PROVIDING NEWS AND INFORMATION TO MASSAGE THERAPY PROFESSIONALS IN NEW ZEALAND

MNZ MAGAZINE

massage new zealand

ISSUE 1 2020

Valuing Diversity

UNDERSTANDING GENDER DIVERSITY - WORKING WITH INTERSEX CLIENTS • VIEWPOINT: CULTURAL SAFETY AND MASSAGE THERAPY • MANGERE REFUGEE RESETTLEMENT CENTRE AND MASSAGE THERAPY FOR REFUGEES • CHILDREN PROSPER THROUGH LOVE AND EMPATHY IS UNCONSCIOUS BIAS IMPACTING YOUR BUSINESS? • CASE REPORT WINNER 2019 • INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH (ICF) • HDC CODE OF RIGHTS • BETTER HEALTH FOR PEOPLE WITH DISABILITIES • MASSAGE IN SOUTH EAST ASIA

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MNZ MAGAZINE
ISSUE 1 2020

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REGULAR

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EDITORIAL ISSUE 1 2020

What does Diversity mean to you? At its' core, it is about valuing difference and treating all people, regardless of their beliefs, values, culture and lifestyle, with respect. Within the healthcare sector, it is about ensuring that everyone has access to services and is provided with the best care possible, and equally important, that people of all genders, ethnicities, ages, backgrounds and beliefs are equally represented in our workforces and decision-making. The challenges facing our world, and indeed our country as we reflect on the events that took place in Christchurch last March, are increasingly requiring that as members of communities, as health professionals, business owners, educators and leaders, that we expand our world views to appreciate and respect others.

In this issue of MNZ Magazine, we are thrilled to present an issue filled with a range of articles discussing diversity and sharing stories about this topic. We begin with an insightful interview with Mani Mitchell - intersex campaigner, human rights activist, educator and counsellor, as they discuss working with intersex clients. GP and senior lecturer Dr Ben Gray discusses cultural safety and shares his viewpoint on the relevance for massage therapists. It provides our organisation with some food for thought on developing a policy around this for members. MNZ life member and educator, Barry Vautier writes about his work with refugees at the Mangere Refugee Resettlement Centre, a fascinating read. Founder of the Child Connection Trust, Eva Scherer writes about the child peer massage programme she pioneered in New Zealand and which teaches school children about nurturing touch within the supervised classroom setting.

Dr Guillermo Merelo from Diversity Works looks at unconscious bias and how it may affect the way you work with clients and colleagues. We look at the World Health Organisation's International Classification of Functioning, Disability and Health (ICF) and note how it may be a useful framework for massage therapists. Wellington MNZ RMT member Grant Jones shares his experiences, observations and reflections about massage therapy from his many travels in South East Asia.

We are also very pleased to be able to publish the gold winning case report from the MNZ 2019 Case Report Contest. After winning the bronze award in 2018, Hayley Ward has outdone herself with her well-deserved win. Take a look at her excellently constructed case report which highly impressed the judging panel.

Our regular features – useful sites and online resources, book reviews and research update all explore the theme of diversity and present readers with some excellent information. You also hear from our President, Clint Knox, our Administration Team, Nici Stirrup and Esther Shimmon, and we are introduced to new Education Officer Doug Maynard, who replaces Rosie Greene.

Plenty to read and digest in this diverse issue!

We wish all of you health, safety, healthy clients and practices over this difficult and changeable period.

Carol and Odette

ARTICLE SUBMISSION AND ADVERTISING SPECIFICATIONS

SUBMISSION DEADLINES

The MNZ Magazine will be published:

Issue 2 2020 – 1st August (deadline 1st June)
Issue 3 2020 – 1st December (deadline 1st October)
Issue 1 2021 – 1st April (deadline 1st Feb)

Note: Dates may be changed or delayed as deemed necessary by editors.

The MNZ Magazine link will be emailed to all members and placed in the members only area on the website.

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ARTICLE SUBMISSION GUIDELINES

The following outlines requirements for submitting articles, original research and case reports. We also consider opinion pieces, reviews and other types of articles, providing that they do not contradict MNZ policies and processes.

Please contact the co-editors to discuss your submission prior to sending in.

- **Word count - Max 1800 words include references**
- **Font - Arial size 12**
- **Pictures - Maximum 4 photos per article, send photo originals separate from article (do not provide images embedded in Word document), each photo must be at least 500k**
- **Please use one tab to set indents and avoid using double spacing after fullstops. The magazine team will take care of all formatting**
- **We prefer APA referencing (see http://owll.massey.ac.nz/referencing/apa-interactive.php)**

Co-editors – Carol Wilson, Odette Wood

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PRESIDENT'S REPORT

Welcome to the first 2020 issue of MNZ Magazine! Hopefully everyone has taken time to recover from the challenges of 2019 and enjoyed summer in some shape or form.

The executive committee has had a break of sorts through the month of January and are now well and truly back to dealing with the many aspects of MNZ to transition us from a reactive process to being proactive and guiding massage into the future. This will require focused time and energy on challenges and tasks that deliver positive outcomes for us all as massage therapists and for the profession as we head towards some form of professional regulation.

Prior to Christmas 2019, the executive came together for a face to face strategic planning meeting, to discuss all the potential areas for growth/improvement and to identify where to start. This meeting was a great opportunity to come together, as usually all committee meetings take place via skype/zoom or some form of technology, due to geographical placement of the executive team.

The topics discussed covered all committee members respective areas and the overall MNZ function. This is very much still a work in progress and can be modified along the way but forms a guideline of what we hope to achieve as a profession and some timing around it all. Currently our executive team have identified 2020's goals to be achieved and have a greater list lined up for 2021, which will also be worked on as time permits and 2020 tasks are achieved. 2020 tasks of priority are: Hui, Communication, Education, Insurance, Relationships.

The Hui project has been simmering away with much time and effort from our Allied Health Aotearoa New Zealand (AHANZ) rep and volunteers, to provide professional representation of MNZ in this type of format, aligned to a conference time delivery. This is a massive undertaking and is providing many challenges and learnings, due to the nature of it being a first for the massage profession in NZ and wanting to represent our work as professional as possible, to align with current recognised mainstream health professions and regulation. Check out the Hui update for the latest progress.

Communication is the largest part of what we do, whether with clients, members or committee members. Due to the constant change of committee members and copious challenges of learning new roles and dealing with "pop up" issues, process can be lost. We are engaging in more transparent and inclusive communication processes so that tasks and information are not isolated to one or two committee members. There is a massive amount of information to be aware of and so to serve MNZ well, we (the executive committee) need to work together well. Additionally, we plan to communicate more effectively with members (MNZ), educators, stakeholders and the public, creating greater relationships and awareness of who MNZ is, our level of professionalism and what we do. This is no small task but one that needs to be tended to now and constantly going forward.

Currently education is an area that takes up a lot of the MNZ education officer's time. New member applications come with a range of prior learning and qualifications to be deciphered. This requires many hours of multiple people's time and is not efficient nor a good use of this MNZ position. We will be looking at historical and current methods with the intention of streamlining this process and having our MNZ education officer interacting/building relationships with our educators, students and stakeholders rather than getting lost in a cloud of chaos.

The insurance topic is one that has been driven by our passionate members and seems like a relatively easy short-term win for all of us. In line with current Southern Cross policy of using MNZ registered members (level 6 minimum) for any massage policy they have, we are hoping to align with some further health insurers in a similar manner. This will provide further recognition of our skills and professionalism along with potential further revenue for our level 6-7 registered members. Watch this space for progress!

Even though relationships seems like the last cab off the rank, it is the topic that underpins all before it. This topic requires no description but does require our full attention, we will be constantly working on relationships.

The tasks identified above don't appear too complex but it is timely to remember that the executive team are volunteers and the normal calendar activities that keep an organisation functioning (before listing these tasks), is relatively full. Time is always precious as committee members are also working to support ourselves, in our massage profession. Once again, we are always open to having assistance on projects, if you have some time to spare and passion to help. Thank you to those who have already volunteered, feel free to remind us if we haven't given you a task yet.

This year we thank Rosie Greene for everything she has done for MNZ to get us where we are, along with all past and present executive committee members. Rosie has stepped away from the committee as new challenges arise in her own business direction and has only done so as she feels confident in where MNZ is right now AND in our new Education Officer.

Please welcome Doug Maynard to the role of Education Officer and check out a bit more about Doug in his profile. As with any role change, it takes time to get up to speed with how things work and the entirety of the role. Doug has been tasked with bringing his experience and style to the team, to help progress us into the future.

This year feels like it's in full swing already and is going to fly by. Please let's remember to take time to look after ourselves and keep fuelling the passion that allows us to help others.

Enjoy another great magazine put together by Carol, Odette and team :)

Your massaging President,

Clint

ADMIN REPORT

Hello MNZ members and welcome to Issue 1 of 2020. We hope you enjoyed the summer season and all the extra hours of sunlight and activity it brought us.

