluids and rest under observation. Principal symptoms are palpitations or irregular heartbeat, pallor, chills, spontaneous sweating and anurea (loss of urinary function). Milder symptoms include disorientation, lack of concentration, anxiety, and forgetfulness, all associated with "Deficient Blood" in Chinese medicine.

In any extreme situation, the sympathetic response of the autonomic nervous system is triggered - the so-called "fight or flight mechanism" - when adrenaline surges into the blood. A state of heightened alert with acute sensory awareness and increased circulation to the heart muscle and peripheral blood vessels readies the person to face the worst. The mind and body are galvanised to act in the moment. Strength and speed may be all that is needed. Pain may be barely felt. At this time the blood supply to certain inner organs is reduced and their normal metabolic functions partially closed down (e.g. digestive secretions and peristalsis).

Then, whatever the outcome, the system needs to recover and, depending on the effort, there can be a sudden collapse with acute symptoms of the kind noted above. Sometimes there is a complete failure of memory which acts as a further protection until the physical demands of the situation are met. At the least, a period of depletion and disorientation follows, requiring sufficient rest. Prolonged or repeated emergencies can obviously have seriously deleterious effects.

Not all traumas have physical injury as the primary factor. Some can be principally shocking to the mind and to the emotions, as when we hear of, or witness, terrible and

unexpected events, but we should remember that the mind and body are interdependent and that effects cross from one field to the other. Physical symptoms do result from mental and emotional trauma. As practitioners of Oriental medicine, we will have less difficulty understanding the links. Qi, and Blood, Essence and Mind (Shen) are indubitably connected.

Here we should properly refer to the "Seven Emotions" or "Passions". These are recognised in Oriental Medicine as the primary internal cause of disease whenever they are excessive, overwhelming or repressed. The list includes both "fear" and "fright", so distinguishing a more extreme state that we might now call "traumatic shock". Fear causes the Qi to descend (a person can go weak at the knees or lose control of their bladder or bowels); fright causes the Qi to scatter. There is an implication that this scattering similarly affects the Mind. The rapid fluctuations in blood circulation described above in relation to the adrenaline response can be seen as shaking the Shen to its roots. The harmonious relation between the Heart and the Kidneys is compromised and so the Will too is affected. These two organs form the "axis of the constitution", regulating Fire and Water, Blood and Essence, Yang and Yin.

If we are well trained in our art, we will know whether, and to what extent, we can treat these severe episodes and their aftermath. It is rare that shiatsu practitioners are involved at the sharp end of medical service, but we can and should take a course in First Aid with Heart and Lung resuscitation. And we can remind ourselves of the key points that are known traditionally to revive and resuscitate: Look up GV 26, Lung 9, Stomach 36, Heart 7 and 9, and Kidney 1 out of interest. Think of Moxa on GV 4, GV 20 and CV6, for exhaustion with extreme cold. Moxa over a ginger slice on CV 8 (the umbilicus) stops diarrhoea due to damp heat (dysentery). CV 6 and 12, and St 25 are also effective. Treat the Small Intestine and Bladder Meridians in relation to spinal injury, whiplash and shock - SI 3 and Bl 62 open the Governing Vessel. HP 6 stops vomiting, and HP 7 and 8 could be part of a strategy to reduce fever. But we should also know our limits and how to call for help. Many

emergencies result in a mixture of symptoms that require diagnosis and treatment using contemporary or traditional methods or a mixture of both.

We are more usually involved in the second phase of treatment, aiding recovery from injuries, accidents and operations, after the emergency phase has passed. Then we will most likely work on or from the Hara, and of course treat according to our diagnosis, bearing in mind the need to treat injuries and pain according to meridian as mentioned above.

It is not the purpose of this article to go further into treatment strategies for injury or acute trauma and its aftermath, but to emphasise the symptoms and signs of shock that can accompany any trauma and to set them in context so they may then be clearly recognised.

The fact is that many people receive essential medical treatment, sometimes life saving, and recover from the acute phase of trauma by one means or another, but are then left to make sense of the more subtle effects of shocking experiences and rebuild their lives as best they can, and many are unsuccessful in this regard.

