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# Service Users' Views of Therapeutic Care

A report produced for the British Red Cross by

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## 1. Executive Summary

- British Red Cross (BRC) commissioned the Faculty of Health and Social Care at The Open University (OU) to undertake research into service users' experiences of the Therapeutic Care (TC) service.
- The overall aim of the study was to evaluate the effectiveness of the Therapeutic Care service delivered by the Red Cross. Specific objectives were to explore service users' experiences and perceptions of Therapeutic Care.
- The Therapeutic Care service aims to promote the health and wellbeing of people made vulnerable by life events and circumstances. The service is delivered in a variety of settings by trained volunteers. It consists of a gentle massage given over clothing to the hands, arms, neck and shoulder areas.
- There is a broad evidence base which indicates that therapeutic massage can be effective in promoting health and wellbeing for people with various acute and chronic health conditions. Therapeutic massage is considered to be a safe therapy with few adverse side effects reported (Watson and Watson 1997, Cambron et al 2007, Ernst 2003).
- The research adopted a qualitative approach with purposive sampling used to identify and recruit individuals from Central Scotland who had received the service in the last 12 months. In-depth unstructured interviews were conducted with 30 service users aged between 39 -100 years, who suffered from a range of health conditions including cancer, Parkinson's disease, arthritis, chronic pain and mental ill health.
- Therapeutic Care had a positive impact on people's health and wellbeing. Service users thought it was an 'excellent service' and expressed a preference for increased availability.
- Positive physical outcomes for service users included a reduction in self-reported pain and muscle tension; fewer headaches and muscles spasms and less joint stiffness; improved mobility and an increased level of independence.
- Positive psychological outcomes included reduced levels of stress and anxiety; feeling calm, relaxed, tolerant and more able to cope; improvements in mood, quality of sleep and energy levels; increased self-worth and self-esteem.
- Positive social outcomes were an increased level of social interaction and the formation of new relationships. These were closely linked to the physiological impact of therapeutic care.
- Service users reported that improvements in wellbeing were immediate and accumulative. They could last for a few days or a number of weeks until the next treatment. Over time this led to a greater and more sustained improvement in wellbeing.

## 2. Introduction

In November 2008 the British Red Cross (BRC) commissioned the Faculty of Health and Social Care at The Open University (OU) to undertake research into service users' experiences of the Therapeutic Care (TC) service.

The research study sought to build upon existing service user engagement processes and add to data routinely captured in service evaluations to produce a more complete picture of service users' experiences of Therapeutic Care services.

The overall aim of the study was to evaluate the effectiveness of the Therapeutic Care service delivered by the Red Cross. Specific objectives were to explore:

- service users experiences and perceptions of TC services
- the benefits of TC services as perceived by the service users themselves

The purpose of the Therapeutic Care service is to promote the wellbeing and resilience of people made vulnerable by life events and circumstances. It can complement individual care packages delivered by other health and social care service providers.

Therapeutic Care consists of a gentle massage to either the hands or arms only or to the neck and shoulder areas. The massage uses gentle effleurage strokes and is given over clothing. The service is delivered by volunteers who are trained in massage and other competencies such as listening and communication skills that are required to assist and comfort others.

Training involves a number of elements including an introduction to the Red Cross; observation of a therapeutic care demonstration session; 13 hours of therapeutic care skills training; competence assessment in disability awareness, protection of vulnerable adults, child protection, confidentiality and service related health and safety issues. Volunteers' competency to deliver the service is assessed every three years.

In terms of service delivery volunteers are supported by a network of Red Cross service managers, co-ordinators and volunteer forums. Ongoing information and training is provided as needs are identified and as required. All Therapeutic Care volunteers must practice in accordance with the values of the Red Cross namely:

- Compassionate and Impartial
- Open and Welcoming
- Practical and Efficient
- Dynamic and Proactive

The Red Cross Therapeutic Care service was established in 1959. Initially, its aim was to improve the quality of life for women in hospitals by supporting recovery, improving their sense of well being and assisting them to cope better with personal crisis. This type of intervention has a long history with women in Britain being given facial massage to relieve general stress or prevent illness as early as 1904 (Heller at al 2005).

The involvement of the Red Cross in the delivery of this type of therapy came through the cosmetics firm of Atkinson's who provided massage therapy for hospital in-patients. Originally, Atkinson's provided free training to selected nurses from various hospitals in England. Increasing pressure on nurses' time however, led to volunteers being sought to help deliver

the therapy. The Red Cross was approached and agreed to provide suitable people and in May 1959, four volunteers from London, Essex and Gloucestershire were trained. At this time, training was focused solely on hand care but included a small element of massage. Over the next twenty years the service gradually expanded and established itself as an important Red Cross activity. By 1983, over 3,000 volunteers had been trained to deliver the service mainly in long stay hospitals, residential and care homes.

With the introduction of the Red Cross Focused National Strategy in 1995, the service was reviewed and re-launched with a focus on crisis care. Having a clear focus on crisis care ensures that the service is delivered in an effective time-limited way, yet meets the needs of vulnerable people. It also ensures that volunteers have the capacity and capability to utilise their skills whenever the Red Cross is required to respond to major incidents or large-scale emergencies. By 1997, the service was being provided in over 90% of Red Cross branches throughout the UK.

The Red Cross continues to work with a variety of organisations to identify people who will benefit most from the service. Therapeutic Care is available to people in hospitals, hospices, GP surgeries, psychiatric units, prisons, community groups and, on referral from a healthcare professional, within a service user's own home. Service users tend to be predominantly female (85%) with a small proportion of males (15%).

## 3. Literature Review

### 3.1 Therapeutic Massage

The word “massage” derives from the Arabic mass, meaning “to press” (Holey and Cook 2003). Taking a historical perspective, it is interesting to note that massage has been practised for centuries as a form of treatment to promote health and wellbeing. References date back as far as 2000 BC when Hippocrates is reputed to have mentioned it as a form of treatment (Goldstone 2000). Modern therapeutic massage was developed by Henrik Ling, Sweden (1776-1839) and was used in association with exercises and specific movements (Holey and Cook 2003). Massage was considered to be an acceptable medical therapy until the early 20<sup>th</sup> century when the focus of care moved to biological sciences (Saks 2005). Even then facial massage was deemed an appropriate treatment for promoting the mental health of women in hospital (Heller et al 2005).

The definitions below illustrate how views and perceptions of massage have changed overtime. Early definitions reflect attempts to have massage accepted as a legitimate therapy and to position it firmly within the emergent biomedical model of health care. Later definitions reflect its resurgence and acceptance as a legitimate therapy.

“Massage is the term used to express certain scientific manipulations which are performed by the hands of the operator upon the body of the patient. It is a means used for creating energy where such has become exhausted, from whatsoever cause, and is a natural method of restoring the part, either locally or generally injured to its normal condition ...:

(Ross 1907)

“Massage may be described as a scientific way of treating some forms of disease, by external manipulations, applied in a variety of ways to the soft tissues of the body.”

(Goodall-Copestake 1926)

“The scientific manipulation of the soft tissues of the body, as apart from mere rubbing.”

(Prosser 1941)

“Massage is the aware and conscious manipulation of the soft tissues of the body for therapeutic purposes.”

(Westland 1993)

“Therapeutic massage is the manipulation of the soft tissue of the body to bring about generalised improvements in health”

(Vickers and Zollman 1999)

“Massage is the manipulation of the soft tissues of the body by a trained therapist as a component of a holistic therapeutic intervention.”

(Holey and Cook 2003)

Massage is classified as a touch based therapy which traditionally uses a variety of strokes including effleurage, petrissage and kneading. See Sherman et al (2006) for a detailed discussion on massage techniques. Touch itself is thought to be therapeutic particularly for those who have limited opportunities for physical contact such as people without intimate friends or family or who have painful physical conditions. Various studies have shown that the simple act of reaching out and touching another person can result in physical benefits (Parachin 1991, Penson 1998, Bredin 1999). According to Parachin (1991) one touch can soothe, comfort and convey caring in a way words never can. He claims that modern psychology and medicine are confirming what people across the centuries have intuitively known, namely the healing power of touch. O'Mathúna and colleagues (2002) on the other hand, are much more sceptical and claim that the healing power of touch is all nonsense and not yet proven.

