

Commentary on Riitta Hoffren-Larsson's *From Touching to Supportive Caring: Results from Two Studies on Rosen Method Bodywork*

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Alan Fogel, Ph.D., L.M.T.
 Rosen Method Bodywork Practitioner and Senior Teacher
 Editor Emeritus, *Rosen Method International Journal*
 Salt Lake City, Utah, USA
 fogel.alan@gmail.com
<http://www.alanfogelrosenmethod.abmp.com/>

I had been a co-editor for Riitta Hoffren-Larsson's article on caring in nursing and in Rosen Method Bodywork (RMB), published in the previous issue of this journal. I had never been hospitalized and my direct experience with nursing care was limited to out-patient office tests or inoculations. Riitta's description of Nursing Theory made sense to me, however, from my experience as an RMB practitioner: that caring nurses empower their patients by providing presence and giving appropriate resources but creating space to allow patients to make their own health care choices. Riitta's idea is that caring is also part of successful RMB treatment, a component that is separate from the special quality of Rosen touch. Caring, according to the SUAC Care model she presents, recognizes the integrity of the client and leads to personal self-care and empowerment in both Nursing and RMB. Since the time that Riitta's article was published, I suffered a heart attack followed by open-heart surgery. My reflections on the concept of caring have been deeply affected by my own direct experience and observation.

February 3, 2016: Caring

It's nighttime; how late I don't know but the room is dark, the curtain drawn. Was I sleeping? Something is not right. I can't get enough air. I'm struggling to breathe. I need to slow down. I'm here. I'm in bed. My shoulder on the left side is tensing. Now I feel tension in my left neck, tongue and throat and just now, I feel tightening around my heart. It's not pain exactly but not good either. The chest pain – not pain but what? – terror that I might not be able to control it? -- the chest is hurting somehow and it's becoming harder to breathe.

I know what to do. I look around the bed and find the call button. I press it. I wait. I realize I am in a panic state. I need to slow down again. Look around. The bed, the chair, the curtain covering the door to the hallway to block out the light when people come in to check my vitals or draw blood: it's all where I remember it. My breathing slows a little bit and I think I'm OK, but I am unable to move; my attention stuck on the wish that the out-of-control feeling of suffocation might stop.

After what seems like 5 minutes, probably less, the nurse comes in the room and draws back the curtain. "Everything OK, Alan?" The light, coming from behind her in the hallway, makes it hard for me to see her face.

"Not really. I think I'm having another heart attack." The words come out of my mouth, for sure, but I'm not the one who is speaking, am I? Did I just say 'I'm having another heart attack?'

Judi steps closer, next to my bed, her side and front now visible by the light streaming in through the doorway. Her face is pleasant, relaxed, not old but experienced. I trust her even though I met her only a few hours ago. She's curious and fully attentive when she says, "What are you experiencing?"

"It's like I can't breathe and my chest is tight, just like last night, just before when we called for an ambulance. It's like that, like it must be happening again." I am truly terrified; I can feel myself unsteady now, my voice wobbly. The heart attack last night was real, confirmed by many tests during the day and an angiogram that showed I had four blocked coronary arteries only one of which could be opened partially with a balloon. I would be getting triple bypass surgery in two more days; waiting to give me a chance to rest and recover. They opened that one artery to buy time, I guess, but I don't know now because this can't be another heart attack, can it? I mean, I'm in the hospital. I should be safe.

Now, here is Judi looking at me calmly, "Probably you need some nitroglycerin to help with the chest pain. I'll look at your chart." Without hurry, she walks towards and stands in front of the computer monitor on the wall near the door. She's reading, scrolling, clicking mouse buttons, and not talking to me.

Now I feel the panic coming back, the breathing getting shorter and more labored. I'm fighting with the urge to scream, 'Pay attention to me!' but instead her calmness – she looks briefly at me in a knowing way – helps me to self-regulate, to slow down again and return to my protective tuned-out place where no screams are allowed.

"Alan, they don't have any nitro ordered for you. I'll have to check with the cardiologist on duty tonight and see what he says. Do you need anything right now? Water?"

