Caretaking, a hidden addition in bodywork (Part I)

By Jack Blackburn

Would you like to experience less stress and be more effective in your work with clients? Would you like to feel more balance between your practice and your personal life? As an entrepreneur would you like to be more prosperous and less conflicted about charging for your services?

I believe that confusion over two roles – caretaker and caregiver – is a major cause of the difficulties that occur in our practices. My observations derive from giving and receiving hundreds of hours of group and individual supervision, from in-depth assessment of my own issues in psychotherapy, from thousands of sessions with my clients, and from continuing education classes I've taught in which issues of caretaking vs. caregiving became prolonged discussions. When we caretake we assume responsibility for our clients' healing. When we caregive we support clients in assuming responsibility for their own healing.

In all helping professions it is necessary to discern whose needs are being met; the practitioner or the client… this is a major reason for supervision. At the deepest level the issue is over who controls the healing process, the client or the practitioner, and for how long? Difficulties arise when we inappropriately assume a parental or caretaking role with our clients. This strategy of treatment usually applies more to medical and psychological intervention than to bodywork. These professionals become authority figures, with parental and legal responsibilities, for the client/patient's progress… playing a directive role that offsets the client's state of helplessness and feelings of inadequacy. The question is whether that directive role is appropriate to the situation.

What is Caretaking? Caretaking is taking over treatment or care of a person, who cannot provide (take over) care of himself. In bodywork caretaking can be temporarily very helpful for the client in distress. Practitioners at times may assume a caretaking role when clients are experiencing physical, mental or emotionally instability and do not feel up to making their own choices. As caretaker the practitioner takes on the responsibility for the choices, goals and outcome of treatment. Caretaking is inappropriate when it derives from the practitioner's need to be needed…to foster client dependency.

What is Caregiving? Caregiving is giving care, aid, help, assistance, treatment, attention, to a client. There is no obligation on the part of the caregiver to produce certain results. Our chief obligation is to be as present to our clients and the therapeutic process as possible. The receiver of care remains fully responsible for his/her own care process, including the choice of practitioner and goals of care.

Here is a partial list of what I consider to be the origins of unwarranted caretaking as it shows up in our lives and practices:

- **The narcissistic parent**. The child learns that the more he/she focuses on the parent's needs, desires, fears, and illnesses, the more he/she is appreciated by the parent. When the practitioner gets a narcissistic client, he lets the clients control the limits of the therapy.

**Example 1*

Janet, a practitioner who was raised by a narcissistic and histrionic mother, has had difficulty maintaining time constraints with certain needy clients. "They are in so much pain, and I seem to be the only one who can help them." She gives extra time to these clients without charging. She has permitted these clients to call her at home on her own time. She cannot let go of certain clients... she continually worries about them and feels guilty for not doing enough to help them

- **Parenting our parents**. Many of us, starting very young, took care of our emotionally distraught or addictive parents. We tend to do the same with our clients.

•**Good boys and good girls**. We learn to fulfill the expectations of adults in order to assure positive outcomes. The same strategy shows up as we try to meet the client's expectations. A litmus test is to notice if we feel guilty for not satisfying our clients.

•**Emotional, physical, and sexual abuse in childhood**. Creates a protective sensitivity to the needs of the abuser. The child learns that "If I can fulfill the needs of the abuser I will stay safe." As a caretaking adult she continues her role.

•**Assumed guilt for losses or hurts in our past**. This could include deaths or severe illnesses of loved ones and pets. We substituted guilt for the pain and helplessness of not knowing what to do… we ease our guilt by caretaking our clients.

**Example 2*

Frank, is a practitioner who has taken workshop after workshop in treatment modalities. He has learned to focus only upon symptoms as he works. He has difficulties with boundaries with female clients. He denies his sexual interests and suggestive language. He considers his practice a way of helping others rather than making a living. He has experienced many losses including the death of his father and his subsequent promotion to man-of-the-house just as he was entering puberty. He is often angry and depressed and has low self-esteem. He has never worked on these issues in therapy.

