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Journal Item

Does Therapeutic Massage Support Mental Well-Being?

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INTRODUCTION AND BACKGROUND

Massage therapy is defined by Vickers and Zollman (1999) as "the manipulation of the soft tissue of the body to bring about generalised improvements in health". Massage was a traditional medical practice of many ancient cultures including that of the Chinese, Egyptians, Greeks, Hindus, Japanese and Romans. The Greek physician Hippocrates (460-377BC) advocated 'rubbing' and related techniques such as anointing, bathing as a treatment for stiffness. In Western cultures however, the association between massage and medicine gradually diminished as Greco-Roman practices were abandoned (Goldstone 2000). While massage continued to be a folk medicine treatment during the Middle Ages, its use by the common people ensured its separation from scientific and medical milieu. Massage was thus denigrated by the medical establishment (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). Despite resistance from the Swedish medical establishment, Ling gained support from clients and physicians, who adopted his techniques and shared them with likeminded colleagues (Holey and Cook 2003). Massage was considered to be an acceptable medical therapy until the early 20th century when the focus of care moved to biological sciences (Saks 2005).

While therapists have adapted Swedish massage so as to place a greater emphasis on the psychological and spiritual aspects of treatment (Vickers and Zollman 1999), massage continues to be 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, 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 commentary, CAM is defined as any treatment or therapy that is not routinely and universally available to people in the UK via the National Health Service.

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). Traditionally CAM has been practised in and delivered by the private sector. However, a small but increasing number of GPs in the UK, 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).

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.

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.

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 therapist 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 well -being, 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 well-being 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 blood pressure. 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 at 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 at al (1999) sought to evaluate the effects of a therapeutic massage intervention in an acute health care setting. This qualitative study included 113 hospitalised 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 one day. The study supported the value of this hospital-based massage therapy programme and uncovered a range of benefits of massage therapy for hospitalised 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 randomised controlled trials are required. Massage therapy has also been used successfully for other conditions such as eating disorders (Hart et al 2001), migraine (Lawler and Cameron 2006) and non-migraine headaches (Quinn et al 2002).

Massage is claimed to reduce stress and anxiety, insomnia and tension and aid relaxation, by a combination of mechanical, neural, chemical and psychological factors (Cochran-Fritz 1993). However, some commentators contest this by claiming that the basis of positive outcomes is entirely due to therapeutic relationships rather than the effect of any particular therapy (Mitchell and Cormack 1998, Thorlby and Panton 2002, Stone and Katz 2005). 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 specialised 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

Does massage therapy support mental well-being? This commentary has considered studies that used different research methodologies to explore the use and efficacy of massage therapy. It has included RCTs, surveys and qualitative research. Despite the different research methodologies applied, the literature suggests that massage therapy is a relatively safe intervention with no significant adverse effects being reported. It can be perceived as a physical or a psychological therapy. These studies however, do not explain in any great detail the interplay of neural, chemical, psychological or interpersonal factors, variables which would surely impact upon any study whatever the methodology used.

Critics claim that positive outcomes are due solely to the interpersonal nature of therapeutic relationships. Yet despite the fact that massage therapy is a treatment that relies on interpersonal relationships, there is a paucity of research that has tried to explore or measure the kind of psychological interactions that take place between the recipient and provider. Is it possible that massage therapy may produce benefits in multiple ways with specific factors and commonalities each having a role to play, but with each having different meanings for recipients? Or alternatively, is massage effective simply because it is a more accessible form of therapy and one where feeling valued is as important to the client as being 'rubbed'?

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