Nowadays the practice of massage is embedded within the field of complementary or alternative medicine (CAM). CAM has been defined as "diagnosis, treatment and /or prevention which complements mainstream medicine by contributing to a common whole or diversifying the conceptual frameworks of medicine (Ernst et al 1995). For the purposes of this report, CAM is defined as any treatment or therapy that is not routinely and universally available to people via the NHS.

In recent years there has been a marked increase in the use of CAM in the UK population (Gage et al 2009). A survey found that 10% of adults in England and Wales see a CAM therapist in any one 12-month period and 40% have used it during their lifetime (Thomas and Coleman 2004). Many patients are however, reluctant to discuss their use of CAM with their doctors (Corbin 2005, Maha and Shaw 2007).

Traditionally CAM has been practised in and delivered by the private sector. However, CAM therapies are increasingly being integrated with orthodox healthcare practice; GPs in particular are referring greater numbers of patients for CAM (Penson 1998). Ernst's study found that 49% of general practices offered access to CAM therapies, whereas in 1995 only 39% did so (Ernst 2004). Surveys have also identified a small but increasing number of GPs in the UK who are practising some form of CAM and a growing number of practices are providing patients with access to certain therapies most notably through in-house provision (Lewith et al 2001, Thomas et al 2001). Thus CAM is now being delivered in conventional settings such as hospices, hospitals, clinics and health centres (Hanley et al 2003, Corbin 2005, Heller et al 2005). While massage in these settings is often practised by nurses or unpaid volunteer practitioners, an increasing number of professional therapists are now employed in NHS hospitals and GP practices (Vickers and Zollman 1999).

In addition, CAM is on the Department of Health's agenda, particularly in relation to primary health care services. This intention is stated in the policy document 'Building on the Best: Choice, Responsiveness and Equity in the NHS', which contains recommendations about working towards a strategy for providing patients with access to CAM via the NHS (DoH 2003).

Therapeutic massage is widely considered to be one of the most popular and safe CAM modalities (Watson and Watson 1997, Fellowes 2002, Cherkin et al 2003). A published review of cases reported in the literature and randomised controlled trials of massage therapy found that few reported any adverse effects (Ernst 2003). As authors of a clinical review of massage published in the British Medical Journal, Vickers and Zollman (1999) note that therapeutic massage is considered to be safe with very few adverse reactions being reported. They also highlight the advantages of massage as a complementary therapy for diverse human ailments, and the crucial need for refined studies of these benefits in controlled clinical trials (Vickers and Zollman 1999).

## 3.2 Use and Efficacy of Therapeutic Massage

Since the early 1990s an increasing number of empirical research studies into the use and efficacy of massage have been conducted. Whilst many of these have been carried out by the medical professions, others have been undertaken by nurses and CAM practitioners. The demand for evidence based medicine requires the integration of clinical expertise with the best available external evidence from systematic research. Thus in the last twenty years the therapeutic uses of massage have broadened and research has sought to investigate its physical, physiological and psychological effects.

The following selective review draws upon literature predominantly from Europe and the USA. It draws on evidence from empirical research that sought to establish the benefits of therapeutic massage for a wide range of long term or chronic health conditions. It includes qualitative and quantitative studies as well as random controlled trials (RCTs) which are regarded as the 'gold standard' for medical research. These studies provide evidence from a range of clinical settings that substantiate the claim that massage can be effective in promoting health and wellbeing for people with various health conditions including cancer, Parkinson's disease, mental ill health, and chronic pain.

### Cancer

The Cancer Plan for the British National Health Service highlighted the need to improve supportive and palliative care (DoH 2000). CAM has been shown to be effective at providing symptom relief, addressing emotional distress and improving quality of life of people with cancer (Gordon 2001, Burstein et al 1999, Coss et al 1998, Jacobson et al 2000) and were amongst the package of psychosocial measures evaluated by the National Institute for Clinical Excellence (NICE 2004).

The literature recognises that palliative care has been at the forefront of integrating CAM into orthodox care. The efficacy of massage therapy as a therapeutic intervention to reduce symptoms in cancer patients has been investigated but the studies tend to be small scale and explore psychosocial dimensions rather than impact on disease. Researchers report that large trials are difficult to design and carry out; one described 'unforeseen challenges' including late-stage cancer patients being too ill to participate and healthcare providers withholding referrals to the study because of a bias against having their patients possibly randomized to the non-massage therapy control group (Westcombe et al 2003).

CAM therapies such as massage are increasingly being used by cancer patients in conjunction with conventional treatment in an attempt to alleviate the symptoms of their condition (Ashikaga et al 2002, Lengacher and Bennett 2002, Mackereth et al 2008, Moyer et al 2004). People with cancer may suffer physical symptoms and psychological distress. Depression for example, has been estimated to be 4 times more common in cancer patients compared to the general population (White and MacLeod 2002).

In a prospective study of 50 patients receiving radiation treatment for prostate cancer in 2000, only 6% of patients reported receiving massage therapy (Kao and Devine 2000). In 2001, 20% of 100 patients seeking care at a private cancer centre reported having received massage therapy, (Bernstein and Grasso 2001). A larger and more recent study reported that of 453 adult patients surveyed 26% acknowledged using massage therapy (Richardson et al 2002).

Despite the popularity and availability of massage therapy for patients with cancer, some patients and their families remain unaware of the potential uses of massage as a therapy for symptom control (Corbin 2005). Massage therapy is however, more widely available in hospices. In Demmer's (2004) survey of 169 hospices 60% of those who responded reported that they offered CAM services at their hospices, with massage therapy being the most commonly offered service (available at 83% of the hospices offering CAM therapies).

The RCT conducted by Soden et al (2004) in a hospice in the United Kingdom, randomized 42 patients with cancer to receive either massage alone, massage plus aromatherapy, or no intervention over a 4-week period. The authors did not find any significant benefits for pain, anxiety, or quality of life, although statistically significant improvements in sleep were seen in both massage groups and a reduction in depression was noted in the massage-only group. Patients with higher initial levels of psychological distress seem to have a greater response to the therapeutic massage.

Psychological distress was also a factor in another small qualitative study from the UK. Bredin (1999) explored the effects of massage therapy on women who had recently had a mastectomy for breast cancer. The participants reported being traumatised and disfigured by their illness and had difficulty in accepting their new and less than positive body image. Bredin (1999) found that by offering touch within a safe clinical environment, massage enabled these women to address issues of body image in a more positive way. She claims that touch involved in massage is a form of communication that transcends the usual boundaries between individuals. It enabled women to be 'held', 'feel safe' and 'accepted' despite having what they perceived to be a 'mutilated and disfigured body'. She found that massage promoted wellbeing, improved sleeping patterns, and reduced feelings of discomfort. It promoted a more positive attitude which in turn helped participants to accept and cope with a radically changed body image.

Positive outcomes were also found in a similar sized study by Smith et al (2002). This RCT study conducted in an oncology unit in America, found that massage therapy was effective in alleviating cancer symptoms. A total of 41 patients undergoing chemotherapy or radiotherapy were allocated to one of two groups which received either massage therapy or one-to-one nurse interaction. The massage therapy was found to reduce pain, improve the quality of sleep, and relieve symptoms of distress and anxiety. In the comparison group, only anxiety was found to be reduced. The authors (Smith et al 2002) argue that these findings show that massage can be an effective nursing intervention for patients. A claim repeated by others such as Bredin (1999), Wilkinson (1996), Norton (2007) and Dryden et al (1998) who explored the use of massage with patients in a neurological unit in the UK.

In 2004 the Cochrane Collaborative group conducted a systematic review of the evidence (Fellowes et al 2004) and undertook a meta-analysis of 8 RCTs that investigated the use of massage to reduce symptoms such as anxiety, nausea, pain and sleep disturbance among a total of 357 patients with cancer. The most commonly reported outcome was a reduction in anxiety for 19 to 32% of patients. The next most common outcome was an improvement in sleep. There was less evidence for physical symptoms such as pain. Only three studies with a total of 117 patients measured pain; a decrease was noted in just one study. Similarly, only two studies with 71 patients demonstrated a reduction in nausea. Criticisms of these studies included the small number of participants and the use of only standardized massages that did not allow the therapist to direct the massage based on the patient's specific situation. The authors conclude that there is evidence that therapeutic massage confers short term benefits on psychological wellbeing (Fellowes et al 2004).