Water? I'm having another heart attack! Don't leave me, please. What's happening? A deluge of worries floods my mind.

"Could you close the curtain?" was all I could say because the glare of that overhead hall light had suddenly jumped to my number-one worry.

"Sure. I'll be back as soon as I can."

When she leaves, the tears come, and then real fear and loneliness, which helps ease my heart and slow my breath. Something about her complete presence is comforting: she's on my side, she seemed to be saying. She's not worried so I don't need to be. I can wait. People – the nurse, the doctor -- know now. I'm not alone. Here comes the aide with ice water and asks if I can be made more comfortable while I'm waiting: More comfort, more caring from another resource person.

On this night, it takes maybe 45 minutes before I have a tiny nitro tablet melting under my tongue and Judi is staying with me, standing next to me, waiting for me. I look up at her and now I'm a small scared child pleading, "It's not helping, Judi," and as I say this I feel the tears coming back.

"OK, let's wait a few minutes and see what happens. I'll stay here with you and I can give you as many as three pills if you need them. But we have to do one at a time and wait between them," Judi explains. Her voice is soft and clear, her gaze on me is steady and untroubled. I feel her calm, her caring, her support sinking into me like maternal warmth, like reassurance. She walks back to check the computer charts. I can

just be here with wet eyes and allow all the unusual and complicated and scary feelings and sensations. On this night, I take 3 pills before my breath deepens into a sigh of relief, before the worries dissipate, before I fall back to sleep, before the morphine drip is allowed to take me, before Judi closes the curtain and walks out the door.

When I have chest “pains” the next night, I know the process, I am calmer and more able to identify what I am feeling and more able to ask for what I need. By now I am a bit more “grown up,” an ill adult in conversation with a skilled nurse, again Judi. We have a shared history and shared understandings. I trust her and the process and most of all, I trust myself.

Caring conveyed in a genuine manner and perceived by the receiver is deeply useful to the one who is receiving. Because I was allowed to safely feel the serious impairment in my heart and the fear – of death? of pain? – with Judi, I could more clearly make the choice to be wheeled into the operating room the next morning to have my chest opened and arteries grafted to my heart to replace the ones blocked with plaque. I was very aware of and afraid of the post-surgical suffering that would, and with overwhelming force did, arrive when I woke up in the ICU with a breathing tube. Yet somehow, I remained calm.

February 5, 2016: Caring and Touch

Again, I’m waking up. This is not familiar, this sleep, this waking. It’s taking a long time to orient to the room. Oh, I remember being taken into the OR and now: this must be the ICU. I’m greeted by the angelic faces and sweet songs of the nurse and the aide as I am coming out of the anesthesia; not real songs but that’s what I hear in their voices. I am struggling to speak and realize I have a tube in my throat and they try to calm me and ask me questions and I am very confused and very frightened that I could choke and that I cannot speak. And my family is there and soon, they take out the tube, and it’s painful and a huge relief and...that’s all I remember.

Now I’m waking up again, or whatever this is, not the same as waking up from the anesthesia and not the same as waking up after a nap or a night’s sleep. There’s pain and achiness in my chest but I can hardly feel anything else about my body. I’m disconnected from it and yet somehow I know I am in this room, that this is me, Alan, I’m alone. No wait, there is a young man in the corner by a computer monitor who is looking at me and not saying anything.

I realize I’m awake and I feel OK and the breathing tube is gone and I’m fine and I survived and I’m alive and all of this takes a long time as I watch the man – young, medium height, sandy colored hair with a part on one side and the other brushed high above his forehead -- stand up and come over to my bed. He puts a reassuring hand on my shoulder and says, “Hi, Alan. I’m Trevor and I’m your nurse. I’ll be here with you the rest of the time you are in ICU, which won’t be too much longer. You’ve been cleared to go back to the cardiac unit, where you’ll have a much nicer room.”

I nod and watch his hair move, his smile, but I’m not completely following what is being said. “It won’t be too much longer and I don’t have to stay here?” a frail voice coming out of me manages to say.