It was fantastic to meet up with the entire MNZ executive committee in Auckland at the end of last year for our strategic planning meeting. This gave us a valuable opportunity to put our heads together, streamline and prioritise goals for now and the future at MNZ. Some of the key words of the day were identity, professionalism, consistency and communication. We highlighted the need to build on and improve MNZ policies and processes to create more reliable and cohesive lines of communication and information sharing within the executive team and with staff and members. We will do our best to develop these goals and projects whilst keeping the background cogs turning throughout the year.

The 2019 MNZ Case Report Contest results came in at the beginning of the year. It was again a great experience to work with the judges and pleasing to see an increase in entries. Congratulations to Hayley Ward for receiving the BizCover Gold Award. Members, we hope you enjoy reading Hayley's case report in this issue and take inspiration and encouragement from it for entering the 2020 contest. We are expecting to see Hayley presenting her gold standard case report at the MNZ Conference in New Plymouth, another great reason to save the date, 18 – 20th September! The MNZ Annual General Meeting is due to take place on Saturday 19th September during conference, so we look forward to seeing you there.

We are now underway with the membership renewal process, so we are very busy getting all the new memberships set up. By now you

should have received an invoice for your renewal. Once this is paid, we are notified and can complete the renewal set-up. As usual, you will receive an email with your certificate attached. We will also send you a hard copy of the certificate along with our Code of Ethics for display with your certificate. This is an incredibly busy time so please bear with us.

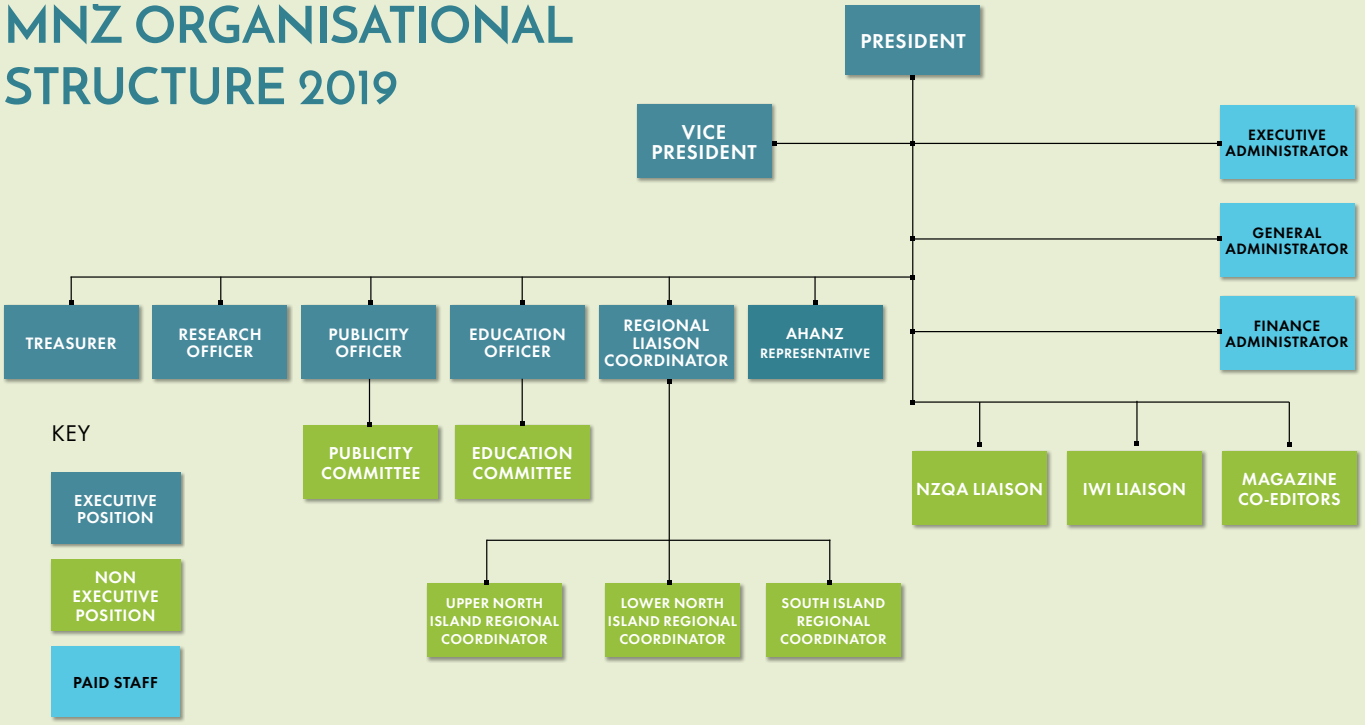
Please be reminded that we rely on you to update your First Aid certification and to log your CPD hours. It is a huge job to chase these up, so we appreciate you keeping these up to date.

If you have any questions about membership, invoicing and CPD please contact Esther to discuss. For other general admin and/or executive enquiries, feel free to contact Nici.

Easter break is just around the corner. We hope you all have an enjoyable and restful time with family and friends.

Nici Stirrup (Executive Administrator) &
Esther Shimmin (General Administrator)

MNZ ORGANISATIONAL STRUCTURE 2019



MEMBERSHIP UPDATE

As of late February 2020 we had a total of 547 members, made up of 419 RMTs, 106 students and 22 Affiliates. Last year in the same period (Feb) our figures were 407 RMTs, 108 student MTs, 21 Affiliates, giving a total of 536.

Comparing figures with 2017 and 2018, MNZ has seen an increase in membership numbers from 377 in February 2017, to 490 in the same period for 2018. The February 2020 figure shows an overall increase of 170 members. The biggest increases have been in student and affiliate members, with student membership increasing by 100% (from 53 in 2017 to 106 in 2020) and affiliate membership increasing by 70% (from 13 in 2017 to 22 in 2020). RMT membership has increased by 32%. The graph shows the recorded numbers from 2017 to 2020, for February, June and October. The dip in numbers in June each year is related to the delay in members renewing. We remind members that it is very important to get your membership renewal done when it is due, rather than waiting until later in the year.

The renewal period is now underway and we look forward to see the resulting figures. We are also looking forward to recent student members taking advantage of our graduate fee to upgrade to RMT membership. To upgrade to an RMT you will need to email your diploma or degree certificate and current first aid certificate to membership@massagenewzealand.org.nz

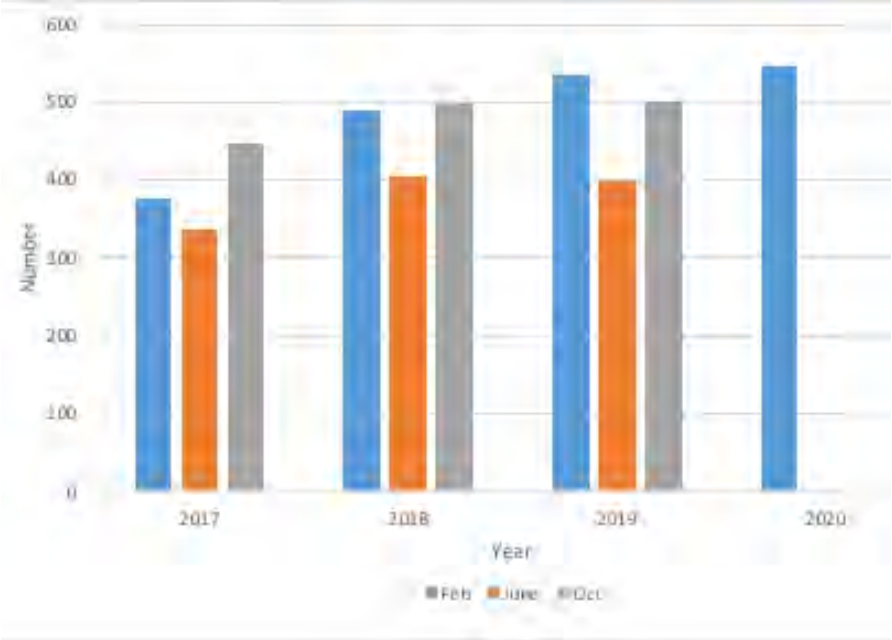


Figure 1 MNZ Membership Figures 2017-2020

We look forward to receiving new student members now that the academic year is underway. If you are a student please encourage your fellow students to become MNZ members too. It's a no brainer really, a free membership with many benefits.

Keep getting the word out there to other non-member Massage Therapists, encourage them to come along to local MNZ Massage Group meetings and let's get them to sign up to Massage New Zealand too. The greater our numbers, the greater our voice, and the more that the organisation can achieve.

HUI ANNOUNCEMENT TO MNZ MEMBERSHIP

Dear membership

The Massage New Zealand (MNZ) Executive Committee advise that the proposed Hui will not be presented in September 2020.

Key issues involved in this decision include the proposed date is 3 days after the next NZ Government Election and the amount of time to prepare a Hui, compromised. Instead the Executive is focusing on developing networks for potential MNZ members, and gathering information that will eventually provide context for the Hui. The Hui website will be removed, to save ongoing financial expenses. For future projects, additional assistance is still required, so please come forward if you are concerned about shaping the profession.