The largest study on massage for the alleviation of symptoms in cancer patients was published by Post-White et al in 2003. This group of researchers randomized 230 cancer outpatients to receive either a standardized massage, healing touch (an intervention whereby the practitioner is believed to modify a patient's energy fields by motion of his or her hands near or gently on

the patient), or just the presence of a nursing staff member in the room. Each therapeutic intervention was given weekly for 45 minutes for 4 weeks. Physiologic effects such as decreased heart rate and respirations were seen in all three groups. Massage therapy lowered pain and anxiety. A reduction in the use of non-steroidal anti-inflammatory medications (painkillers) was also noted.

A larger, retrospective, observational study was conducted in the USA. A total of 3,609 massages were delivered to 1,290 inpatients and outpatients over a 3-year period. Patients were assessed at three points; just prior to the massage, immediately following the massage and 48 hours after the massage. Immediately following the massage an average of 50% reduction in symptoms was recorded. This ranged from a 21% improvement in feelings of nausea to a 52% improvement in anxiety. Follow-up surveys 48 hours later showed that the benefits persisted. Patients reported an improvement in symptoms including pain, fatigue, anxiety, nausea, and depression. Results were believed to be clinically significant and, although the study did not have a randomized design, it supports the use of massage in symptom control for patients with cancer (Cassileth and Vickers, 2004).

Use of CAM by people with cancer has been controversial (Ernst 1995). However, there is an increasingly wide evidence base to suggest that CAM therapies including massage can have positive outcomes for patients (Ernst 2007) with no side effects being reported (Cambron et al 2007).

## Caregivers

Massage also has been found to have positive outcomes for family carers of cancer patients. In one study 36 carers of patients undergoing stem cell transplants were offered either two 30-minute massage sessions (13 participants), or two 30-minute healing touch sessions (10 participants), or a 10-minute nurse visit (13 patients). The researchers found that anxiety, depression, and fatigue were reduced by a statistically significant amount in the massage only group (Rexilius et al 2002).

Another study by Goodfellow (2003) focused on 42 spouse carers who were given a 20-minute therapeutic back massage. The effects of the intervention were measured at three time points; pre-intervention, immediately post-intervention and 20 minutes post-intervention. Carers were randomly assigned to either the control group or the massage group. The massage was found to reduce stress, increase relaxation and improve the mood of family carers (Goodfellow 2003).

## Parkinson's disease

Therapeutic massage is often used by people with Parkinson's disease to help alleviate their symptoms (Morling 1998, Paterson et al 2005). It is reported to be one of the CAM therapies most commonly used and of most benefit (Low 2001). In a study commissioned by the Parkinson's Disease Society, Low (2001) explored people's use of CAM therapies. Because of the reported beneficial effects of massage on people living with PD, Law recommended that therapeutic massage should be made available through the Society's local branches. Paterson et al (2005) subsequently evaluated a project set up in the Manchester area as a result of that recommendation.

Participants in this study by Paterson et al (2005) reported problems such as tiredness, difficulty walking, stiff and clumsy hand and arm movements, and difficulties with writing, speech, poor concentration and memory. Many of the 7 participants had been forced to restrict or give up some or all of their activities. They were offered 8 one hour sessions of massage over a period of 8 weeks. During follow up interviews three months later, individuals reported improvements in self-confidence, wellbeing, walking and other activities of daily living.

Another small study into the effects of massage on 16 people with Parkinson's disease by Hernandez-Reif et al (2002) compared massage therapy to muscle relaxation exercises given over a 10 week period. At the end of the study only participants who received massage therapy felt they were better able to manage the activities of daily living and were experiencing less disturbed sleep. These studies, although small confirm the benefits of massage therapy for people with Parkinson's disease.

### Mental health, stress and anxiety

Research has documented the trend amongst users of mental health services to move away from conventional treatment towards CAM therapies such as massage. For example, Thomas et al (2001) found that in a sample of 703 people in England, 39% of visits to a CAM therapists were for 'stress' or 'relaxation'. In the USA a major survey explored the use of CAM by 9,585 people who were considered to have a 'mental disorder' (Unutzer et al 2000). Of these, 16.25 % of respondents reported using CAM in addition to conventional medicine in the previous twelve months. Another survey of 2055 people discovered that CAM was most likely to be used by people with self-defined anxiety attacks and severe depression (Kessler et al 2001). Nine out of every ten patients with anxiety who were under the care of a psychiatrist also used some form of CAM therapy; and six out of ten patients with depression who were being seen by a psychiatrist were also using CAM to treat their condition. These rates were the same irrespective of the socio-demographic characteristics of patients (Kessler et al 2001).

Also from the USA, Russinova et al's (2002) study of 157 people with 'severe mental illness' such as schizophrenia, depression and bipolar disorder provides evidence of the benefits of CAM. The authors conclude that CAM seemed to promote a recovery process beyond the management of emotional and cognitive impairments by also enhancing social or spiritual capacity and promoting the individual's own capacity for self-functioning.

This move towards CAM therapies appears to be motivated by a general dissatisfaction with the impact of conventional medication and the lack of autonomy and choice involved in treatment programmes (Unutzer et al 2000, Heller 2005b). Massage therapy is increasingly being proposed as an alternative or supplement to pharmacological and conventional treatments to counteract mental health conditions like anxiety, agitated behaviour, depression, and to slow down cognitive decline in people with dementia. Its efficacy however, is contested.

A high proportion of the general population experience stress and anxiety and these conditions are amongst the most common reasons for patients consulting their general practitioner (GP). A small study conducted in Scotland sought to evaluate the effects of therapeutic massage on the management of stress within a GP practice population (Hanley et al 2003). The researchers wanted to compare the effects of massage with the use of relaxation tapes. Patients, drawn from those attending a stress management clinic at their local health centre, were randomly selected to one of three treatment groups. Patients in the first group received six sessions of therapeutic massage, carried out by a nurse trained in this technique. Patients in the second group were given six sessions using a relaxation tape in the surgery and those in the third group were given a relaxation tape to use at home. Data measurement and analysis tools included the General Health Questionnaire -30 (GHQ-30), the Adapted Well Being Index (AWBI); a sleep scale; general practitioner (GP) consultations for any reason in the six weeks before treatment, during treatment, and six weeks following treatment; and patient satisfaction. A total of 69 patients completed the treatment. Following completion of the treatment, the majority reported a significant improvement in their general health and wellbeing, less emotional disturbance, better quality of sleep and fewer visits to the GP. The authors conclude however, that despite very strong patient preference for therapeutic massage, it did not show any benefits over either a relaxation tape used in the surgery or a relaxation tape used at home.

Sharpe et al (2007) conducted a similar study with older adults living in the community that sought to assess the effects of massage therapy and compare them to guided relaxation. Over a period of four weeks adults aged 60 years and over, received either 50 minutes of massage therapy or visualisation and muscle relaxation exercises. Significant improvements were found in scores for anxiety, depression and general health. The findings suggest that massage therapy enhances positive wellbeing and reduces stress among older adult.

A meta-analysis of 37 research reports exploring the use of massage therapy for mental ill health was undertaken by Moyer et al (2004). They found evidence that anxiety and blood pressure levels could be reduced after only a single session of massage whereas there was no immediate effect on pain or negative mood. After a number of therapeutic interventions the evidence suggested that massage could also reduce pain levels. The most commonly reported effect was lower levels of anxiety and depression (Moyer et al 2004).

A few studies on anxiety have focused on older people living in residential and long term care settings. One such RCT study designed by Fraser and Ross (2008) to measure the effects of back massage on anxiety levels, focused on older people living in a long-term care home. Twenty-one residents, 17 females and four males, were randomly assigned to three treatment groups which received either back massage with normal conversation, conversation only or no intervention. Anxiety levels were measured at three time points: prior to back massage, immediately following, and 10 minutes later, on four consecutive evenings. The Spielberger Self-Evaluation Questionnaire (STAI), electromyography recordings, systolic blood pressure, diastolic blood pressure (DBP) and heart rate were used as measures of anxiety. The authors found that there was no statistically significant reduction in BP. There was however, an improvement in the mean anxiety (STAI) score between the back massage group and the no intervention group. Given the small size and inappropriate methodology of this particular study, these results are questionable. Verbal reports however, from the participants suggest that they found the back massage relaxing. The authors conclude that massage may be an effective, non-invasive technique for promoting relaxation and improving communication with patients and recommend that touch be encouraged in caring for the elderly (Fraser and Ross 2008). The reduction in anxiety as an outcome of therapeutic massage is confirmed by several other studies (Field et al 1996, Mok & Woo 2004, Billhult & Maatta 2009).