“Your vitals look good, your breathing and your lungs are clear, your heart is doing well, there’s no need to keep you here much longer. We just have to do a few things and wait until your new room is ready for you. I’ve got your meds ready for you to take.” Tears come again: a relief knowing that I’m well-enough to stay only one day in ICU. The verbal communication of caring and his initial touch that embodies genuine respect

and concern provide me with reassurance. I am not alone in this situation and I have both physical and verbal cues to allow me to identify that this other person is my caregiver in this environment and is caring for me.

Trevor watches while I take the pills, explaining each one to me but I can't track the details. Trevor tells me that he needs to put another IV port in my left arm, just in case there might be a problem with the one already in my right arm (How did that get there? And the drainage tubes coming out of my chest? And the urinary catheter?). It seems that installing the new IV port isn't a choice, unless I want to risk a failed IV which I don't, but his way of asking is more like an invitation to something that's good for me. It's something we can do together and it will help prepare me to move out of the ICU. I like Trevor but yes, yes, I do want to move out of the ICU.

Sitting comfortably next to my bed, he holds my arm securely and tenderly with one hand and works with the other. The caring quality of his touch, his body language and expression provide support directly to my body and nervous system. I feel close to him and safe with him and free of worry or concern. The procedure takes a long time, or maybe not, but that's what my mind on narcotics experiences. Trevor's touch is very Rosen-like, gentle and assured, being a container for the discomfort of the procedure but at the same time allowing me to feel as much as I can or want to. I recognize that he's not trying to make it better for me. I get that. It is something we have to do together and it's uncomfortable and it takes a long time because he has trouble finding a good vein. But I am fine, and I can handle this, and I'm going to be leaving soon, and I'm still alive, my heart and lungs are good, and I'm going to recover.

Care-Receiving and Care-Giving

The caring from the practitioner supports the client further to achieve new learning and self-awareness that strengthens the client's self-relation and makes it easier to make more appropriate self-assessments. Moreover, the support encourages the client to progress and to independently change the circumstances that threaten her or his health or wellbeing (Hoffren-Larsson, 2015, p. 19).

Being met in this way, in the unknown territory of a health crisis, in altered and child-like states of consciousness, is not unlike my experiences as a client in RMB. As RMB clients, we allow ourselves to open to the unconscious and the unknown with the guidance of a trained and trusted practitioner. It is in these vulnerable states of human experience that we most need caring to navigate the intensity of what is happening inside. In an acute health care situation, as in RMB, the client has a choice to *surrender to the possibility of being cared for*. This is made easier when the provider of care is self-aware of his or her own boundaries and abilities and creates a sense of *respect for the human integrity of the client, especially in states of relative disorganization and disorientation*.

In the 8 days I was in the hospital, I was assigned to perhaps 15 different nurses, only one of which I would describe as uncaring. That is similar to the ratio of caring to uncaring RMB practitioners that Hoffren-Larsson found in her Study 2. Although neither her sample nor mine is representative, the concurrence suggests that training and experience in these professions creates practitioners who have the skills needed for the work and the boundaries required for allowing them to truly care for their clients.

When I was a trainee in RMB, it was difficult to distinguish **caring for** from **taking care of**. Taking care of someone meant that I needed to help the person solve their problem and make it better for the person.

Taking care of someone created for me a high level of stress, a performance anxiety related to being good enough to meet someone's needs.

As I grew into RMB and became a practitioner, I realized that **caring for** someone meant to be present and to listen. I developed a boundary that allowed me to refrain from imposing on clients my own needs to help them. With this, I could better hold a safe container for clients in which they could simply feel themselves and make their own choices for what was needed. This letting go of **taking care of** clients, curiously, led to the emergence of genuine **caring for**: a loving feeling toward clients (a feeling that Marion often mentioned) that was more fulfilling and less effortful. This **caring for** gave clients space to feel both good and bad, success and failure, joy and pain.

I don't remember an explicit teaching about **caring for** clients, neither in my own training nor when I have taught intensive training classes. But it is certainly a possibility to bring this theme more explicitly into the RMB training curriculum. Reflecting on the how we are communicating care can be a very useful learning process for RMB students, interns and practitioners.