For more information, please contact Iselde: ahanzrep@massagenewzealand.org.nz

Aotearoa New Zealand MASSAGE HUI

INTRODUCTION
DOUG MAYNARD – EDUCATION OFFICER

Having been in the massage therapy profession, and a proud member of MNZ for 20 years, I felt now was the right time for me to give something back.

I have known many colleagues over the years who have been involved with MNZ at every level of our superb organisation. I have had many discussions regarding the future of our profession and how MNZ works tirelessly to provide us all with security, support and positivity.

Observing the movements within MNZ through 2019, it became apparent to me to put my hand up to support MNZ from within the organisation rather than on the fringes. Looking at the positions available it was obvious to me that the education aspect suited my experience - 17 years as a lecturer at NZCM (Auckland campus) delivering aspects at all diploma levels with the last 15 years being a senior lecturer for Level 6 and 7 in the Clinical Therapeutics module, and currently lecturing level 6 Diploma in Remedial Massage at Wintec, on the NMT component of the Clinical Therapeutics module.

At the MNZ AGM 2019 I volunteered to assist the Education Sub-Committee to help spread the workload and offer my knowledge, experience and passion to help progress MNZ and our professional profile within the health sector in New Zealand and internationally. Shortly after joining the Sub-Committee, attending meetings and being involved in MNZ education related correspondence, with the Education Officer & Sub-Committee members, an opportunity arose where I was offered the position of Education Officer on the Executive Committee – an offer I couldn't refuse and am incredibly honoured and proud to have been considered.

The direction MNZ is heading in is incredibly exciting and promising for our massage therapy profession. Currently, myself and the Sub-Committee are involved in continuing to streamline the Recognition of Prior Learning (RPL) process that has been superbly handled by my predecessor Rosie Greene.

I will endeavour to build on this process to protect and re-iterate MNZ's policy on allowing therapists from overseas and/or other qualified modalities to be offered registration as a massage therapist in NZ. As an RMT in NZ, we offer an incredibly high level of professionalism, knowledge and expertise, and it is a privilege to do what we do to help others. Part of this process requires continuing to build sound professional relationships with all our educational providers offering the highest standards of massage therapy education in NZ and recognised as such internationally. Along with continuing to build a healthy, professional and mutually respectful relationship with NZQA.

I will do the best I can to work alongside the remarkable, talented and incredibly experienced and passionate Executive Committee and Admin Team at MNZ to represent and support you all in promoting, protecting and securing a promising and successful future for massage therapy in NZ.

Doug Maynard

SPIRONICS

A highly effective method to realign the fascia, muscles and joints via the spiralling tendency of the body.

Everyone has a dominant spiral pattern in the body which relates to all the structures and systems of the body. The trouble is that stress, emotional tendencies, and particularly postural habits, exaggerate that pattern. This in turn creates muscle tightness and laxity, joint immobility and fascial imbalance.

SPIRONICS teaches you how to recognise which is the dominant spiral and how to balance it, using PNF, Positional release, Kinesiology and a unique non-manipulative joint mobilisation system.

There is a basic and advanced course which is over 2 weekends. The technique can be easily added to your existing massage techniques and is a highly effective means in itself to eliminate joint and muscular structural pain.

Ross Keen, the founder of **SPIRONICS** holds Diplomas in Osteopathy, Naturopathy, NST & Kinesiotaping, and is registered as a professional Kinesiologist. Ross has been teaching **SPIRONICS** for 20 years.

PRE-REQUISITE FOR ATTENDANCE:
Level 6 Diploma in Massage Therapy.

The next basic course will be on 9th & 10th May 2020 in Swanson, Auckland. Cost is $390, or $350 early bird. Early bird price expires on 19th April. Books will be supplied.

For more details, contact Ross Keen
rosskeen@gmail.com

WHAT'S ON...

EVENT	WHAT/WHEN/WHERE/HOW TO REGISTER
Northland MNZ Networking Sambur, 11 Maraenui Drive, Kerikeri	Tue 21st April **Contact**: Sam Burger bewell@sambur.co.nz
Coromandel MNZ Networking	Are you keen to see networking meetings in your region? Volunteer and become involved! **Contact**: Kristin Carmichael upperNIrep@massagenewzealand.org.nz
Whakatane MNZ Networking	Are you keen to see networking meetings in your region? Volunteer and become involved! **Contact**: Kristin Carmichael upperNIrep@massagenewzealand.org.nz
Northshore MNZ Networking Kawai, Purapura	Monday 18th May - speaker to be confirmed **Contact**: Kristin Carmichael upperNIrep@massagenewzealand.org.nz
Auckland MNZ Networking NZCM Auckland, Greenlane	Tue 7th April, 7pm **Guest Speaker** - Pip Lodge, Fertility Massage Therapist Tuesday 16 June with Maria Monet-Facoory presenting on "Singing for Self-Care, Wellbeing & Joy" Tuesday 18 August with James Stichbury presenting on "Craniosacral Therapy" **Contact**: Jeannie Douglas jeannie@biodynamicmassage.nz
Hamilton & Surrounds MNZ Networking The Cancer Society's Lions Lodge, Hamilton	Tue 21st April, 7pm Wed 24th June, 7pm Mon 24th August, 7pm Thu 22nd October, 7pm Mon 7th December, 7pm **Contact**: Annika Leadley regional.liaison@massagenewzealand.org.nz
Tauranga MNZ Networking	Are you keen to see networking meetings in your region? Volunteer and become involved! **Contact**: Kristin Carmichael upperNIrep@massagenewzealand.org.nz
Napier/Hastings MNZ Networking Lotus Centre	Wed 22nd April, 6.30pm **Contact**: Janita Dubrey lowernirep@massagenewzealand.org.nz
Wellington MNZ Networking NZCM Wellington, Level 1, Railway Station	Thurs 7th May, 6pm **Guest Speaker** - Mark Gray **Contact**: Ali ali@bodyofwork.co.nz or Allison allison@bodyofwork.co.nz
Kapiti MNZ Networking	**Contact**: Trevor Hamilton fbodyworks@gmail.com
Blenheim/Nelson environs MNZ Massage Group	Are you keen to see networking meetings in your region? Volunteer and become involved! **Contact**: Annika Leadley regional.liaison@massagenewzealand.org.nz
Christchurch MNZ Massage Group	Are you keen to see networking meetings in your region? Volunteer and become involved! **Contact**: Annika Leadley regional.liaison@massagenewzealand.org.nz
Dunedin MNZ Massage Group	Are you keen to see networking meetings in your region? Volunteer and become involved! **Contact**: Annika Leadley regional.liaison@massagenewzealand.org.nz

Dont forget to like the facebook pages of your area and MNZ also – to keep up to date

UNDERSTANDING GENDER DIVERSITY – WORKING WITH INTERSEX CLIENTS

An interview with Mani Mitchell
By Odette Wood

ABOUT MANI

My name in Mani Bruce Mitchell, I have lived a complex and now satisfying life. If you're interested in learning more about me and my life journey the New Zealand Listener did a great article a few years back, which you can find online (refer to Useful Resources section further down).

It has been a life where I come to value and appreciate the wisdom and gentleness of the healing profession, especially those with knowledge of complex trauma.

COULD YOU EXPLAIN WHAT INTERSEX MEANS

Intersex people are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies.

Intersex is an umbrella term used to describe a wide range of natural bodily variations. In some cases, intersex traits are visible at birth while in others, they are not apparent until puberty. Some chromosomal intersex variations may not be physically apparent at all. According to experts, between 0.05% and 1.7% of the population is born with intersex traits (UN, n.d.).

HOW MANY PEOPLE IN NEW ZEALAND ARE INTERSEX?

The truth is we don't really know. We do not keep statistics on this group of citizens, and there is no reason to believe that New Zealand Aotearoa would be any different from other countries so it would be 1.7% of the population. Intersex has been and remains a shame issue that people struggle to talk about. The majority of people who are intersex are not open about the fact.

Mani at the family farm aged 7

HOW ARE PEOPLE BORN INTERSEX CURRENTLY TREATED MEDICALLY?

This is difficult. We have a medical model and concepts that are locked in the binary model of gender, a model that still believes people will suffer psychological damage if they have bodies that are/look different. It is a model that is rooted in 1960s ways of thinking about gender, sexual orientation and what 'normal' is. In the past, babies (intersex issues are identified at varies life stages) were typically given medical work ups, a gender was assigned, and then surgery was carried out to make the child look more 'normal'. For the last 25 years the intersex community has pushed back on this model. Identifying as damaging and deeply traumatizing, instead we have been asking for an all of life model that supports us to be healthy and well. A model that allows for surgery that is only for the purpose of saving life. That delays all other surgery, recognizes bodily autonomy and the person who owns the body is the one who should have agency over what happens to it. A model that supports parents and whanau in a psycho-social model, supports parents to engage with their children in age appropriate ways. So the child is informed and feels comfortable in the body and their own efficacy. A model that understands gender identity is a process that often does not have an answer or a 'shape' until the child emerges from puberty.

HOW DOES BEING INTERSEX AFFECT PEOPLE?

