# Tough places to be tender: contracting for happy or 'good enough' endings in therapeutic massage/bodywork?

by Peter Mackereth

Listening to others has inspired this paper, as they share their experience and analyse their practice, and in the process uncover what is quintessential to therapeutic work. Of course stories and insights can illuminate our own reflections and in turn deepen our understanding of what it means to be a nurse and massage therapist. They can also challenge what we think to be truths and sacred cows. This paper is about how confusion can be our best teacher when we seek to understand notions of contact and engagement in therapeutic work. When a patient says 'yes' to massage/bodywork what do they expect? Perhaps the massage will ease backache or leave them feeling profoundly relaxed; or could it be that the human contact is the most important need, but that need may be harder to express or even acknowledge.

In examining the issues raised by this paper the author proposes a model of massage/bodywork contracts: 'Structural, Emotional and Energetic' (S.E.E.), and recommends that therapists seek supervision and support for their work.

Key concepts: listening, hearing, containment, release, clarification of massage/bodywork contracts, supervision and scope of practice.

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This paper was inspired by two events in 1999. Firstly, a presentation given in London to a large group of psychotherapist and massage/bodywork therapist by Gerda Boyesen, a renowned body psychotherapist and the originator of biodynamic massage. Secondly, preparing a paper for a Palliative Care Conference held at Springhill Hospice Rochdale, where an emerging theme was the importance of both listening and hearing in therapeutic relationships. Gerda in her talk stressed the importance of the therapeutic presence, to 'listen without prejudice' and to enter a calm 'alpha wave' state (quoted in Reedyk, 1999 p. 10). Gerda also emphasized in this presentation her goal of working for 'happy endings' with clients, borne out of a concern that they would not be left feeling distressed or unsupported at the end of each session. In preparing my conference paper this idea of 'happy endings' made me think of the great work done by the hospice movement in providing compassionate care and support for patients and their families.

Such good intentions and concern for their patient's well being may also undermine autonomy in both situations. For example a patient might reject our help in working through anger towards the disease or in achieving reconciliation with a family member. Likewise as therapists we cannot stop a patient from feeling anger, despair or profound sadness. How much responsibility can we take for a patient's feelings or responses to our touch? And what can we do or not do to ensure that the patient feels supported and held when experiencing these strong feelings?

## Tough places to be tender

The use of complementary therapies in healthcare is most common in areas where conventional medicine struggles to treat symptoms of chronic and life threatening disease. Nowhere is this more apparent than in palliative and critical care settings. Many patients turn to these approaches as their disease progresses, just at a time when they are most vulnerable and the issue of mortality adds to the drama. Desperation may be felt

acutely with hopes piled high on possible solutions and helpful therapists. Complementary therapies emphasize the link between mind and body and their potential in the defences against disease (Greiner, 1995). This is in sharp and sometimes painful contrast to conventional medicine where quality of living in the present is sometimes severely compromised for a promise of a cure or more time in remission. Modern paternalistic medicine deems it a price worth paying in the short term not just for the individual but also for the lessons learnt to improve treatment for others. Relatives can equally engage in pushing for tolerance of hard and punishing treatment regimes, in the hope of extra time with a loved one.

Complementary therapies are by nature radically different in their purpose and claims. Labelled as 'touchy feely', they are perceived as a treat without side effects or contraindications. Indeed there are ways of adapting massage treatments to work in a very gentle and less invasive manner. But it is important to acknowledge that listening, attending to what you hear combined with touch can be powerful and even shocking. Being the therapist in these situations can also be challenging and moving.

## Welcome contact

Research workers have reported that patients with acute and enduring neurological diseases have valued the therapeutic and interpersonal skills of the complementary therapist, and their time together. The use of these therapies have led some of these patients to experience emotional release, sharing of their worries which have been linked to improvements in self-esteem and general wellbeing (Cromwell et al, 1999; Trousdale, 1996). Both Corner et al (1995) and Penson (1998) reported similar findings and conclusions, in palliative care settings, with effects seen as cumulative peaking typically on the fourth session.

Complementary therapies provide what Sanderson and Carter (1994) see as touch interventions that enable the patient to become more self aware, feeling they are the focus of care and that they can engage and communicate with the therapist. In reviewing the literature on reflexology and massage, Vickers (1996) suggests that patients not only fulfill a need to be touched but also learn to trust the therapist in the process.