Latent or chronic shock

We must penetrate further into the background to understand the obscure scenarios of chronic or unresolved shock that result when effective treatment is lacking or does not go far enough, and a latent condition persists that can have far-reaching consequences – not only for the patient but for people around them, including those who treat their illnesses.

It is itself somewhat shocking to realise that many people are suffering from the effects of traumatic episodes but have received no adequate treatment at all, and that this goes unrecognised even by the persons concerned.

When we treat these people for any condition, be it soon after a traumatic incident or many years afterwards, we should be alert to signs that shock may be present in the system and prepared for its effects to emerge from the latent state, *which our form of therapy makes more likely*. And we should be as ready as we can to withstand any disturbing manifestations and support the

client / patient in the process of completing recovery and reintegrating consciously and energetically the defensive blocks and previously suppressed memories.

Shock is contagious. People suffering from chronic and suppressed shock states often involve those around them in fixed patterns of behaviour - defences that are unconsciously carried by the whole group. When the blockage shifts, the realisation of what happened reactivates the shock, now with the possibility of completing recovery. However, if those around fail to respond adequately and resist, feeling themselves too exposed and shocked in turn, then the person can be re-traumatised and there is no resolution. A therapist or anyone else involved may interpret the situation as an emergency crisis when this is not necessarily so, or, taken unawares, react defensively or inappropriately in some way. A valuable opportunity may then be lost.

The incidence of chronic shock - in people and in society

Ordinary accidents will always occur – people will go on falling out of trees, or from horses or ladders, and we will be caught off guard by terrible storms on mountainsides or at sea; we will crash our cars and sometimes be caught in bigger tragedies like train wrecks. All these are hard enough to deal with for the injured and for the bereaved, but they are at least seen and acknowledged as accidents and there is a chance that families and communities will understand and openly rally to the support of those affected - just a chance. However, there are large gaps in our collective consciousness, regarding the cause and effects of worse and self-inflicted disaster.

After initial resistance, many in the medical profession at the beginning of the twentieth century began to take notice of Freud's experiments with the unconscious and his cataloguing of the workings of the mind. But psychology was still in its infancy when the horrors of the Great War erupted across the Globe. The prolonged confrontations in the trenches saw many soldiers suffering from extreme forms of mental stress as well as physical injury and deprivations. Those lucky enough to survive

came home traumatised beyond comprehension, dazed, speechless and incapable of adjusting to ordinary life. Exhausted officers found respite in residential clinics and were offered various experimental treatments, but the clinicians had few answers for their nerve-wracked condition. The term "shell-shock" was coined and entered the language – the first recognition of the lasting effects of trauma. However, the ordinary soldier had no option but to carry home the violence endured and witnessed, as he had always done, and families no recourse but to suffer the consequences and manage as best they could.

By the time of Vietnam, half a century later, the euphemism "battle fatigue" was employed instead of shell-shock and, despite advances in psychology and psycho-therapy, there was still little help for the survivors of war. Many veterans were left with inadequate means to deal with what they had been through and alienated from the self-preoccupied consumerist culture to which they had returned.

Of the vast numbers of civilians who suffered and continue to suffer on both sides in such conflicts, we can hardly bear even to imagine their plight. *We suppress it.* Since Franco invited the Luftwaffe to bomb the town of Guernica, up to the recent aerial attacks by Israel on homes in Beirut, governments have seen fit to kill civilians, including women and children, indiscriminately - and terrorists have followed their example. The best of our compassionate humanity may be drawn to help in rescue operations and medical assistance. But the trauma lives on in us all. War has been endemic in our species.

The tragedies that occasionally engulf communities - mining accidents, landslides and floods – produce heroic responses from rescue services and compensation from the government, but it was not until late in the last century that "counselling" became an accepted therapy in official circles and began to be offered to victims and their families as a matter of course.

Now, "Post Traumatic Stress Disorder" is an official medical term, but treatment is not universally available and there are many areas where these advances have made little impression.