This is a complex issue and there is no 'one' way of how being intersex impacts on us. Many of us live with the impact of trauma that was the result of invasive medical practice that was not trauma-informed, and parents who simply did not have the confidence or the skills to engage with us in a health-centred way. So many of us live with the complications of these complex

realities. (Intrusive painful examinations, medical photographs (naked) – used as medical teaching 'objects', told lies, awkward silences.) Then we have all the actual variations of sex characteristics (there are over 40) and each of those has its own unique challenges and realities – some minor and some not so.

Many of us struggle to find, safe, gentle, informed practitioners who can help us understand our variation and how to live well with the variation. The internet has made such a huge difference with many of us finding information and support from peers around the world with similar variations.

INTERSEX PEOPLE ARE INCLUDED WITHIN THE LGBTQIA UMBRELLA. HOW DOES IT FIT THERE GIVEN THAT IT RELATES MORE TO PHYSIOLOGY?

Some of us are also queer and/or trans, as well as being intersex. However ALL of us have been impacted by the negative stereotypes that still 'infect' the thinking in many parts of medicine. We do 'belong' in the rainbow – but it is an historically uneasy 'partnership' with many people not understanding intersex issues and not understanding that intersex is separate and different to sexuality and gender identity issues.

WHAT HEALTH AND WELLBEING ISSUES SHOULD MASSAGE THERAPISTS BE AWARE OF WHEN WORKING WITH CLIENTS WHO ARE INTERSEX?

I think firstly it is important for massage therapists to understand the huge diversity in this community. Working from a trauma-informed practice model would keep you and your client safe. For example, I was 40 before I started my own journey and healing. In the early years I had to learn about safe touch, about how to be 'in body', (my default position was to dissociate). If you asked me how I was, in a physical sense, I had no idea, I could not tell you. I had to learn about my body, learn to trust it and learn from it. That has been a process that continues to this day.

If you have an intersex client, build a rapport. The person may be well informed about their body and what it needs, or they may struggle to talk. In the shame and secrecy that has surrounded this issue, many people have a poor understanding, especially regarding childhood interventions. I would always encourage client-led practice.

Your intake form and process should allow for the client to share information on their terms, which may help the client to feel more comfortable than being asked direct questions.

WHAT CAN MASSAGE THERAPISTS DO TO ENSURE AN INTERSEX CLIENT FEELS SAFE, TREATED WITH DIGNITY AND HELPS THEM TO AVOID UNINTENTIONAL DISCRIMINATION?

- Use a client-led, trauma-informed practice model - always!
- Be sensitive to issues relating to gender identity. Your patient may be cis-identified, but they may not.
- Ensure your intake forms allow clients to identify as non-binary or gender fluid, rather than only giving male and female options.
- Be aware of the language you use when communicating with a client who is intersex and be prepared to use gender neutral personal pronouns. They may prefer 'they/them'. Never assume that because an intersex client physically appears to look like one particular gender that they are ok being referred to as that gender.
- As with any client who has gone through trauma in their past, providing a safe and supportive physical environment for clients is important. If you are in a large practice or share toilet facilities with other businesses, gender-neutral signage may be appropriate and help clients to avoid any uncomfortable situations when using bathrooms.

WHAT SORT OF SUPPORT IS THERE IN NZ FOR INTERSEX PEOPLE?

Intersex Trust Aotearoa New Zealand (ITANZ) is New Zealand's own intersex organisation. Our focus has been training and education and you can find out more at the website http://www.itanz.org.nz/

We have an online support model for youth http://www.intersexyouthaotearoa.com/

Adult support is Australasian and can be found at https://www.astraeafoundation.org/stories/ais-support-group-australia-inc/

We usually meet twice a year and hope in the not too distant future to have regular gatherings in New Zealand.

WHAT RESOURCES/ADDITIONAL INFORMATION WOULD YOU RECOMMEND TO FIND OUT MORE INFORMATION?

Visit our website, donate and/or read the Darlington Statement which is the community statement about our issues and the changes we want to see in society (link in the Useful Resources section).

If you are a massage therapist/health professional, you are very welcome to contact me direct for more information: mani.mitchell@xtra.co.nz

USEFUL RESOURCES

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GLOSSARY

Cis – The term cis is derived from the Latin word meaning "same side". In gender contexts it is a shortened form of cisgender or cissexual and means that the person identifies with the gender that they were born with, e.g. they were born female and identify as female.

LGBTQIA – An acronym for lesbian, gay, bisexual, transgender, queer, intersex and asexual/ally

Trans – The term trans is derived from the Latin word meaning "across". In gender contexts it refers to people whose gender identity different from the sex they were born as, e.g. a transgender person may identify as a woman despite having been born with male genitalia.

AUTHOR BIO

Mani Mitchell has been Executive Director of the Intersex Trust Aotearoa New Zealand for over 20 years. A leading human rights activist Mani is also a board member of ILGA World (International Lesbian, Gay, Bisexual, Trans and Intersex Association), which is the world's oldest LGBTI human rights organisation. Mani is also an educator, runs training programs across New Zealand, lectures regularly at Massey and Victoria Universities, and as a guest lecturer at Otago Medical School. Interested in communications and media, Mani was involved in the production of the award winning documentary *Intersexion*. They are also a member of NZAC and is a member of the ethics team. Their interest in body work comes from a long personal journey/exploration to recover from the complex impacts of childhood trauma.

VIEWPOINT: CULTURAL SAFETY AND MASSAGE THERAPY

By Dr Ben Gray, Senior Lecturer, Department of Primary Health Care & General Practice

All registered health providers are required under the Health Practitioners Competence Assurance Act 2003 "To set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession". Since that time all the registered health professional authorities have developed standards on "Cultural Competence' or "Cultural Safety" for the nurses. They also require training in cultural competence during their degree studies. At Otago University we have developed an explicit curriculum on Cultural Competence for our undergraduate medical degree.

Whilst Massage Therapists are not covered by this Act, this is a strong argument for the profession to align their activity in the area of Cultural Competence with the other health professions and develop a policy around cultural competence, and provide training within the undergraduate qualification.

The New Zealand Medical Council has recently released its "Statement on Cultural Safety" (2019). This replaced its earlier document "A Statement on Cultural Competence" (2006), and builds upon the material in that document. As one of the better resourced professions, a lot of very good work went in to developing both of these documents and they are probably a good starting point if Massage Therapy were to want to develop their own document. Below are some relevant quotes from the document:

KEY POINTS ABOUT CULTURAL SAFETY

Council requires doctors to meet the cultural safety standards outlined below.

Cultural safety requires doctors to reflect on how their own views and biases impact on their clinical interactions and the care they provide to patients.

Cultural safety benefits all patients and communities. This may include communities based on Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability.

Cultural safety focuses on the patient experience to define and improve the quality of care. It involves doctors reflecting on their own views and biases and how these could affect their decision-making and health outcomes for the patient.

TOWARDS CULTURAL SAFETY AND HEALTH EQUITY

Cultural safety focuses on the patient experience to define and improve the quality of care. It involves doctors reflecting on their own views and biases and how these could affect their decision-making and health outcomes for the patient.

The Medical Council has previously defined cultural competence as "a doctor has the attitudes, skills and knowledge needed to function effectively and respectfully when working with and treating people of different cultural backgrounds". While it is important, cultural competence is not enough to improve health outcomes, although it may contribute to delivering culturally safe care.

Evidence shows that a competence-based approach alone will not deliver improvements in health equity.

Doctors inherently hold the power in the doctor-patient relationship and should consider how this affects both the way they engage with the patient and the way the patient receives their care. This is part of culturally safe practice.

Cultural safety provides patients with the power to comment on practices, be involved in decision-making about their own care, and contribute to the achievement of positive health outcomes and experiences. This engages patients and whānau in their health care.

Developing cultural safety is expected to provide benefits for patients and communities across multiple cultural dimensions which may include Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability. In Aotearoa / New Zealand, cultural safety is of particular importance in the attainment of equitable health outcomes for Māori.

A DEFINITION OF CULTURAL SAFETY

Council defines cultural safety as:

The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.

The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.

The awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities

CULTURAL SAFETY STANDARDS FOR DOCTORS

When considering the needs of your patients, cultural safety requires you to reflect on, take ownership of, and consider in your practice:

a. The effect of your own culture, history and attitudes.
b. The ongoing development of your own cultural awareness and an understanding of how your social-cultural influences inform biases that impact your

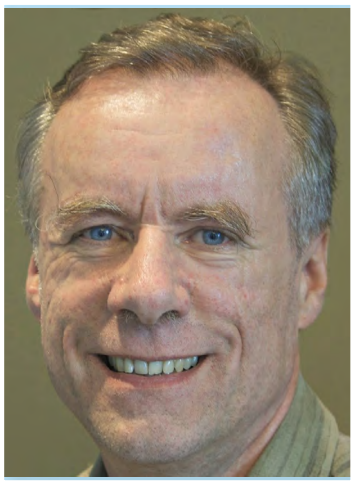
interactions with patients, whānau, and colleagues.

c. Consciously not imposing your cultural values and practices on patients.
d. Recognising that there is an inherent power imbalance in the doctor-patient relationship, and ensuring that this is not exacerbated by overlaying your own cultural values and practices on patients.
e. Challenging the cultural bias of individual colleagues or systemic bias within health care services, which may contribute to poor health outcomes for patients of different cultures.