In nursing practice touching patients as part of a 'comforting' process is acknowledged (Morse, 1996) but studies in high stress areas such as Intensive Care Units (ICU) indicate that nurses predominately touch patients to perform tasks rather than to comfort (Ashworth, 1980, Turnock 1989, Estabrooks, 1989). More recently Cox and Hayes (1997) reported that 50% of ICU nurses asked said they would give additional medication to reduce anxiety, 66% would incorporate verbal reassurance and only 27% would use touch. Perhaps in these situations they avoid this highly charged medium of communication for fear of upsetting physiological parameters or making contact that requires more than they can possibly give.

## Listening, hearing and making contact

In offering complementary therapies we are opening ourselves to new possibilities in nurse patient relationships. This requires learning to be in the moment, listening and hearing messages both verbal and nonverbal from the patient, as well as from your internal critic and guide. This is the part of you that considers and questions issues and concerns that arise as you work or when you reflect later on incidents and working relationships.

Clinical supervision can help refine these processes, as it creates a consistent and regular time to engage with a supervisor or supervisory group to facilitate supportive analysis of therapeutic work and professional development (Mackereth, 1998). This relationship is managed using an agreed contract and requiring participants to honour the work and themselves in the process. In turn this ethos and process can be brought into clinical work with patients so safeguarding their interest while protecting the therapist's professional and personal boundaries.

In sharing reflections from practice with others I have learnt that it is not uncommon to feel momentarily lost in the work, but this should not be confused with incompetence or insecurity in your skills. As a massage/bodywork therapist myself the process can feel like detective work, looking for clues about the massage pressure needed, the areas to work on and noticing how the patient and you are responding to the touch and contact. This is about not having specific goals but being open to what might be and is emerging in the relationship and the space. It is giving oneself permission to really be with another, tempered by acknowledgement of both parties needs and expectations.

If the time that you have together is 50 or just 15 minutes, then how can that be used therapeutically and safely? In planning the work together it is important to ask the patient questions to clarify your contract:

• What do you expect to happen and experience in receiving a massage?
• How do you feel now?
• Do you have any concerns or questions about the treatment?
• How would you like to feel at the end of this session?
• Do you feel comfortable to ask to stop or take a break from the treatment or ask a question or say how you are feeling at any time during the session?

Equally important is our own preparation and examination of our intentions. Be clear you can answer these questions before agreeing to initiate the work:

• Does the patient really want touch?
• Does the patient understand my level of skill and the boundaries to the work?
• Is this space and time available conducive to the intervention proposed?
• Am I calm and centred enough to be present for this person?
• Am I comfortable about asking the patient for feedback or stopping to clarify the work at any time?
• Do I have the managerial and supervision support necessary to work with this patient?
• Have arrangements been made to follow up this session/ provide a means of contact or support if it should be needed?

There are numerous massage/bodywork approaches all with their own unique perspective on how they work and benefit the patient. The model proposed in box 1 attempts to give a framework to some of the outcomes and expectations commonly linked to massage/bodywork. The three groupings are not mutually exclusive but provide a menu to assess the patients requirements and expectations. An initial contract is also open to renegotiation as a session progresses as well as in any subsequent sessions. A patient may initially want structural work for a tense neck but then find a slower holding form of massage touch more enjoyable or relaxing. Agreeing that the patient can ask to stop the session and reclarify the contract at any time could actually be tested in the first session. For example a therapist could suggest that the patient actually stop the session verbally in the first few minutes and then ask for a change in the work. This could be repeating a movement or working firmer or more gentle or just stopping for a moment. This could help to affirm the contract agreement that they can ask to change the contact or stop the physical contact.

Changing a position from prone to then lying on the back provides an ideal opportunity to briefly evaluate the session so far and recontract for the remainder of the time available. Evaluation is about noticing responses to the work both from the patient and you as the therapist. Are they breathing slower and deeper? Are their muscles less tense and the skin warming to the touch? Am I having to work really hard? Do I feel relaxed? In biodynamic massage work the therapist observes these reactions and also listens to intestinal noises via a peristaltic stethoscope. Gerda Boyesen developed a system of working with peristalsis, using it as a guide and feedback mechanism to the massage work, based on her theory of psychoperistalsis (Westland, 1996). These sounds or their absence can indicate a person's states of being such as emotional release, anxiety or loss of contact.