In the field of developmental psychology and in the treatment of alcoholism and drug abuse, it was realised that the environment and the manner of a child's upbringing had important effects on their mental and emotional stability. Patterns of alcohol or drug abuse and violence ran through families for generations and the roles of victim, rescuer and aggressor were interchangeable over time in complex patterns that unconsciously perpetuated the damage in families and communities. This picture began to throw a new light on the whole of society.

Television programmes that revealed the level of child abuse existing in England during the nineteen-eighties shocked the nation and help-lines began to change the culture of denial.

It is now more common for police to receive special training in regard to the treatment of persons reporting rape or domestic violence but many women and gays of either sex still find such recent, hard-won concessions difficult to believe and trust.

In Spain, where I now live, people are just now coming to terms with the levels of domestic violence that have been quietly tolerated for untold generations and finding ways to deal with it openly.

Hatred still simmers under the surface in many communities, themselves injured and unrecovered from past trauma, and so erupts in further acts of racial and religious and intercommunity violence. This has been the clear cause of recent wars, from The Balkans to Somalia.

The use of torture is still a contentious issue in the community of nations.

Chronic Shock is itself endemic among human beings. Nature's protection numbs the pain, erases memory and helps us survive, but our own ignorance and fear impede our full recovery and cause unconscious repetition of violence among our own kind. Denial negates our true human potential for compassionate healing and creative endeavour.

Functional stages of shock and recovery process

Shock is a normal response to extremes that gives a person the possibility to carry on – it is a friend at the time.

Shock occurs when events happen too quickly or intensely for the neural system to cope. The first stage is an immediate, unthinking or instinctive response, a more primitive state of the neural system where there is initially hyper-sensitivity and hyper-alertness associated with increased adrenaline, vaso-dilation at the surface and raised blood-sugar.

Then, in the second stage, there is numbness, a less alert, absent sense, short attention span and lost recall. There is generally reduced sensitivity and strange behaviour, with the person believing that he or she is unaffected.

All of the above can remain in chronic shock states to varying degrees. It can be very difficult to return to a more normal (present, open and sensitive) state, and indeed requires a great deal of trust, as the shock process was a necessary response for survival, even though now it may not be.

A third stage is the gradual return of memory with an increased self-awareness, including of physical functions as they stabilise, but the symptoms of clinical shock related to low blood pressure may also manifest and delay or compound this stage. There can be varying degrees of exhaustion, requiring rest.

The fourth stage of recovery and full reintegration is often ignored. It involves the need to talk and to work things through, to be able to re-live the event in a sufficiently safe and supportive environment. There is a great need to really assimilate and accept what has happened.

If this need is not met then people will somehow keep returning to it to try to understand – but it is often never fully resolved. Feelings of guilt, that somehow this could have been avoided, or anger and blame for others, all compound the situation. Unresolved, it is repressed and shelved, but its energy can contaminate the psyche and affect relationships with others. Very often there is depression along with chronic

physical disease. At worst the suppressed elements resurface in irrational tempers and a compulsion to repeat violent acts.

Individual or group counselling is very helpful, if it is of the right sort. People need to recount their experiences and be heard without judgement. The family or community may offer this possibility and render official therapy less necessary. The spirit of the pow-wow is recalled. But it is also through touch that this essential process is often initiated. Here we approach the core of the issue.

Chronic shock in the Shiatsu clinic - recognition

There are three main “diaphragms” in the body:

- 1) The head – the muscular structures of the temple and the jaw.
- 2) The Diaphragm itself, at the base of the ribcage.
- 3) The muscles of the pelvic floor.

In addition to their specific functions, these horizontal structures act as regulators, controlling the flow of energy and feeling impulses from one area of the body to another. *Any one of these three diaphragms or “gates”, to use an image from Qigong, may get blocked, but when all three are frozen this shows shock.*

There is a resonance with all horizontal structures and similar tensions and blocks may be encountered in the soles of the feet, the knees, waist, or neck, and at the top of the head. This pattern points strongly to the “Liver System” in Oriental Medicine. *The Liver is responsible for ensuring the “free flow of Qi and Blood throughout the body”. Keeping open the pathways of Qi - the up and down flow of the meridians - puts the Liver in charge of all horizontal gateways.* Obstruction (pain) at these sites gives rise to symptoms typical of Liver patterns – vertex and temple headaches, “plum stone” sensation of blocked throat, oppression in the chest and diaphragm, contracting menstrual pains (dysmenorrhoea) etc. - and many of these have repressed emotional content with anger or rage.