Cultural safety requires you to engage in ongoing self-reflection and self-awareness. This includes:

a. Being aware that there are limits to what you know and being open to learning from your patients.
b. Understanding how our colonial history, systemic bias and inequities have impacted Māori and Māori health outcomes, and ensuring that your interactions with and care of patients do not perpetuate this.
c. Acknowledging that general cultural information may not apply to specific patients and that individual patients should not be stereotyped.
d. A respect for your patients' cultural beliefs, values and practices.
e. Understanding that your patients' cultural beliefs, values and practices influence their perceptions of health, illness and disease; how they respond to and manage their health; and their treatment decisions and interactions with doctors, other health care professionals and the wider health system.
f. Understanding that culture is dynamic and evolves over time, extends beyond ethnicity, and that patients and their whānau may identify with multiple cultural groupings at any one point in time.

This document is of course is written by those from the culture of Medicine, that has some significant differences from the culture of Massage Therapy. As an outsider, there are some obvious differences. There are times when people are required to see a doctor whereas almost always people only attend a Massage Therapist because they have actively chosen to. The power differential is different. Whilst doctors on occasion will have significant physical contact with patients for most consultations this is not the case, whereas for most if not all consultations Massage Therapists will be touching patients. Negotiating the different cultural norms around what is culturally acceptable body exposure and touching is a central part of what a Massage Therapist must do.



AUTHOR BIO

Dr Ben Gray has been a GP at Newtown Union Health Service in Wellington for the past 25 years and a Senior Lecturer at the University Of Otago Wellington for the past 14 years. As a GP he cares for a wide diversity of patients and has gained skills in working with interpreters and providing cross-cultural care. This experience has flowed into the University work where he has published widely on working with an interpreter and Cultural Competence. He completed a Masters in Bioethics and Health Law and convenes the undergraduate medical module in professionalism and ethics, with a particular interest in cross cultural ethics.

The movement from a competence-based approach to a safety-based approach was stimulated by the work of Irahapeti Ramsden and the Nursing Council and is a distinction that I wholeheartedly endorse. You cannot learn to be culturally competent, you have to be culturally safe. The implication is that you measure a competence. However safety is a feature of each individual consultation and is determined by the patient/client.

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MANGERE REFUGEE RESETTLEMENT CENTRE AND MASSAGE THERAPY FOR REFUGEES

By Barry Vautier BHS, ND.
Life member MNZ

RRC Mangere, Auckland.

Since July 2015 I have worked at the Refugee Resettlement Centre (RRC) in Mangere, Auckland as a body therapist with men. I work on a 0.5 Salary for Refugees as Survivors (RASNZ), a not-for-profit, non-government agency whose role is to assess, counsel and advocate for refugees of all ages who are being settled in New Zealand (NZ) through the United Nations High Commission for Refugees (UNHCR).

New Zealand currently takes about 170 people six times a year, giving an annual quota of 1000 UNHCF refugees. Most are at the Centre as family groups. They are housed, fed and take part in educative and group sessions.

The refugees are screened offshore for their suitability by immigration officials of UNHCR and Immigration officers from NZ and become permanent NZ residents on arrival. They are also screened medically and go to the RRC School for 6 weeks to learn English and be educated about New Zealand culture. Some of the refugees are highly educated and some are illiterate. Refugees' ethnicities currently include: Afghanistan, Congo, Columbia, Eritrea, Iran, Iraq, Myanmar, Pakistan, Palestine and Syria. On leaving the centre they are allocated social housing in various cities around NZ where they are supported by Red Cross volunteers.

Men are referred to me, by the on-site medical team and the RASNZ counselling team. With most refugee clients, an interpreter is utilised and they stay in the room while clients are assessed and treated. The men are typically in chronic pain both psychosocially and physically. Some of the men have been tortured, and the women raped. The stories are on the extreme end of the mental, emotional and physical aspects of human abuse that one can imagine. Some of the mental suffering is vicarious, through witnessing extreme violence and persecution. Some are seen by a by a visiting psychiatrist and formally diagnosed with Post Traumatic Stress Disorder (PTSD).

The body therapy at RASNZ is gender specific for cultural and dignity reasons. My female colleague, Naomi Cassels and I collaborate with the medical and psychological teams for the best client outcomes, but given the short time frame of client interaction, often triaging and screening is all that can be achieved at the centre and ongoing referral is required. We keep electronic notes for each client and may need to write a medical report for ongoing referral to go to their general practitioner in the town they settle in. Client confidentiality is extra critical as there is often a lot of shame associated with their distress. Sometimes we work through clothing for appropriate cultural touch.

Mostly I work without massage oil. The techniques I apply include Bowen technique, myofascial release, trigger point techniques, PNF stretching, spironics, and general relaxation massage strokes. Much of the massage is aimed at settling the nervous system and breathing education is often included in each session. The clients are given homework and post-care instructions. The most I can see a client is weekly for 6 weeks, however referrals can occur any time in the 6 week period they are at the centre for and sometimes I get to see a client just once. Ongoing referral to further physical therapy is often indicated.

Overall, it's important not to re-traumatise refugee clients by applying painful techniques as some are hypervigilant and sympathetically aroused. The men range from being hyper-vigilant, hypersensitive and emotionally vulnerable with a low pain threshold, to hypo-vigilant, hyposensitive and emotionally withdrawn with a high pain threshold. Many are shallow breathers.

Some of the psychosocial symptoms presenting include disturbing thoughts and feelings, nightmares and dreams related to past events, mental or physical distress to trauma-related cues like the slamming of a door, attempts to avoid trauma-related cues such as being around people, alterations in how a person thinks and feels, and a general increase in the fight, flight or freeze response. Some are at a high risk for suicide and intentional self-harm.

De-arousal body therapy is very important with refugees to evoke the parasympathetic relaxation response and the body's natural healing response. However, many refugees also present with physical injuries and postural disturbances as the result of physical and emotional trauma. They may present with all the usual pathologies we see in general practice. Addressing posture and habitual holding patterns can often be a key to psychological recovery as the physical pain subsides.

I love the varied clientele and enjoy the camaraderie with the counsellors, psychologists and medical staff. It can be a highly emotionally charged environment and we each receive outside supervision and peer support. We are encouraged and paid to do professional development in our

field. The satisfaction of being part of a larger team in a diverse environment is very satisfying. I also facilitate three refugee mens groups and play ukulele with the primary school children at each intake.

Interested in massaging refugees? There is currently a vacancy for a part time male body therapist at the RASNZ mobile team based in Onehunga. The NZ quota for refugees is increasing to 1500 per annum from July 2020 and thus there is a need for more massage therapists. This may suit a recent graduate wanting mentoring or an experienced practitioner wanting to reinvigorate their practice or overcome the isolation of sole practice.

Contact Barry Vautier for further information, questions and comments, at barry.vautier@gmail.com or 021 706 488.

AUTHOR BIO

Barry is a body therapist at the Refugee Resettlement Centre, Mangere, and at the mobile team in Onehunga, Auckland. He is also in private practice as Ripple Ora Massage, Mt Eden, Auckland.

Previously, Barry was the principal and Instructor for Fascial Kinetics (Bowen therapy), he has taught body therapies and health science over the last 25 years and has presented at conferences and seminars. His passion is the fascia of the body and the mystery it may hold.

"The greater the doubt, the greater the awakening. No doubt - no awakening."

- CC Chang, The practice of Zen.

CHILDREN PROSPER THROUGH LOVE AND EMPATHY

Poland - Warsaw Integrational Kindergarten

By Eva Scherer, Founder and CEO of Child Connection Trust, Affiliate Member MNZ

Harlow (1958) published research showing that, as mammals, we need nurturing touch and comfort more than food for survival. Mammals, including humans, nurture their young through touch stimulation. The questions were raised: Are we doing enough to nurture our children through touch in their early years? Are we respecting the origin of human love when raising our children (Prescott, 1996)?

ATTACHMENT THEORY

Bowlby's attachment theory (Bretherton, 1992) discusses that the precious "together time" of listening to a child and giving loving attention, is when attachment and bonding are created between the primary caregivers and the child. It could be that lack of attachment may lead to teenage pregnancy, suicide, alcohol or drug addictions (Holmes, 2014).

Teachers often notice the children receiving quality loving attention at home. This may be visible through observing the child's behavior. Children may be less aggressive, happier and more involved in their learning.

Many parents and caregivers are familiar with baby/child massage, but the Child Connection technique via the peer massage programme is different, in that it is designed especially for school and kindergarten students, aged 4 to 7 years. Peer massage (children massaging children) provides nurturing touch in a safe supervised environment of the classroom.

DOES MASSAGE MAKE A DIFFERENCE?