## Blocking contact and collaboration

There are many things in life that can abstract our attention from being in the present with a patient. Equally a patient can disconnect with the contact for many reasons. They can become the arm or neck that is being massaged rather than the person receiving and experiencing the contact. For example looking for an exit or drifting somewhere, anywhere just out of being here, here being the feeling of vulnerability or uncertainty with the contact. A problem identified by a patient can operate as such a distraction. For example a muscular or sleeping problem (structural) may have an emotional component that the patient has not made a connection with. In having massage they might become more in touch with this aspect and talk about it to the massage therapist. Ruminating on a problem posed by a patient can close off to the 'feeling' component and make the focus problem solving. Finding a solution(s) can build confidence in our skills as problem solvers. Indeed the nursing profession has a history of pursuing solutions, trying to build nursing knowledge and prizing expertise.

We can become so driven by hoped for outcomes that it creates a barrier or block to making contact with the person before us and with ourselves. In the extreme we can as dedicated professionals become locked into 'work harder' and 'be busy' mentality so much so that we find ourselves munching packets of biscuits (getting the sugar level up to do battle) and fidgeting to get on with the next problem or distraction.

It has been suggested by Wegela (1996) that there are three stages to losing awareness, involving shifting from bewilderment to retreating and then to building defences and patterns of behaviour against 'heartfelt understanding… fear of letting our minds and hearts be open' (p 92). An alternative strategy is then to move beyond simply listening to really hearing how it feels to be 'stuck', 'uncertain' or 'fearful'.

To begin to do this we need to first acknowledge and accept our own bewilderment and confusion. Viewing difficult issues as a puzzle rather than a problem can also help to encompass bewilderment or perhaps more importantly acknowledge that it might remain unfathomable or an enigma. The therapist can no longer hide behind the role of the expert but can become present to the uncertainty and all that reveals for both the patient and the rapist.

Being challenged by problems might be a patient's way of protecting you from their inner world. Dig deep and despair or anger may be unearthed. They could hit bottom. Whether they can the rise from it is the big risk. They could ride somewhere in the middle glimpsing hope and yet aware of despair just below the surface. Either way, opening this door is usually beyond the professional scope and skills of massage therapists but rather the territory of a psychotherapist or counsellor. Equally the patient may not have envisaged the session would take this turn and you would be asking them to recontract for work they had not been fully prepared for. Maybe it is enough to be simply held by the presence and holding touch of a compassionate massage therapist and nurse. Maybe that is a 'good enough' outcome.

There is a challenge in creating a sense of 'security to those who cannot be cured' according to Norton (1995 p.347) but that can be to contain or protect our own fear of witnessing their depth of despair and even anger. Patients themselves might work at meeting your expectations for a happy ending or provide you with a problem(s) to occupy the conversation or steer it away from a feeling level. Recognizing and skilfully managing these situations is preferable to attempting to engage in complex process work without an agreed contract and the appropriate skills, support and supervision for that work

## Conclusion

Our need for happy endings begs questions about who is being made happy or whether the happiness is a mask, a means of containing despair or anger. Life is full of dynamic processes many of them subtle and difficult to observe and comprehend. The act of asking someone what they want from a massage raises further questions, many of them both difficult to ask and answer. In this paper some preparatory question and the S.E.E model for massage/bodywork contracts are proposed as a framework for clarifying the purpose and intention of the work. It is acknowledged that through the contact and developing therapeutic relationship patients may share emotional issues and problems.

Therapists need to be wary of the urge to always intervene or answer questions with every possible solution. This is perhaps an attempt to be the perfect parent, to feel useful and in the process be valued and appreciated. Winnicott (1965) coined the phrase 'good enough' mothering, that acknowledged that a degree of inadequacy, sometimes failing or disappointing the child as necessary to their growth and development. Perhaps as nurses and therapists we need to be satisfied with good enough rather than pursue the exclusivity of expertise. The strive to always be problem solving and making happy endings may prevent patients looking more deeply at what they might know themselves or even how it feels not to have answers. In pursuit of doing something or anything for people in difficult circumstances we avoid 'being' with them, which is of itself 'good enough'.
(continued on p17)

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