Another small study by Sansone and Schmitt (2000) looked at the effects of gentle massage on two groups of elderly nursing home residents: those suffering from chronic pain and those with dementia who were anxious or agitated. The massage was given by care assistants who had been trained by a professional massage therapist. The project was divided into three 12-week phases with different staff and residents involved in each phase. At the end of each phase, anxiety and pain scores for 59 residents who completed the programme had decreased. Eighty-four percent of the care assistants reported that the residents enjoyed receiving the massage, and 71% thought this type of intervention improved their ability to communicate with the residents.

In contrast to residents of residential or long term care, Smith et al (1999) sought to evaluate the effects of a therapeutic massage intervention in an acute health care setting. This qualitative study included 113 hospitalized patients who received up to 4 massages during the course of their hospital stay. Although they do not say what health conditions participants experienced, the results suggested positive outcomes. The most frequently reported outcomes were increased relaxation (98%), a sense of well-being (93%), and positive mood change (88%). More than two thirds of patients attributed enhanced mobility, greater energy, increased participation in treatment, and faster recovery to the massage therapy. Thirty-five percent stated that benefits lasted more than 1 day. The study supported the value of this hospital-based massage therapy programme and uncovered a range of benefits of massage therapy for hospitalized patients that the authors claim should be studied further.

In relation to the effects of massage on dementia, Hansen et al (2006) provide an online review of research on the use of massage for this condition. They critically examined a total of 18 studies of the effects of massage interventions but felt that the majority were too small to provide adequate evidence. They considered only two were of sufficient methodological rigour to provide reliable evidence. They concluded that the small amount of evidence currently available is in favour of massage and touch interventions for people with dementia, but is too limited in scope to allow for general conclusions. They claim that further, high-quality randomized controlled trials are required.

### Back pain

Back problems and pain are among the most prevalent conditions affecting the adult population and one of the most common reasons for using complementary and alternative medical (CAM) therapies. A number of studies have looked at the efficacy of massage for this condition.

Ernst's (1995) earlier review of studies for example, identified four random control trials which included massage therapy as a control group. These studies reached conflicting conclusions and were considered to be small and of poor quality. However, a larger random control trial conducted by Cherkin et al (2001) suggest that massage is an effective short-term treatment for chronic low back pain, with benefits that persist for at least one year. This study compared the effectiveness of acupuncture, therapeutic massage, and self-care education for persistent back pain. Participants were aged between 20 to 70 years and had recently visited a doctor with back pain. Most patients had first received treatment for back problems more than 1 year earlier. The majority had experienced pain continuously for the past year and were using pain medication or non-steroidal anti-inflammatory drugs. Exclusion criteria included symptoms of sciatica, acupuncture or massage for back pain within the past year, back care from a specialist or CAM provider.

Participants were randomly allocated to acupuncture (n=94), massage (n=78) or self-care (n=90). Therapists were allowed to schedule up to 10 visits over 10 weeks for each patient. Those allocated to the self-care group were provided with educational materials which included a book, a 40-minute videotape on self-management of back pain and a 25-minute videotape demonstrating exercises. These materials included information about back pain and its treatment, techniques for controlling and preventing pain and for improving quality of life, and suggestions for coping with the emotional and interpersonal problems often accompanying chronic illness.

After 10 weeks the effects of treatment were significant with 74% of patients rating massage as very helpful compared with 46% for acupuncture. Of those using self-care materials, only 17% considered the book very helpful and 26% found the videotapes very helpful. The massage group had less severe symptoms than the self-care group and less dysfunction than the self-care and acupuncture groups.

After one year, the outcomes for massage and acupuncture were unchanged. Massage was reported as being superior to acupuncture in its effect on symptoms and function. The use of medications also remained lower in the massage group than in the other groups. The self-care group also reported some improvement although these were not statistically significant. The researchers concede that the reasons for the better outcomes in the massage group are unclear. They concluded that therapeutic massage provided long-lasting benefits and was therefore, effective for persistent back pain. They suggest that massage might be an effective alternative to conventional medical care for persistent back pain.

In a later publication Cherkin et al (2003) claim that for back pain conventional treatments, although widely used, have had limited success. And this is why increasing number of patients are turning to CAM therapies for treatment. In conducting a review of relevant studies, Cherkin and colleagues sought to provide a rigorous and balanced summary of the best available evidence about the effectiveness, safety, and costs of the most popular complementary and alternative medical therapies used to treat back pain.

They included systematic reviews of randomized, controlled trials (RCTs) that were published since 1995 and that evaluated acupuncture, massage therapy, or spinal manipulation for nonspecific back pain. Two authors independently extracted data from the reviews (including number of RCTs, type of back pain, quality assessment, and conclusions) and original articles (including type of pain, comparison treatments, sample size, outcomes, follow-up intervals, loss to follow-up, and authors' conclusions).

The three RCTs that evaluated massage reported that this therapy is effective for subacute and chronic back pain. They concluded that therapeutic massage was an effective intervention for persistent back pain. The effectiveness of acupuncture remains unclear. All of these treatments seem to be relatively safe. Preliminary evidence suggests that massage, but not acupuncture or spinal manipulation, may reduce the costs of care after an initial course of therapy.

## Headaches

Few studies have explored the efficacy of massage for other types of commonly occurring pain such as headaches. Lawler and Cameron (2006) for example, used an RCT to explore the use of weekly massage therapy as a treatment for migraine. Assessment of migraine experiences and sleep patterns were assessed daily over a period of 13 weeks. Participants receiving massage experienced less frequent migraines, improved quality of sleep, reduced stress and better coping ability. The findings provide support for the use of massage as a non-pharmacological treatment for migraine.

Quinn et al (2002) explored the effects of massage therapy on chronic non-migraine headache. Sufferers of chronic tension headaches received therapeutic massage therapy directed toward neck and shoulder muscles. Headache frequency, duration, and intensity were recorded and compared with baseline measures. Within a week of the massage the frequency and duration of headaches was significantly reduced and continued for the remainder of the study. The intensity of the headache was however, unaffected by massage. Like Lawler and Cameron, the authors concluded that massage therapy technique has the potential to be a functional, non-pharmacological intervention for reducing the incidence of chronic tension headache.

Massage therapy has also been used successfully for other health conditions such as eating disorders (Hart et al 2001), carpal tunnel syndrome (Field et al 2004), arthritis (Field et al 2007), multiple sclerosis, migraine, high blood pressure (Hernandez et al 1998a, 1998b, 2000).

## 3.3 Therapeutic Relationships

Some commentators claim that the basis of positive outcomes in CAM is entirely due to therapeutic relationships rather than the effect of any particular therapy (Mitchell and Cormack 1998, Thorlby and Panton 2002). The term 'therapeutic relationship' refers to the relationship between a health care provider and a person seeking treatment; a relationship within which therapy is delivered. Within the therapeutic relationship it is anticipated that a rapport is

established between the practitioner and the person seeking treatment. This rapport exists alongside any therapy or treatment being delivered. With the field of CAM, the therapeutic relationship is viewed as being intrinsically beneficial and a possible catalyst for self healing (Stone and Katz 2005).

Another way of thinking about the therapeutic relationship is as something that goes beyond practitioners' practical skills and the interaction between practitioners and their clients. In this sense the therapeutic relationship involves the whole therapeutic encounter with users where ideally the entire therapeutic process exerts a beneficial and empowering effect (Mitchell and Cormack 1998). When such an encounter generates trust and confidence it forms the basis for a positive process and outcome (Thorly and Panton 2002).

Lambert and Barely (2002) maintain that certain factors within the therapeutic relationship can influence client outcome. They categorise these into four areas: extra-therapeutic factors, expectancy effects, specific therapy techniques, and common factors. They claim that what they term 'common factors' such as empathy, warmth, and the therapeutic relationship have been shown to correlate more highly with client outcome than any specialized treatment intervention. Thus Lambert and Barely (2001) conclude that all therapeutic encounters are interpersonal processes in which a main curative component is the nature of the underpinning therapeutic relationship.