Safe, proper touch may help students to improve low self-esteem, improve their

Opunake – Community Kindergarten

Poland –Raszyn Kindergarten

emotional trust in relationships with others, promote a positive body image and help children develop a deep personal connection to their bodies and themselves, build compassion and may help prevent bullying in the classroom (Von Knorring et al, 2008).

Morgan (2006) examined the Children Massaging Children (CMC) programme in New Zealand (NZ), where over a 15-week period, 140 students at a decile 1 school in Hastings practised the Children Massaging Children programme. The research showed that the programme improved the children's ability to engage with their school work, improved relationship with peers and interestingly the children's relationship with fathers at home also improved.

The CMC programme was developed 20 years ago. The program is used extensively throughout Poland. You can find out more information here:

http://childconnection.org.nz/cmc-users/

It is our mission to strengthen compassion. For this to happen we want to encourage the whole of society to recognise and respect the Universal Law of Attachment and practise it in different forms. This could begin, not only at home, but also in the NZ education system. Massage Therapists could build the bridge for this to happen, by introducing the Children Massaging Children programme in their local area schools.

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AUTHOR BIO

Eva Scherer is a professional massage therapist and body-worker. Owner of Y Massages – a group of Sports & Therapeutic massage clinics located at YMCAs around Auckland (www.ymassages.co.nz).

Founder and CEO of Child Connection Trust www.childconnection.org.nz and creator of programmes:

- Tiny Explorer/ Toddlers
- CMC/Primary Schools,
- Positive Touch for Adolescents
- Herb Fairies Academy www.herbfairiesacademy.com

Contact: Eva@evascherer.com, tel +64 9442 5799

IS UNCONSCIOUS BIAS IMPACTING YOUR BUSINESS?

By Dr Guillermo Merelo (Manager, Diversity Works, NZ)

Diversity Works New Zealand Diversity Manager Dr Guillermo Merelo looks at how unconscious bias could negatively affect the way you work with clients and colleagues.

Scientific research has demonstrated the existence and prevalence of unconscious bias - unconscious beliefs and attitudes that go beyond our conscious perceptions of ourselves and others. Whether we accept it or not, we tend to make assumptions of people based on the prevailing information and sentiments of the many groups in which we grew up. Many of these ideas get stored in our head and unconsciously affect our decision-making processes. It takes just 50 milliseconds to register someone's gender when we first see them and only twice that long to note their racial background.

In a healthcare scenario this can influence both, the way professionals process information about a client, and also how a customer perceives the whole healthcare experience. Evidence shows that conclusions can be based just as much on who a person is as on the symptoms they present (McKinlay, Potter, Feldman,1996), which can lead to inequalities in the care provided and a less effective relationship between client and practitioner. Biases can also impact the internal operations of healthcare clinics – they can prevent individuals from making objective decisions, causing people to overlook great ideas, ignore an individual's potential, and create a less than ideal work experience for their colleagues. The good news is there are strategies you can implement to mitigate the impact of unconscious bias.

WHY DO WE HAVE BIASES?

Our brains are perfectly suited for quickly filtering huge amounts of information, prioritizing, categorizing, and summarizing our surroundings for us unconsciously. This served us well hundreds of thousands of years ago, when we lived alongside wild animals with sharp teeth and claws, and many of the daily choices we made were life and death decisions. We needed to be able to quickly judge our surroundings and rely on our fight or flight impulses. Our unconscious biases were extremely functional (and potentially life-saving) tricks our brains learned to help us avoid being eaten. We live in a different world today, but our unconscious biases still help us make thousands of decisions without us having to think about them. Avoiding cars, ordering your coffee, deciding where to sit on the bus... most of what we're feeling and deciding is driven by unconscious processing, which helps us get through the day efficiently.

But sometimes it can lead us astray, affecting our decision making in ways you cannot even imagine. John Bargh, a social psychologist at Yale University, conducted a study in 2008 in which subjects were asked to briefly hold a warm coffee mug, then fill out an evaluation of a person described ambiguously. The survey subjects reported warmer feelings toward the target person versus when they were asked to briefly hold an iced coffee. It showed that physical sensations may unconsciously translate into psychological interpretations – something as benign as having a comforting hot drink can influence your decision making. The findings are in agreement with emerging knowledge about the role played by the insula within the brain in both the sensation of one's physiological state and the detection of the trustworthiness of others. (Menon & Uddin, 2010).

HOW DO WE ADDRESS BIAS?

We can't eliminate our unconscious biases. Actually, research shows that they are more likely to remain stable throughout our lives. The good news is that research also shows that awareness is a mitigation strategy in itself. Although our biases are stable we can get to know them and slow our thinking to see when they interfere with our decisions. Awareness thus can bring changes to thinking and behaviour. This means education and training around unconscious bias for people at all levels of an organisation is vital.

But when it comes to training, it's important to use experienced facilitators who can take these broad concepts and help people to understand their relevance to themselves and to the decisions they make in the workplace and the impact this has on the success of the organisation.

Diversity Works New Zealand offers unconscious bias training that not only raises awareness of this issue but helps take the next step in managing it. It provides an understanding of the neuroscience underpinning unconscious bias, helps participants learn to identify their own unconscious biases and those of others, looks at ways to challenge their thinking and build new neural connections and provides strategies to manage and mitigate bias as individuals, groups and organisations.

Unconscious patterns have an enormous impact on both our individual behaviour and on organisational behaviour. Only when we find the courage and curiosity to engage in a journey to consciously become aware of and address something that is, by nature, concealed can we begin to see more clearly into our blind spots.

Awareness and growth do not happen overnight. Increasing our diversity, inclusiveness, and cultural competency requires us to undertake a long journey of continuously challenging our perceptions and slowing down our impulse to judge instantaneously and reactively. This means we must continually confront unconscious bias. Ultimately, the result will be more conscious, inclusive and humane workplaces and organisations with greater opportunity for all, more engaged individuals and higher profitability. Isn't that worth the effort?

COMMON BIASES FOUND IN THE WORKPLACE

AFFINITY BIAS

The preference for those similar to ourselves or those perceived as part of our "in-group". This leads to gender bias, racial bias and age bias in particular. It is common in hiring and promotion decisions and is also called "mini me syndrome".

RECENCY BIAS

Recent events tend to weigh more heavily on our decisions than events in the past. Recency bias would indicate that we don't learn over time as well as we remember the last thing that happened.

HALO/HORN BIAS

Allowing your judgment to be influenced by a particular trait (either positive or negative) overshadowing other traits and behaviours.

ATTRIBUTION BIAS

This is when we over emphasise the role that we/someone played in the outcome to the detriment of the context they operated in.

EXPERIENCE BIAS

When you assume based on your previous experience that your perceptions are accurate or when you defer to an 'expert' without asking questions.

CONFIRMATION BIAS

When people tend to favour information that confirms their already established beliefs. It's also known as the "bias enhancer."

ANCHORING BIAS

When we're faced with a decision, Anchoring Bias causes us to give more weight to the first bit of information we gather.

COMMITMENT BIAS

The tendency to increase our commitment in a decision based on prior investments despite evidence that the cost of continuing down our current path is much greater than any expected benefit.

EXPEDIENCE BIAS

When you think that if something feels familiar and easy it must be true. It's particularly strong amongst senior leaders and long-standing teams.

STEREOTYPES BIAS

Assumptions and judgments are made based on the stereotypes of the category that an individual belongs to such as gender or race.

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AUTHOR BIO

Dr Guillermo Merelo - BL, MPA, PhD University of Auckland, Diversity Works New Zealand Diversity Manager

With a strong background in public management and public policy, Guillermo has worked as a senior public officer, columnist, lecturer and academic researcher in Latin America, Europe and New Zealand. He is a published author on integration and inclusion. His academic work revolves around the value of migrants' processes of integration to their receiving societies. He is also a HR specialist with more than 20 years of experience in talent management, organisational development and change.

Brought up in a family of strong women and being a member of the LGBTI community, Guillermo truly cherishes diversity and he is convinced that diverse workplaces have the potential to foster understandings of the self and others, unleash organisational potential and make this a better world.

To find out more about Diversity Works New Zealand training courses to advance inclusion in the workplace, visit www.diversityworksnz.org.nz, email training@diversityworksnz.org.nz or call 0800 DIVERSITY (0800 348 377)

Massage New Zealand is delighted to announce that Hayley Ward has been awarded the BizCover Gold Award for her case report. Hayley entered the contest in 2019 with her case report, "Chronic Tension Headaches and the Use of Neuromuscular Therapy on Scalenes, Sternocleidomastoid, Temporalis, and Masseter: A Case Report". We are pleased to publish Hayley's full case report for members to read here.

CHRONIC TENSION HEADACHES AND THE USE OF NEUROMUSCULAR THERAPY ON SCALENES, STERNOCLEIDOMASTOID, TEMPORALIS, AND MASSETER: A CASE REPORT

By Hayley Ward (BTSM)

ABSTRACT

Background: Chronic tension headaches (CTH) are one of the leading causes of health loss worldwide and manual therapy is indicated for treatment due to the myogenic mechanisms. Specifically, treatment that focuses on cervical musculature, including trigger point therapy, has been shown to reduce headache frequency. There is limited literature on the efficacy of massage therapy to treat CTH.