Apart from these key elements there are a number of further clues that help us recognise the presence in a client of latent shock:

- 1) **No progress.** In spite of following various courses of treatment a person feels that nothing works for them; they keep coming back to the same place. This may echo their experience of life in general. When a client presents for the first time with a long history of persistent or compounding problems we may think that there is some latent shock, but we must not jump to conclusions.
- 2) **Diminished affect.** This is equivalent to what in Chinese medicine is referred to as "damaged Shen". The eyes do not shine, the voice is flat, the tongue has no spirit and the person lacks vitality and animation.
- 3) **There is a degree of denial.** The person cannot see their situation clearly. They fail to make "obvious" connections. They can also show a marked lack of sensitivity both for themselves and others. In treating these people we may slowly become aware of what is not there, what is missing, unmentioned.

Treatment – moderate touch is the essence

I do not believe that we should think in terms of treating chronic shock. Even with specialist training the idea is to me a little worrying. We should address the *person*, primarily, and devote ourselves to understanding the patterns of disharmony according to our training. To my mind, awareness is all that is needed for a healing process to begin. Treatment proceeds in natural order. I have learned from the medical and therapeutic traditions of both East and West and received helpful pointers on this contentious topic from many teachers and colleagues. In the course of my professional life, however, my patients above all have showed me how I could best help them, through attention and integrity, and through touch. Over the years my approach to my clients changed as I abandoned most treatment imperatives and end-gaining techniques and learned to be more present in the diagnostic process. This attentive attitude unfolded into the more sensitive rhythms of

communication and spacious touch within which the necessary simply manifests.

Caring hands are a principal key in reaching and resolving chronic shock. When we are touched with sensitivity and confidence our whole system openly responds. When coupled with a caring and capable disposition and the necessary skills, there is great potential for healing.

As infants we are held in arms, nourished and protected in our most vulnerable condition. Whatever the degree of safety and harmony we experienced in passing through this dependant phase of our lives, it serves as a reference and a trigger for all later responses to physical closeness, intimacy and touch. As we grow up our confidence in human contact of all kinds continues to depend on an adequate fund of appropriately caring and respectful physical touch.

As adjusted adults in modern western societies, we come to accept the limits and norms of the culture but, unfortunately, many of us have either lacked good nurture on this level, paid a distorted price for it or, worst of all, suffered abuse at the hands of those who should have been our protectors.

Our bodies react to such negative experiences with defensive contractions of the soft tissues and our nervous system adjusts to cope. A process that Reich first described as "bodily armouring" begins that reduces our sensitivity and defines elements of our perception and behaviour. Some people may pass through various crises or periods of difficulty and recover fully, others become chronically tense in key areas of the body, and some are already in a kind of "shock state" at an early age. Such people may be seen by others as "accident prone", "unlucky", "foolhardy" or "tough", among a gamut of labels that their habits confirm. If they become our clients/patients, they are simply persons.

Here are three reasons why shiatsu treatment will pre-dispose for the emergence and possible resolution of latent shock:

- 1) Because we work with touch and because, through training and experience, our sense and use of touch is refined, sensitive and caring, we will have the capacity to dissolve some of

the defensive blockages that our patients carry within.

- 2) Further, because we are guided by diagnostic methods to locate patterns of blockage and we are attuned to subtle movements of Ki, we will encounter soft spots and trigger points as Tsubos, or "resonant energetic connections", which can reactivate sensory pathways and open up key processes in the receiver.
- 3) Most importantly, many of our clients, even the most defended and inwardly vulnerable, slowly come to trust us – both as professionals and as persons – sufficiently to risk allowing the hidden to emerge, and this can sometimes trigger an avalanche of feeling which is the shocking thing.