## Conclusion

This review of the literature considered studies that used different research methodologies to explore the use and efficacy of massage therapy. It has included RCTs, surveys and qualitative research. The review has found that the use of CAM and massage is increasing within the NHS and cancer treatment centres in particular. Moreover, an increasing number of GP practices are providing CAM directly to their patients or referring them for it. Despite the different research methodologies applied, the review has shown that massage therapy is a relatively safe intervention with no significant adverse effects being reported. The available evidence indicates that it is a popular and an effective intervention for a wide range of health conditions and complaints including cancer, Parkinson's disease, mental ill health and chronic pain. This body of evidence suggests that therapeutic massage is an intervention eminently suitable for use with vulnerable people in crisis situations.

## 4. Research Design

As part of an ongoing user engagement process the Red Cross has recently conducted a pilot evaluation of the Therapeutic Care service in eight sites around the UK. The evaluation used a quantitative approach and gathered data by means of a structured questionnaire. This recent data gathering exercise informed the research design for this study.

The design selected was a qualitative one that would add to and complement the quantitative data already gathered. While the current 'gold standard' of research methodology is regarded as the randomised controlled trial (RCT), it is considered inappropriate for the study of CAM therapies such as massage (Foster 2002). Others have argued for the inclusion of qualitative research methods claiming that RCTs address only one limited question; whether an intervention has a statistically significant effect (Verhoef et al 2002). A wholly traditional positivist approach was therefore considered inappropriate for a study whose overall aim sought to understand service users' subjective interpretation of events and experiences. Moreover, a qualitative design was deemed most appropriate because it would firstly provide an insight into the nature of service receipt as understood and experienced by those involved. Secondly, it would offer a rich description of service users' perceptions, beliefs and feelings as well as the meaning and interpretation they gave to events and behaviour. Finally, it would help Red Cross as the service provider to understand service users' subjective interpretation of events and experiences.

### Negotiating access

The managers of health and social care services whose clients were recipients of Therapeutic Care services were approached for help in identifying a suitable sample. They contacted service users, explained about the study and asked if they were willing to participate and if so, give permission for the name and contact details to be passed to the researchers.

### Sampling strategy

Purposive sampling was used to identify a suitable sample of service users. Participants were selected on the basis that they had received Therapeutic Care within the last 12 months. The study included respondents who had received the Therapeutic Care service in a variety of accommodation types including their own homes, sheltered housing, care homes and hospital wards. In total 34 service users living in central Scotland indicated their willingness to take part in the study; 30 were actually interviewed. Respondents included eighteen women and seven men whose ages covered a wide range with the youngest service user being thirty nine and the oldest, one hundred years.

Respondents included carers and persons who had or were currently experiencing a personal crisis due to one or more of the following:

- A long-term condition such as Parkinson's disease, arthritis or diabetes
- A chronic physical impairment as the result of an injury or accident
- A congenital physical impairment
- A mental health condition
- Age related needs such as impaired mobility
- An acute medical condition

### Data collection

The main method of data collection was in-depth unstructured interviews with service users. Service users were contacted by telephone and during the ensuing conversation, the researcher introduced herself, reminded the service users that they had agreed to their name being passed on, outlined the aims of the study and again sought their verbal agreement to participate further. Once a mutually convenient time and location had been agreed a letter confirming the arrangements was sent to each service user.

Interviews were held in private and began with a personal introduction by the interviewer, who described the purpose of the study and stressed the importance of service users' contribution to the research. Respondents were assured that their views would be treated in the strictest confidence; that they would be recorded in anonymised form and used for research purposes only; that published findings would be presented in aggregate form so that no individual response could be identified. Respondents were also reminded that they could stop the interview at any point or decline to answer any questions they were not comfortable with.

The interviews were in-depth and unstructured but informed by a topic guide, drawn up following discussions with stakeholders involved in the commissioning and delivery of care services (see appendix 1). The interviews lasted from 40 minutes to just over an hour. The questions asked were open-ended and subsequent ones asked in response to issues introduced by respondents. The aim was to allow issues and themes to develop freely in order to gain an insight into services users' feelings and experiences. All interviews were recorded and partially transcribed.

### Data analysis

The principles and procedures of grounded theory guided data analysis. This grounded and interpretive approach enabled common themes to be identified through a process of constant comparison.

### Ethical considerations

The research was conducted in accordance with the Ethical Guidelines laid down by The Open University. This process involved scrutiny of the research proposal by the Ethics Committee to ensure that all potential risks to research subjects and researchers had been identified and steps taken to minimise them. In accordance to the guidelines, a letter setting out the aims of the research was given to all potential participants. A consent form was included with the letter assigning copyright to the British Red Cross and The Open University. All participants were informed that they had the choice whether or not to take part and that returning the consent form did not commit them to participating should they change their mind. Contact details for the researcher and senior staff at The Open University were given in case of any questions or concerns. Signed informed consent was obtained from all participants prior to commencement of interviews.

## 5. Service Users Views

All service users said that they benefited from Therapeutic Care. Only one woman and one man were ambivalent about the service but did concede that it had been beneficial. While benefits can be categorised as being mainly physical and psychological some people considered that they had also benefited socially. Differences in impact can be related to service users' individual circumstances, most notably age, medical condition and living situation. Service users said:

I benefited physically, mentally and socially

It gave me strength and renewed my vigour. It's about your health.

It helps my physical pain and my mental wellbeing

### 5.1 Physical Benefits

Services users reported an overall feeling of physical wellbeing following the Therapeutic Care session. The most frequently reported physical benefit of Therapeutic Care was an easing of tension in neck, shoulder, arms and hand areas and subsequently, fewer headaches. Less stiffness combined with easier head and neck movements and fewer muscle spasms also led to increased mobility. One man who suffered chronic pain as the result of an accident said:

I get spasms in my neck and I have constant pain in my left ear and when I'm in really severe pain it (TC) can help. It's helped with the pain in my left ear and to relax the tension in my neck. I have my hands done once or twice but for me it's more beneficial on the neck and shoulders

I'm prone to tension headaches, but don't know why. But it [TC] definitely seems to help

Of particularly importance to people with Parkinson's disease was that feelings of relaxation and the release of muscle tension as a result of Therapeutic Care improved the involuntary movements of the head, face, neck and tongue muscles (dyskenesia) which is a characteristic of their condition.

I think because it's relaxing me physically...She's very good at loosening knots in your shoulders and things like that. Obviously when you're anxious you tense up a bit and that – especially around the shoulders, so you just close your eyes and let it wash over you

I definitely know if I'm relaxed I've got less pain and stiffness – massage helps that way because it helps you relax a bit too – there's a definite link between stress and ill-health and pain... The massage is really, really good and beneficial – it's the mind and body link. You could be the fittest man on the planet but if you don't work your body what does it matter?

Another frequently reported physical benefit was pain relief. Service users who suffered hand, joint, shoulder, back and neck pain through long term or chronic conditions such as cancer or arthritis also found that Therapeutic Care relieved their symptoms. This enabled them to do more in their daily lives and/or to manage daily routines with less pain. One older woman living alone found that she could do more household chores by herself instead of having to wait for a member of her family coming round to help. Thus Therapeutic Care also promoted the independence of service users.

Other service users experienced a significant improvement in back pain. They talked of a 'knock-on' effect whereby the physical relaxation induced by the massage led to a reduction in muscle tension in their head and shoulders, which in turn reduced the severity of back pain experienced.

My back pain has been eased and the tightness of the muscles in my neck and shoulders

I've get an easing up of the pain ... like the stiffness in my hands and knees

Sometimes I get a lot of pain in my shoulders and it can help...I could feel that helping my shoulders

She always did my hands first... I liked that, it felt good and it helps with the physical pain... I feel like my hands are new again

I feel great after it's done – you lose that tight feeling that I have all the time

The muscles go into spasm so if they release the tension in the muscles it helps. And a lot of people get lots of pains in their arms because of the Parkinson's. I find that the massage really helps because with the spondylosis up here right across my shoulders and into both my arms, it seems to ease the ache.