Method: A 22-year-old female diagnosed with CTH received six massages over four weeks in accordance with Shield and Smith's (2017) study that involved general therapeutic massage to the upper body and targeted neuromuscular therapy to scalenes, sternocleidomastoid, temporalis, and masseter. Her goals were to reduce the intensity and frequency of headaches and progress was recorded using the Headache Disability Index (HDI) and a headache diary utilizing the Defense and Veterans Pain Rating Scale.

Results: The HDI and headache diary showed moderate improvement and the client reported a significant improvement to her quality of life. The client no longer met the diagnostic criteria for CTH with the incidence of headaches and medication usage decreasing from six days to one day per week. Six-months post-treatment, most of the benefits have been sustained.

Conclusion: Targeted manual therapy of scalenes, sternocleidomastoid, temporalis, and masseter for treatment of CTH may address the myogenic mechanism and facilitate improvements in CTH frequency, intensity, and duration of headaches. Massage therapists may wish to consider the inclusion of these muscles as a valuable treatment approach for clients with tension-type headaches. Further study is needed to determine if this cost-effective, non-pharmacological alternative to more invasive treatments is effective and if the results are generalizable to a wider audience.

Keywords: chronic tension headache, tension-type headache; massage therapy; neuromuscular therapy; DVPRS

INTRODUCTION

Headaches affect thousands of New Zealanders each year and are a major cause of health loss in Aotearoa New Zealand (Ministry of Health, 2013). Worldwide, headaches are so prevalent that over 90% of adults experience at least one headache per year (BMJ Best Practice, 2018). In addition to impacting individuals' quality of life, headaches also place large financial burdens on the healthcare system, workforce, and society. The most common type of headache is the tension-type headache (TTH) that is either episodic (less than 15 days per month) or chronic (more than 15 days per month) (International Headache Society [IHS], 2019). Chronic tension headaches (CTH) frequently cause pain to radiate from the bilateral forehead to the occiput in a band-like fashion (Millea & Brodie, 2002). Described as tightness, pressure, or a dull ache, the pain can radiate to the neck and upper shoulders (Walton, 2011). The pain is not aggravated with routine physical activity and can be accompanied by either photophobia or phonophobia, however, nausea and vomiting are not within the typical clinical presentation of TTH. By contrast, migraines are characterised by unilateral throbbing pain, nausea, and photophobia (BPAC, 2017).

The pathophysiology of TTH is unclear however current theories support myogenic mechanisms in the head and neck (hypertonic muscles, myofascial trigger points (MFTPs), eyestrain, postural syndromes such as forward head posture, and joint issues) (Nutting, 2017). Werner (2016) notes that the neck supports 8-9 kilograms on the small contact area between the occipital condyles and the facets of the C1 vertebrae – essentially, balancing a bowling ball on the surface area of two fingertips. Therefore, cranial and cervical musculature work together to maintain balance and allow movement of the head. However, additional stress to these muscles, such as from a postural syndrome or simply looking at an electronic device for periods of time can cause creep (Melmer, 2017) that can overload these muscles and over time, lead to central sensitisation phenomenon (de Tommaso et al., 2008).

Sustained and repetitive pericranial myofascial nociceptive stimuli can trigger prolonged increases in neuronal excitability and synaptic efficacy in central nociceptive pathways – the central sensitisation phenomenon (Bendsten, 2000; Chowdhury, 2012). The nervous system goes through a "wind-up" process and is regulated at a persistent state of hyper-responsiveness that lowers the pain threshold and can outlast the original noxious stimuli (e.g., injury or pain condition) (Nijs et al., 2011). This is expressed by hypersensitivity to pain and is a feature of fibromyalgia, complex regional pain syndrome, and some types of headaches (Woolf, 2011). Furthermore, both taut and lengthened muscles, as typically seen in creep and postural deviations, are more prone to MFTPs that have been associated with TTH (Chaitow & DeLany, 2008; Moraska et

al., 2015). Trigger points are palpable, hyperirritable nodules within taut bands of muscle fibres that display a local twitch response that radiate pain when stimulated (Davies & Davies, 2013). According to Moraska et al. (2015), MFTPs could explain how episodic tension headaches progress into CTH as they could be the primary source of sustained nociceptive input from peripheral myofascial tissues, which sensitises the central nervous system and therefore, increases its excitability. Another consideration when treating chronic pain is the interaction of physiological and psychosocial processes detailed in the gate control theory (Gatchel & Howard, 2008). Facilitating positive health behaviours for improved outcomes can be addressed through the biopsychosocial lens.

Standard treatment for CTH involves non-steroidal anti-inflammatory drugs and the identification and avoidance of triggers such as alcohol, perfume, and lifestyle and occupational factors (Clinch, 2001; Millie & Brodie, 2002). If the client displays any postural deviations, these should be addressed within their treatment plan (Speicher, 2016) as a positive correlation between muscle hyperalgesia in the head, neck, and shoulder areas and headache frequency has been clinically established (Abboud, Marchand, Sorra & Descarreaux, 2013; Fernandez-de-las-Penas et al., 2009; Vahtrik, Bergmann, Vanahunt & Braschinsky, 2018). As TTH are believed to be myogenic, the literature suggests that manual therapy focused on cervical musculature, including trigger point therapy, can reduce headache frequency (Fernandez-de-las-Penas, 2015; Montalva, 2006; Moraska et al., 2015; Shield & Smith, 2017; Walton, 2011). Shield and Smith's (2017) comparative experiment showed that remedial massage therapy (MT) applications to the temporalis, masseter, sternocleidomastoid (SCM), and scalenes muscles reduced the frequency of headaches in participants with CTH.

This case report seeks to build on Shield and Smith's work and contribute to a case series on the benefits of therapeutic massage for TTH. This manuscript is a retrospective case report detailing the effects of neuromuscular therapy on anterior face and neck muscles on a 22-year-old female with CTH. The client met the diagnostic criteria for CTH and was receptive to remedial MT. Her primary goal was to reduce the intensity of the headaches and thereby improve her ability to participate in life activities, and her secondary goal was to reduce the frequency of headaches. Limited evidence exists that supports the use of MT as a valid treatment option for CTH and the therapist hypothesised that this treatment approach would lead to a clinically meaningful improvement in the intensity and frequency of the client's headaches.

METHOD

Case Presentation

The client was a 22-year-old Caucasian female who presented with CTH that began 18 months prior to treatment. Her primary goal was to decrease the intensity of the near-daily headaches and reducing the frequency of headaches was considered a bonus. Since the original onset, the severity of the headaches had intensified from 4/10 to 7/10 on the numerical pain rating scale (NPRS) (Haefeli & Elfering, 2006) but plateaued within the last two months. She instructs primary children in a school program and practices the guitar and piano recreationally. Twelve months prior to treatment, she received a diagnosis of CTH from her doctor and was prescribed Nuromol (ibuprofen and paracetamol) and advice on avoiding triggers. The client is unable to identify any potential triggers but does have moderate scoliosis in her lower thoracic and lumbar spine (diagnosed by x-ray and doctor).

On average, she has 5-6 headaches per week that can last 2-48 hours. Symptoms include pressing diffuse pain on the top of her head extending down to the anterior frontalis and temporalis muscles and posterior occipital areas bilaterally (highlighted area in Figure 1), as well as photophobia, lethargy, and difficulty concentrating. Aggravating factors are stress, poor posture, and being sedentary; relieving factors include painkillers, heat, sleep, shoulder massage, and "compressing the top of [her] head." She usually takes one Nuromol tablet if a headache persists more than one hour (five days per week) that effectively suppresses the pain.

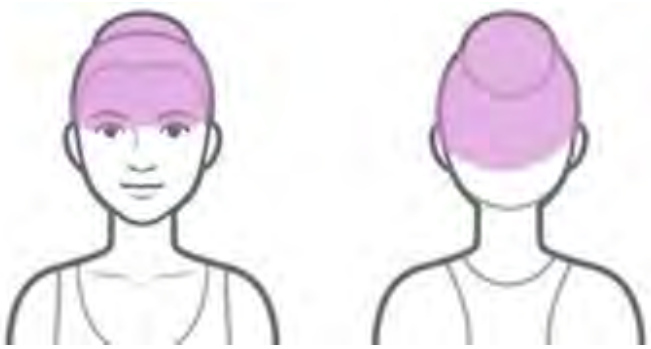

Figure 1. Representation of client's headache pattern.

The pain often distracts from her activities of daily living such as her chores and music. She rarely wakens with a headache; they begin throughout the day and steadily worsen. Other symptoms that the client suspects are related to the headaches are nerve pain in the median nerve distribution of her right forearm and hand (she is right handed) and palpable tension in her bilateral upper shoulders, possibly due to her guitar and piano playing. Overall, the client is in good health with no comorbidities or contraindications to treatment.