This is when we need to know that a person at this precise time is not going into shock as it can seem, but *emerging* from the long held shock state with all the urgent fears, confusion and physical turmoil that pertained in the original situation. There can be strong projections. The person may feel convinced that we have precipitated the crisis through the treatment. At first there may be only a faint sense of connection to their own past experience. Things will not just "click into place". It takes time and sometimes repeated positive experiences for a full realisation and resolution to take place. We must hold the space long enough for the sense of crisis to pass. We must keep a cool head, an open heart and our Hara well grounded.

What does this mean in practice?

Resolution

In the middle of a treatment the person becomes disturbed or agitated. They feel that something strange is happening to them, but at first they try to deny it and control themselves. Often it is the practitioner who first notes the change and asks if the client feels alright. Perhaps they have started to hyperventilate, or their teeth begin to chatter, the jaw muscles feel tense and the person works the mouth or yawns to ease the discomfort. Perhaps they feel a bit faint or suddenly dry in the mouth and thirsty. They may ask us to stop what we are doing. We

need to be attentive and respectful, *but not panic*.

On the contrary, we respond as naturally as possible. First we can talk to them about what is happening. They may not be so sure, but we can say to them that this is probably something their body needs, a natural response of their system to the treatment. It may not have happened before but there is always the possibility of some deeper level that needs to surface for healing to continue. They may accept this but still not be able to calm down. Perhaps they have broken into a cold sweat; we cover them with a blanket. It is *not* valid at this point to try to carry on with our normal shiatsu but we must use our intuition and adapt our touch to their needs. Two hands placed, one on the belly and one on the chest, with the intention to steady their breathing; holding their hand in ours and pressing Stomach 36 with the free thumb; holding their feet at Kidney 1, or touching their head; all these are possibilities but every step must be simple and steady, direct and straight-forwardly explained. Sometimes this is enough and they slowly regain a more normal state; sometimes not. We fetch water and let them drink; we give them some homoeopathic Arnica or some drops of "Rescue Remedy"; we explain to them a little about shock. There is no hurry – they can have the time they need – we will explain any delay to the next client; we will call a taxi to get them home, or any suitable strategy. Probably they will calm down, but they may feel quite shocked.

They will then quite likely need to talk a bit. There may have been some relevant insight, but perhaps nothing has yet made any sense and we will need to wait until their next visit to talk. If we have the facilities, we can offer tea and let them regain their stability before leaving; advise them not to drive until they feel quite able.

We will need to show great patience and understanding, perhaps over several sessions. They may have fears regarding future treatments. These must be heard and dealt with sympathetically. The possibility of referring people to a trained therapist or counsellor should always be considered, but let us recognise too the value of persevering with what has usually only emerged because the circumstances

are "right". There are no special strategies apart from addressing the issues as they present, and here I would like to make the clear point that we do not need to change our normal approach. We should not go "hunting the Snark". Our usual way of giving shiatsu treatment is an authentic offering to the client's need. On future visits we should simply continue and again be ready to deal with whatever arises.

It is important that we know how to maintain our boundaries while acting with honour and integrity. Normally, we will know something of the person concerned, and will by some sense distinguish an unexpected therapeutic crisis from any real emergency. If we are in any doubt, and always in cases of collapse and unconsciousness, we should call the emergency services. If we work alongside other colleagues it is advisable to speak to them about any crisis issues that occur.

They can give us support if necessary. Even if we work alone we can talk with colleagues about our doubts and concerns. This is part of a necessary opening up around traumatic conditions and their wider effects.

Acupuncture training clinic, 1978. Certain patients occasionally have reactions similar to those described above, even after having previously received many treatments that have passed routinely. We are told that this is "needle shock", and that we should remove the needles immediately and massage or moxa Stomach 36. Observing this on several occasions, I become convinced that it is not the acupuncture needling itself that is responsible for the shock, as implied, but some inner release due to the action of the needles that appears as shocking. I begin to talk my own patients through such experiences when they occur, with hands on support but without removing the needles. This is nearly always appreciated and fruitful. My experience of Shiatsu has given me confidence in touch, a resource that benefits my acupuncture patients as well.