The above quotes reveal that pain relief as an outcome of Therapeutic Care was not confined to one particular part of the body; that it had a positive impact on service users' necks, heads, hands and backs. In many instances, these individuals were also taking prescribed medicine to combat their pain. Many felt that Therapeutic Care was equally if not more, effective in this respect. The relief of pain and tension could have such a significant impact on service users that one person described it as transforming. She said that:

I go out a different person from getting TC than I am coming in, definitely – it's just like a weight off your shoulders – and if like you've got a splitting sore head and you can go out without it – well that helps so much!

## 5.2 Psychological benefits

Irrespective of their personal circumstances or health condition, service users reported a number of psychological benefits as a result of receiving Therapeutic Care. The most frequently reported psychological benefits were feelings of relaxation and calmness, reduced levels of stress and anxiety and better quality of sleep.

I get a very intense feeling of relaxation. Carers don't take time for themselves... this was stimulating, enervating and I felt my energy was renewed and I was ready to face things now

It's a sort of stress release...you think great, I can have half an hour without worrying about anything or anyone.

The night after I have it [TC] I always have a good sleep because I feel relaxed right through my body and you can lie in bed and still feel that relaxed way, so it's quite good that way

I also find that you even feel better in your mind – you feel more relaxed. ...the weight on you just seems to change ... you can come out feeling happy, so I find it's good that way.'

Others felt that it also improved their mood, energy and concentration levels and this subsequently, led to improved interpersonal relationships. Some also reported that they were more tolerant of other people because they felt better within themselves, more relaxed, less stressed and better able to cope. This was particularly pertinent to carers and those who suffered from mental ill health.

I was more tolerant after it and less stressed...my husband noticed that...it gave me strength and renewed my vigour

I find it very, very difficult to relax and this is one of the things that help me cope

It loosens the tension and also releases a lot of stress.

Sometimes I could be feeling really low and when she does the massage and she talks to you she can bring you back up again – from the low mood she can bring you back up a wee bit and make you feel better in yourself. By the time you get your massage and go back through you're thinking 'I feel a bit better now.'

Many service users said that after Therapeutic Care they experienced an increase in self-esteem and self-worth. This was often conveyed by such expressions as:

It lifts my mood and makes me feel better about myself. I can be feeling really low but it brings my mood up... generally after it I will go out and I'll feel happier and more at ease.

I leave feeling better about myself... not just feeling like a 'patient' or a 'Parkinson's sufferer' but 'me – the person I am not just a number on a computer.'

Feeling valued and respected was important to service users especially those with mental ill health. They believed that if someone, especially volunteers, were willing to spend time with them, and were happy to listen while giving them massage therapy; it conveyed respect for them as an individual. Having the respect of a therapist who was held in high regard by service users, was a key factor in promoting feelings of self-worth.

Another important aspect of Therapeutic Care was that it created a short space which allowed service users to take time out from the reality of their lives and the challenges they faced. Being able to forget about their problems for a while and making time for themselves was described as 'switching off', or 'taking time out'. The fact that Therapeutic Care 'let's you leave other things behind' was valued. Service users also valued being involved in something positive in comparison to focusing on their problems or health condition.

because you're feeling pretty grotty when you're going for this stuff and obviously there have been a lot of medical problems prior to you arriving at that stage of that treatment – so anything that gives you even the slightest lift has far more impact than if you were bursting with health and having the same thing

when you're down as low as you can be and also you've had some fairly devastating news about your own health which I had recently had ...it's got more worth to you, you appreciate it a lot more – you may well have taken it for granted earlier on when you were feeling full of health and that. When you are a bit down it's more valuable to you.'

One woman highlighted the fact that physical and psychological benefits cannot be separated when she said:

I think they are mutually reinforcing – it's difficult to put into words – it's a feeling of comfort, a feeling of warmth and knowing that you just have to enjoy the massage, you don't have to think about anything very much, you don't have to do anything, you just have to receive, so to speak – which is quite good. I find it very, very difficult to relax

### 5.3 Social benefits

While the impact of the Therapeutic Care was reflected mainly in improvements on service users' physical and psychological health, some also reported social benefits. The main benefit was an increase in the level of social interaction and the ability to form relationships with other people. This was as a direct result of increased feelings of wellbeing, self-worth and self esteem generated by Therapeutic Care.

Therapeutic Care had therefore, an impact on service users' social activities and arguably, on other people too. This was most marked for carers or people with mental ill health who lived in their own homes but who were able to make their way to a day care or drop-in centre where they were able to mix with others immediately after their treatment. This extended impact of Therapeutic Care was illustrated by one woman who felt that she was much more social and talkative after her treatment and by engaging with others, believed she was 'giving something back'. Service users said:

If you're feeling happy and good about yourself and you go out and speak to other people then you are positive towards other people – I mean I've gone through there and they've said 'how was that?' and I say 'brilliant'. It makes me more chatty and then I feel I'm giving something back

the bond in here with everybody making you feel so welcome and what have you is brilliant – you could come in and say I'm having a bad day ...and from when you open that door and come in everyone, staff and clients, says hello to you and asks how are you – and it's really meaningful and more – it gives you something

you come here because of your problems, but when you get your TC that half hour takes you out of the space that brought you here –and when you go out you feel really good about yourself – you're cutting yourself off and getting this treatment for half an hour and you go back out and you're putting something positive back into that, from where you came from

In settings where BRC volunteers were perceived very specifically as an integral part of the support team, for example, in mental health care facilities, some older people's services and oncology units, several participants commented on the importance of the social interaction with them too. Services users with mental ill health said:

She smiles at me a lot – not many people smile at me

She always asks you how you are doing and what kinds of things you've been up to – she goes into a conversation with you

## 5.4 Temporal Aspects of Benefits

One of the areas explored with service users was how long perceived benefits lasted. All reported feeling immediate benefits from Therapeutic Care. For some the improvement in wellbeing lasted from a few hours to a few days. Others said that an improvement in their wellbeing lasted much longer and in some cases for as long as two weeks until the next Therapeutic Care session.

Some service users believed that benefits were accumulative. This meant that the benefit gained from one session of Therapeutic Care built upon that gained from the previous one and over time this led to a greater and more sustained improvement in wellbeing.

I immediately felt the benefits. The feeling of wellbeing lasts well into the evening and sometimes for at least a couple of days after it

All night and the next day and sometimes until she came back again

It helps me feel better and then when I start to feel down again I know I will get it again in another few days... the improvement lasts for nearly two weeks between my appointments

My hands are really stiff but after the massage they feel looser and less painful and then after the next one they feel better still. I think the more I get the more I benefit

It lasts for a while, at least for a couple of days after it

I feel better for a few days afterwards then gradually the pain gets worse again but it does last a time

There also seemed to be a cumulative effect especially in relation to how quickly they were able to 'relax into' a session and how much they looked forward to the next one. They reported that on each subsequent treatment session they were able to 'relax' more quickly than when they first started.

## 6. Communication with Service Users

An area of particular interest was the role of communication between volunteers delivering the service and services users as recipients. Delivery of Therapeutic Care requires effective use of three different forms of communication. It requires verbal communication, non-verbal communication and listening skills.

An area of particular interest was what role, if any, did verbal communication between therapist and service user play in promoting positive outcomes? Was it simply the opportunity to talk about their lives or their problems to someone who actively listens, that allowed services users to unburden themselves and foster feelings of improved wellbeing? There is plenty of evidence which shows that being able to talk to someone about problems and issues does promote feelings of wellbeing (Lambert and Barley 2001). Were service users simply using BRC volunteers as substitute counsellors?