•**Inappropriate non-sexual intimacy**. Having played the role of confidant to a parent or mentor in childhood can lead the practitioner to unconsciously play a solicitous caretaking role in relationships where the client has more power. This scenario occurs when the client is perceived as having higher status due to income, gender, or profession.

•**The devoted, self-sacrificing parent**. This parent subsumes his/her own wants and needs and prepares the child to assume the same role as an adult. The practitioner overlooks his/her own symptoms and puts his/her own growth on hold while focusing upon the symptoms/growth of clients.

. •**Authoritarian parent and seductive child**. The child has attained passive control over his/her life by manipulating/seducing the controlling parent. The caretaking practitioner is valued for pleasing/pleasuring and holding out a seductive promise of favoritism to the controlling client.

•**Caretaker role models**. The bodywork community is replete with caretaking professionals whose entire identity and reputation is derived from their ability to "fix" their clients' symptoms. We try to emulate them in our own practice.

**Example 3*

Dr. Brown, a teacher/mentor of bodywork for many years, was considered a genius in bringing through a new technique for relieving patients of their pain and restrictive movement patterns. She focused solely on eliminating these negative patterns in her patients. Her whole life and personal identity revolved around her work. She rarely received any kind of personal care for her own body... and then only from her own protégés. As old age and ill health overtook her vigor she became increasingly sardonic, recalcitrant and isolated.

•**Treatment of physical symptoms only**. We are exposed to an ever-growing number of modalities that emphasize the treatment of physical symptoms rather than involving the client in the dynamics of his/her own healing. In this sense even most professional licensing programs are geared towards caretaking.

•**Giving to get**. I give or sacrifice in order to merit some kind of payback. In caretaking there is a fear of clearly stating and negotiating expectations. Many of us were encouraged to live up to the principle; "it is better to give than to receive". We designed our whole lives around giving and sacrifice because we wanted to be better people. A hidden motivation behind this giving is the implied system of rewards. In caretaking there is a sense of leveraged control because the recipient of my sacrifice owes me – even though that is never clearly stated. When their unexpressed needs are not met, caretakers feel hurt and unappreciated.

•**Empty nest syndrome**. As soon as our own children start to leave home we become tempted to continue our parenting roles in other relationships.

Caretaking can be seen as a shadow side of our profession, a hidden addiction to control, parenting or fixing that is hard to acknowledge and difficult to correct. Caretaking is a major reason that bodyworkers burn out from physical and emotional depletion. A caretaking relationship produces less personal growth for the therapist and client. Sustained caretaking produces an emotional charge (e.g. parent/child co-dependency) that becomes a hindrance to giving care. The relationship roles of client-as-victim and practitioner-as-rescuer become the focus of the therapy rather than the goals of change and maturation. Unconscious caretaking can be a reason that practitioners feel conflicted about establishing and maintaining a practice; how can they charge for the role they're playing when it is already fulfilling their need to parent?" Overly sensitive caretakers often take on the client's symptoms. Like some shamanic practitioners, the caretaker puts herself in the role of fighting the client's battles. This approach is self-deceiving to the practitioner and disempowering to the client. The caretaker over-emphasizes her own importance, underrates the skills of her peers, and the strengths of her clients. Hidden beneath the therapy lies a secret agreement – by taking care of you, I take care of myself. Over time the addicted caretaker becomes isolated and despondent because caretaking does not produce the results sought... staying safe and in control by "fixing" others.

The issue of caretaking is not black and white. All of the above situations create mixed feelings of awkwardness and dissatisfaction and energy depletion for the caretaking practitioner. We do not consciously set out to repeat our childhood patterns with our clients and when we discover that we are, it is an opportunity for self-healing. Coming to terms with caretaking our clients is a process we all go through in maturing our profession and ourselves. What is most helpful is to become aware of these patterns and to consciously walk the delicate path between caregiving and caretaking. There are times, such as the processing of heavy grief, when clients need to be taken care of but it should not be to satisfy the needs of the practitioner. The practitioner needs to have the flexibility to shift in and out of caretaking. It can be an appropriate therapy strategy but it must not become a permanent role.

The next article will discuss the symptoms and addictive aspects of caretaking.
**The examples have been fictionalized to protect the privacy of the individuals. But the material is derived from real practitioners' lives.*