Later, during the course of Bio-energetic Analysis and Training Workshops, my understanding of the shock process is developed and my intuition is confirmed, supporting my clinical work with both acupuncture and shiatsu patients over the years.

Cases

1) A man at a party is, it seems, only the worse for wear with drink, but when no-one can revive him from his stupor, and he appears cold and lifeless there is talk of calling an ambulance. However his pulse shows a steady rhythm, if rather weak. Strong pressure on GV26 on the top lip, under the nose, towards the root of the gum revives him rapidly. He gets to his feet and tries to account for himself. Nonetheless he is accompanied back home by a responsible friend.

2) A female patient, 48, with a complex medical history, who has been receiving treatment for several years, begins to tremble and shake during a session. She says she is not cold but her teeth chatter uncontrollably and she feels stifled and unable to breathe. This occurs on one or two occasions and is managed by gentle but firm pressure on CV 17 and CV 6 with verbal reassurance. Sometimes she feels faint and other revival points are used. During a similar recurrence in a later session, she suddenly shuffles away and sits up, staring at me sideways, wild-eyed, not recognising me and telling me, "Get away from me; get away!" I keep my distance but ask gently for direct eye contact, using my voice to remind her, "I am Paul. You appear to be seeing me as someone else and I know you feel threatened, but I am Paul. You are in my clinic and you are safe. I will stay here near you and you can keep talking to me. I won't touch you till you feel its ok. If you want I will call in my colleague (named). Please, try to breathe, you are safe here", and so on. She seems to realise where she is and lies back, exhausted. The session is concluded satisfactorily with contact and talking.

This was a break-through regarding memories of childhood abuse, which she later worked through with a therapist. She also continued with shiatsu treatment and acknowledged the benefit if those crucial sessions.

3) After several routine sessions, a divorced female client, a mother of two

young children, had one or two angry outbursts during treatment, apologising quickly each time and saying she did not know what had come over her. Though her symptoms were of a physical nature, I also knew from her case history that she had "issues with men". In a later session she became suddenly disoriented, shivery and cold, projecting an abject and disconsolate image, she curled up in a ball on the futon saying she needed to be hugged. I covered her with a warm blanket and explained that I would just sit close and hold her. Placing one hand on her arm near the shoulder and steadily holding the area of Ming Men (GV 4) and other spots along the spine, I invited her simply to say what she was feeling if she could.

She continued with shiatsu treatments for another few months, occasionally showing anxiety but also allowing herself a degree of vulnerability. Her general condition improved somewhat and she stopped treatment. Two years later she wrote me a letter of thanks, explaining that the various "problems" with men that she had alluded to had included domestic violence and a male therapist who had abused her. She had later formed an "association" for those abused in therapy. She had not felt able to bring all this out at the time but the sessions with me had given her confidence and helped her to trust men again. She wrote that, shortly after finishing treatment, she had formed a new relationship that continued to be nourishing and supportive and that she remained well.

4) A young man of 26 years had received repeated treatments for a knee problem related to a sports injury. This always improved with treatment, but recurred when he increased his level of sporting activity. During one treatment he appeared to go "into shock", with a sudden "crisis" of cold shivering. He could not get warm for some time but was given blanket and reassured. Later, as he recovered, he talked of a bad experience suffered on an exposed mountainside in which he had feared for his life. He had omitted to mention this key episode before. I used moxa over GV 4 (Life Gate) and other points on the lower back. After that his knee problem was quickly resolved. Perhaps it was a way of reaching back to that earlier incident that had left him

with memories and feelings he had been reluctant to admit?

5) A woman of 58 years had persistent leg and knee pain, after a "successful" hip operation. Repeated treatments brought relief but the pains recurred for some months. Eventually she recovered a much better level of pain-free mobility, but only after several tricky sessions in which she "went funny". Her panicky feelings were always managed satisfactorily, however. She usually felt reassured when I held her feet and pressed Kid. 1. During those sessions she spoke about her fears regarding dependence on her more elderly husband, which she had harboured since her operation and throughout her "convalescence".

Paul Lundberg for the Second European Shiatsu Congress Kiental 2007