It is important to note that service users did not use this service as a substitute for counselling. Persons who currently used or had previous experience of counselling services perceived the nature, content and meaning of the dialogue between them and Red Cross volunteers to be entirely different. They said:

It's different. With counsellors you maybe go into more detail – maybe different things you would talk to them about – with her [volunteer] you'll talk about things that go on at home but with the counsellor you would talk about deeper things – you would do like the general stuff with the volunteer – but she doesn't advise you or anything like that, but she talks to you

Out of the counsellors you're getting help with the problems while with the massage you could talk about new things ... so it's a different aspect from the support you get – you know, it's taking your mind off your problems

### 6.1 Verbal communication

In relation to verbal communication during Therapeutic Care, service users fell into two discreet groups; those who enjoyed talking to volunteers throughout their treatment and those who preferred to receive Therapeutic Care in silence. Some service users considered verbal interaction to be an important aspect of the service and that there were real benefits from being able to talk to a volunteer who always showed an interest in their wellbeing. When asked whether conversation was an important part of the experience, service users said:

I think so, yes. I had a massage (somewhere else) and they never spoke to you and I just didn't like it – it just didn't feel right ...they didn't speak to you at all and I thought 'this is eerie'

There are times I've been emotional and cried. But when she asks you how you've been and you start to talk you start to feel better because you've spoken to someone and you feel a bit better in yourself

A few shared personal and confidential information with volunteers. They did however, recognise and indeed value the fact that anything they said to the volunteer would be kept in strict confidence. Services users said:

I knew anything I said wouldn't go any further

It's nice to talk about things – you know it is in confidence – but it's up to you to talk if you want

it's good for you to talk especially if you're a carer - you can say things to them and you know it won't go any further

I'll tell her how I'm feeling – like I've been struggling for about eighteen months with a disorder which is pretty dreadful so I've been talking to her about that and she's been chattering away to me while doing the it [TC] which has been helping to reduce the stress levels a good bit

Other service users did not share information with volunteers. They did however, appreciate being listened to. One woman said:

She listens to you. She actually listens to what you are saying to her, which is a good thing – that's what you hope when you're talking to somebody; that they're going to listen to what you're saying

Another man acknowledged that people might react differently but said that for him verbal interaction was as important as the massage:

You are actually interacting with someone and that helps rather than just getting the massage itself. I think it's more beneficial getting some interaction while they are doing the massage. (The talk) might not be as important for everybody – some people might just like to sit and chill out more than they like talking

The most frequent type of verbal communication between services users and volunteers was usually described as 'a chat' or 'a wee talk'. Services users said:

It's just idle chit chat

Yes we talk together. Well we talk about family or other things... It just idle talk. I enjoy that wee chat with her

You benefit by talking to volunteer, especially if you can talk sensibly. I could talk about things years back – didn't confide personal things.

She talked about hands and what you could tell from them – also just general chit chat like the weather – I waited on the lady asking questions.

Other service users preferred no communication with volunteers during their session. They seemed to value the silence and the quiet space in their lives that the TC session created for them. The session allowed them to essentially 'take time out' from the reality of their lives and the challenges confronting them. It is testament to the skills of volunteers that they managed this sensitive aspect of the service. Service users said:

The silence is good in helping me to focus on self ... I like it that way

I had no intention to talk about problems – I just like to sit quietly – it helps me relax

She's very good at what she does... she could just chatter away incessantly and in fact you don't want that because you're feeling pretty weary and probably not very well while the procedure is going on...She actually feels when you just want to sit quiet for a moment and she just carries on with what she's doing and then she'll ask a question or whatever or ask 'how does that feel?' and you can respond as much or as little as you want to... they have to be fairly perceptive people to work out how to react to the person they're working with – I think that's probably quite an important aspect of it

In relation to verbal communication, it was clear that service users had their own individual preferences which influenced the level, tone and amount of conversation with BRC volunteers.

## 6.2 Non-verbal communication

Non-verbal communication (massage therapy) is an integral part of Therapeutic Care. But was it the combination of verbal *and* non-verbal communication that promoted positive outcomes or was massage therapy with no verbal communication perceived to have the same benefits?

While service users considered that all types of communication were important, several believed that the massage therapy was more so. They felt that it was this aspect that distinguished Therapeutic Care from other support services and it was the massage therapy rather than verbal communication that promoted their wellbeing.

Non-verbal communication was important to and valued by service users from all client groups who said:

There's just something about the touch that is very healing – it's nice and warm and it's like you're being cared for ... so you just close your eyes and let it wash over you

It's a trust thing letting someone touch you and you feel you have a bond, you feel safe and you feel secure and it makes you feel good about yourself and it actually does help me to sleep at night

You feel as if they respect your body, your feelings, your bones and everything – they are respecting your body because they are being careful with it

Touch does a different type of good... talking therapies heal your mind a wee bit and make you feel more relaxed but whereas if you've got pain and stiffness then the touch therapy is definitely better...

The speech gets into some parts and the contact into others, so the two together can make you more relaxed, more comfortable and more at ease

I think they are mutually reinforcing – it's difficult to put into words – it's a feeling of comfort, a feeling of warmth and knowing that you just have to enjoy the massage, you don't have to think about anything, you just have to enjoy it

One service user who had a serious and life threatening condition described the massage therapy as:

It's not an intrusive type of touch. You can treat it like a professional touching but... It's not intrusive, but it's there and it gives you a link. It gives you a connection that you wouldn't have if you were just sat talking to someone... when she's there and actually doing things with your hands as well I think it's probably a closer type of communication

The quotes above illustrate clearly that while massage therapy is essentially an activity carried out by skilled practitioners, it has both material and psychological dimensions. The material dimension includes massage as work or labour towards the wellbeing of individuals. The psychological dimensions encompass a range of emotions which have to do with emotional support and feeling concern for the wellbeing of others. Service users acknowledged and were sensitive to the psychological dimension of massage therapy.

## 7. Delivery of Therapeutic Care

### 7.1 Referral

In delivering the Therapeutic Care service, the first stage in the process from the service users' perspective is the referral process. Service users were referred in one of two ways. Some were informed about the Therapeutic Care service through staff in the support or treatment facility they attended. These included day care units for older people, carers' centres, NHS oncology units and voluntary organisations that supported people with particular conditions such as Parkinson's disease or mental ill health. Older people were referred to the service by the managers of care homes or sheltered housing complexes where they lived. Service users reported that they were able to access the service quickly and easily and that there appeared to be no waiting list for it.

### 7.2 Receipt

In general, service users were well informed about the purpose and nature of Therapeutic Care prior to receipt of the service. Very few however, actually appreciated that it was a service for people described as 'vulnerable'. In talking about themselves no one used the term 'vulnerable' so it is unclear how many people perceived themselves to be in this category. Service users who seemed to be well informed tended to be younger and in receipt of other holistic health care services.

Older people living in care homes or sheltered housing were not fully aware of the service's purpose. This may be because it was never fully explained to them or that they had been told but were unable to recall this. Many of them had some degree of cognitive impairment and had been identified as being in need of Therapeutic Care by their managers. One older woman who suffered severe pain due to arthritis said:

They explained what they were trying to achieve – doing my hands and that in particular they explained how it sort of loosens your hands. I was told it should help, make them feel a bit easier and a bit more flexible and it does. They do give you some information on it – they don't leave you cold

There was significant demand for the service from this client group and their manager tried to ensure that all those who he considered to be vulnerable, were referred. There were one or two individuals who tended to be housebound who he knew were willing to have an extra session at short notice. So if someone was unable to keep their appointment there was usually someone able to take their place at short notice.

### 7.3 Fit with other services received

Therapeutic Care was often only one of a number of services that people received. Thus the study was interested in how it fitted with these core health and social care services; did it complement other services and the overall care package. There was considerable variation amongst participants with regard to their perception of this issue. In settings where Therapeutic Care was well integrated with other services it was seen as a complementary and valuable part of the support on offer. This perception was most marked when there were positive relationships between the staff, volunteers and users in the service setting. One person receiving other services said:

It's very much a complementary thing; it fits in well with other services I get. I have a home support worker who sees me twice a week and gives me practical help and advice

A small number of participants, usually older people living in care homes, saw no relationship between the Therapeutic Care service and other support services they received. They did not perceive it as part of their overall package of care. This view may have been related to their particular physical or cognitive incapacity and the environment within which they lived. They tended to view Therapeutic Care as just another activity offered which they could choose to take part in. This does not mean that Therapeutic Care was not valued; these respondents appreciated it as something positive in their lives which simply helped them to feel better.

## 7.4 Therapeutic Relationships

All people interviewed mentioned the importance of the relationship with, and qualities of, volunteers delivering the service. According to the literature, development of a positive therapeutic relationship helps to promote positive outcomes (Stone and Katz 2005).

Service users knew that Therapeutic Care was delivered by volunteers but they recognised and appreciated their professional approach and sometimes regarded them as part of the health care team. One man who received Therapeutic Care at an oncology unit said:

She is a bright, breezy character – she’s part of the team. Even if she sees you in the waiting room she doesn’t just walk on by – or if you meet her in the corridor she stops and talks to you

Service users felt this professionalism was conveyed by the way in which they were treated with courtesy and respect; they were treated as individuals and always asked what they wanted, it was never assumed that the volunteer would decide on their behalf. This approach was valued because it allowed service users to feel that they were in control of the situation. This experience was in contrast to how they were sometimes treated within conventional health and social care settings where the power of professionals was evident and service users tended to feel overwhelmed and disempowered.

The skills and professionalism of volunteers, their smiling and friendly manner helped service users to build up a rapport with volunteers. They recognised that in allowing someone to touch them they were placing their trust in the volunteer. Service users also reported that volunteers were sensitive to their moods and feelings and were able to perceive when they wanted to talk or just sit quietly.

She’s just very down to earth and very friendly, if you want to chat she will, but if you don’t want to she’ll be quiet and just do the massage. She caters to your needs very much whatever you want

They also valued the fact that volunteers were able to tell through experience and non-verbal communication that service users were feeling tense or in pain.

In general service users reported that the Therapeutic Care service they received was excellent. Some did express a preference for it to be available more frequently than it was. There was however, a lack of clarity over the timescales being referred to. Other service users said they would like the service extended to include other CAM therapies such as relaxation and reflexology.

## 8. Discussion and Conclusions

This study shows that the Therapeutic Care service is achieving its objective of promoting the health and wellbeing of people made vulnerable by circumstances. The results demonstrate that Therapeutic Care has a positive impact on the quality of service users' lives and health.

As a result of receiving Therapeutic Care, positive outcomes for service users were a wide range of physical, psychological and social benefits. These were experienced immediately after receiving Therapeutic Care and lasted varying lengths of time; from a few hours to a few days or weeks until the next treatment. Others experienced an accumulative effect whereby, the benefit from one treatment built upon that from previous ones. Over time this led to greater and more sustained feelings of wellbeing.

Positive outcomes in relation to physical benefits, was a reduction in self-reported pain and muscle tension. People experienced fewer headaches and muscles spasms and much less joint stiffness. This overall improvement in health and wellbeing also promoted the mobility and independence of service users who were better able to manage day-to-day activities. This was true irrespective of the type and nature of self-reported health conditions. Thus people with arthritis and cancer benefited as did those diagnosed with Parkinson's' Disease and chronic pain conditions.

The most frequently reported positive psychological outcomes were reduced levels of stress and anxiety. Consequently, service users were emotionally supported and felt calmer, more relaxed and experienced better quality of sleep. Improvements in mood, concentration and energy levels were also reported. Other outcomes were increased tolerance and ability to cope. This was particularly so for carers and those suffering from stress and anxiety disorders.

Services users experiencing mental ill health also reported increased feelings of self-worth and self-esteem which in turn contributed to social benefits. Social benefits reported were an increase in social interaction and the formation of new relationships. These benefits were possibly as a direct outcome of greater feelings of self-worth and self-esteem, factors that impact on individuals' self-confidence and which play a key role in the formation of relationships. Understanding and explaining fully the complex relationship between social benefits and Therapeutic Care is out with the scope of the current study and an area requiring further research.

The other pertinent factor in relation to social benefits was the location of service delivery. Service users can be disabled not only by their health condition but also by imposed social isolation. In many cases Therapeutic Care was delivered in an integrated service centre rather than in individuals' homes. Providing Therapeutic Care within this type of environment offers advantages to certain groups of services users. By bringing together people with similar health conditions, the physical environment also facilitated social interaction.

The location of Therapeutic Care within an integrated service setting was a valuable and complementary part of the support on offer. When it was delivered in care homes it was less likely to be viewed as part of the overall package of care. Thus providing Therapeutic Care in an integrated setting allows effective delivery of quality assured care in a supportive environment, which can be conveniently accessed at the same time as other support services.

The therapeutic relationship between service users and volunteer practitioners was an important part of services users' experience. In most but not all cases, service users saw the same volunteer practitioner for several sessions over an extended period of time. While there was mutual respect between volunteer practitioner and service users, a therapeutic relationship

is not the same as a friendship. This was recognised and acknowledged by the majority of services users. Nonetheless, in any therapeutic encounter people want to be treated with respect, to be listened to and to have a sense of importance in relation to knowing about their own health (Lee-Treweek and Stone 2005). This is possibly one reason why service users valued the personal qualities of volunteer practitioners so highly.

The centrality of the therapeutic relationship is supported by research which claims that the provision of massage therapy is an interpersonal process in which a key component is the nature of the therapeutic relationship (Penson 1998, Lambert and Barley 2001). Establishing a relationship between the volunteer practitioner and service user was paramount and central to the therapeutic encounter. In general, service users thought that Therapeutic Care was an 'excellent service' and the only criticism levelled was about the time-limited availability of it. Many would like to receive the service on a more frequent and on going basis.

A limitation of this study is that because of the small sample size, its findings may not be generalisable to the wider population. However, the results of the present study are similar to those conducted elsewhere which used different methodological approaches and larger samples of participants. The literature for example, provides evidence that massage therapy is an effective and safe therapy (Cambron 2007) for a range of health conditions including Parkinson's disease (Low 2001, Paterson 2005), a range of mental health conditions (Moyer et al 2004, Sharpe et al 2007), and cancer (Fellowes et al 2004, Norton 2007). For patients with cancer, massage is particularly important because many patients find that people are afraid to touch them. Possibly one of the greatest gifts that massage has to offer is acceptance. Acceptance of the body and therefore, of the person, is conveyed via the therapists touch (Penson 1998). Massage has also been cited as being the most appropriate therapy for carers (Penson 1998).

The study has identified a wide range of positive outcomes for service users. Two unanticipated positive outcomes were also identified: namely the promotion of independence and the range of social benefits reported by service users. Although small, this study is valuable because it confirms that the Therapeutic Care service is meeting its aims of promoting the health and wellbeing of people made vulnerable by individual circumstance.

## APPENDIX 1: Topic Guide for Qualitative Interviews

# Service user's views of Therapeutic Care

Date:	
Name:	
Interview venue:	

The following areas should be covered during the interview:

- **Client group and age group**
- **Information and knowledge of TC prior to delivery**  
How did service user hear about the service?  
What had they been told about it beforehand?  
Check understanding of its purpose
- **Referral process**  
Who, what, how and why  
How long did it take from referral to receipt?
- **Delivery of service**  
Experiences  
Description of the service – i.e. what actually happened to them  
Place of delivery (home or elsewhere)  
Number of sessions over what length of time  
What did they like about the service?  
Was there anything they did they not like about the experience?
- **Verbal and non-verbal communication**  
Role of communication related to benefits?  
Would perceived benefits be the same if it was one without the other?
- **Perceived impact on wellbeing (benefits)**  
In what ways did the service help them / or not as case might be  
Physical  
Emotional  
Social
- **Timescale of impacts**  
Were benefits instant, took time to feel?  
Did benefit last, if so, for how long, is it ongoing and lasting?
- **Other service receipt**  
What other services did they receive at the same time and from whom?  
How did these fit with the TC service?
- **Anything else of importance to the person being interviewed**

## APPENDIX 2: Copy of Permission Form

### Consent Form

#### Evaluation of British Red Cross Therapeutic Care Service

##### Agreement to Participate

I, ..... agree to take part in this research project.

I agree to my name and contact details being passed to Joyce Cavaye at The Open University in Scotland in order that she may contact me to discuss my participation.

- I have had the purposes of the research project explained to me.
- I have been informed that I may refuse to participate at any point by simply saying so.
- I have been assured that my confidentiality will be protected as specified in the letter.
- I agree that the information that I provide can be used for research purposes, including publication.
- I understand that if I have any concerns or difficulties I can contact:

**Joyce Cavaye, Senior Lecturer**

The Open University in Scotland  
10 Drumsheugh Gardens  
Edinburgh  
Tel: 0131 549 7904

If I want to talk to someone else about this project, I can contact:

**Peter Syme, Scottish Director** on: 0131 226 3851

I assign the copyright for my contribution to the British Red Cross and The Open University for use in research and publication.

Signed: .....

Date: .....

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