Clinical Findings

Active range of motion (AROM) testing was performed at the neck, as per Shield and Smith's (2017) study, to provide a screen test for movement (Lowe, 2006). A positive AROM result indicated that the action elicited pain. Isometric (indicates contractile tissue involvement) and passive (indicates joint and lengthened tissue involvement) range of motion testing were not selected due to time constraints of the sessions. AROM neck flexion, extension, and lateral rotation were all negative but pain was present on AROM neck lateral flexion to the right and left (bilateral upper trapezius region). The location of the pain in relation to the positive and negative tests indicates that the structures implicated on the right side are the right upper trapezius and levator scapula, possibly splenius whereas the left side indicates tension in the left upper trapezius and levator scapula. Limited range of movement was observed on lateral flexion to the right and left, as well as lateral rotation to the left, supporting the involvement of upper trapezius.

The positive findings were supported by shortness tests for the bilateral upper trapezius and levator scapula muscles which were all positive (Chaitow & DeLany, 2008; Grace & Deal, 2012). Palpation of the neck, shoulders, and back showed tenderness and hypertonicity in bilateral upper trapezius and SCM. To explain the client's nerve pain in the median nerve distribution, the Upper Limb Tension Test 1 (ULTT #1) was performed to test for median nerve entrapment which was positive (Lowe, 2006). Postural analysis revealed that the client has mild upper cross syndrome, but no lower cross syndrome. She also has moderate structural scoliosis (c-curve to the right) that was observed in the lower thoracic and lumbar spine.

Chronic Tension Headache Diagnostic Criteria

The client met the diagnostic criteria for CTH: headaches occurred more than 15 days per month for at least three months; duration of hours to days; bilateral location; pressing characteristic of moderate severity; photophobia; symptoms not aggravated by routine physical activity; and no nausea or vomiting (IHS, 2019). Differential diagnosis included cluster headaches, migraines, acute sinusitis, and MFTPs in the cervical and cranium muscles (BMJ Best Practice, 2018). Table 1 below outlines the SOCRATES mnemonic used in healthcare professions to assess headaches (BPAC, 2017).

Table 1. SOCRATES mnemonic for assessing the symptoms of clients with headaches pre-treatment.

Characteristic	Pre-Treatment – Day 1
Site	Bilateral top of the head, extending to temporalis and frontalis muscles.
Onset	Gradual onset (30 min – 2 hours).
Character	Pressing.
Radiation	Bilateral forehead.
Associated Symptoms	Photophobia during headache, but no vomiting or nausea. "Nerve pain radiating down [her] right arm."
Timing	5-6 days per week for 2 hours-2 days.
Exacerbating and/or relieving factors	Aggravated with slouching, sedentarism. Relieved with painkillers, sleep, shoulder massage, compression to top of the head.
Severity	7/10 on NPRS.

Assessment Measures

Outcome measurement tools were selected to record changes in the client's headache intensity and frequency, her treatment goals. The Headache Disability Index (HDI) measures the impact of headaches on daily living (Jacobson, Ramadan, Aggarwal & Newman, 1994) and pre-treatment, the client scored 64/100 that the HDI describes as a severe disability. The HDI was completed by the client and the start and conclusion of treatment. The Defence and Veterans Pain Rating Scale (DVPRS), as part of a custom headache diary, provided a functional measure of the client's subjective pain experience as well as the biopsychosocial impact of pain on daily living. The daily self-reported headache diary recorded the frequency, severity (using the DVPRS 24-hour pain score), duration, and any medication taken. The diary was checked throughout treatment to monitor the client's response to the intervention and her compliance with the assessment tool.

Intervention

This case report followed Shield and Smith's (2017) comparative experiment of remedial MT protocols where participants who received remedial massage specifically to temporalis, masseter, SCM, and scalenes reported more benefit than those who received remedial massage to the upper shoulder, neck, and occiput. Therefore, treatment was predetermined and neuromuscular therapy-based (NMT) with other techniques utilised as required. Massages were 45-60 minutes in duration, with the six sessions conducted twice weekly over four weeks in July 2018 – not three weeks as in Shield and Smith's (2017) study due to the client's work trip during the third week. Three of the massages focused on general therapeutic massage to the neck, upper shoulders, and occiput; the other three included targeted massage to temporalis, masseter, SCM, and scalenes. Progress was monitored via assessment at each session but the treatment protocol (Table 3) did not deviate irrespective of assessment findings.

NMT protocols can create significant tissue change and decrease muscle tension, myospasm, and myofascial restrictions and Chaitow and DeLany's (2008) NMT protocols were used in the interventions. Myofascial release (MFR), soft tissue release, compressions, heat, trigger point therapy, and a scraping technique with a ceramic spoon were included in treatment with the intent of improving the quality of tissue (Chaitow & DeLany, 2008; Davies & Davies, 2013; Fritz, 2013; Grace & Deal, 2012; Lowe, 2006; Premkumar, 2004; Speicher, 2016). Although the mechanisms are unknown, anecdotal evidence and the therapist's clinical experience support their efficacy at creating tissue change.

The original study did not address self-care so to conform to its parameters, self-care advice was limited to standard advice: hydration, heat packs, and stress management. This case report was completed as part of the therapist's third-year coursework for the Bachelor of Therapeutic and Sports Massage degree at the Southern Institute of Technology, Invercargill, New Zealand. All interventions were within the therapist's scope of practice and sessions were conducted at the client's home or at the institute's clinic. The client gave written informed consent to participate in this case report, and all identifying information has been removed.

Shield and Smith: 45 minutes	Treatment Delivered: 45-60 minutes
Session 1 Focus on relaxation massage	**Day 1** *Progress* Not applicable. *Assessment* Tension in upper shoulders and reduced movement on AROM lateral flexion and lateral rotation. *Treatment* 45-minute relaxation massage to neck, posterior shoulders and back. *Outcome* Headache intensity decreased from $^{6.5}/_{10}$ to $^{2}/_{10}$, the client reported that she "can actually think now. . . I was losing some of my brainpower before." AROM lateral flexion improved, no change to lateral rotation.
Session 2 Temporalis, masseter, suboccipitals, SCM, and scalenes	**Session 2 Day 3** *Progress* Headache disappeared following treatment but 2 headaches requiring Nuromol the following day. *Assessment* Moderate tension in SCM and scalenes bilaterally, temporalis tender. AROM right and left lateral flexion and lateral rotation limited. *Treatment* 45-minute NMT massage to bilateral SCM, temporalis, and masseter. Each SCM had 2 MFTPs that referred pain to the temple, mastoid, and face; all successfully treated with digital ischaemic compressions and stretching but did not leave enough for bilateral scalenes to be treated. *Outcome* Significant tissue change and SCM tension dissipated. Client felt "loosey goosey" with no referred pain. AROM lateral flexion improved.
Session 3 Upper shoulders, neck, and occiput	**Session 3 Day 8** *Progress* No headaches previous 2 days. *Assessment* Several neck AROMs evoked pain in her mid-thoracic spine, occiput, and upper shoulders as well as reduced range of motion. *Treatment* 45-minutes general therapeutic massage to upper shoulders, and suboccipital area. MFTP successfully treated in right trapezius with digital ischaemic compression and stretching that referred pain into right eye and temple. *Outcome* Client "[felt] so good, dizzy but good." Only suboccipital pain present and AROM lateral flexion and lateral rotation movement improved.
Session 4 Temporalis, masseter, suboccipitals, SCM, and scalenes	**Session 4 Day 10** *Progress* Headache intensity "don't seem as bad" and frequency and duration have subsided slightly. She reported that several days, she was able to forgo painkillers and the headache would dissipate by itself. *Assessment* Again, several neck AROMs evoked pain in her mid-thoracic spine, occiput, and upper shoulders as well as reduced range of motion. *Treatment* 60-minute NMT massage bilateral SCM, scalenes, temporalis, and masseter. No MFTPs in either SCM muscle *Outcome* SCM and scalenes responded very well to treatment. AROM results same as previous session.
Session 5 Temporalis, masseter, suboccipitals, SCM, and scalenes	**Session 5 Day 23** *Progress* Client was very tender for few days after last treatment but only experienced 1 headache in 14 days since last session. *Assessment* Neck AROMs were pain-free but movement limited on lateral flexion and lateral rotation. *Treatment* 60-minutes NMT massage bilateral SCM, scalenes, temporalis, and masseter. *Outcome* Significant tissue change but took longer than the last sessions 2 weeks ago. Minimal improvements to movement of neck AROMs.
Session 6 Upper shoulders, neck, and occiput	**Session 6 Day 28** *Progress* Client presented with $^{5}/_{10}$ headache and reported an intense headache the day prior that required medication. She believed both were due to work stress and excessive tension in her upper shoulders. *Assessment* Palpable tension in upper shoulders. AROM neck flexion elicited mid-thoracic spinal pain. Minimal restrictions in AROM movements. *Treatment* 45-minute NMT massage to bilateral upper trapezius and levator scapula. Right-side responded faster and with more tissue change. *Outcome* Headache decreased to $^{3}/_{10}$ and most tension dissipated from upper shoulders. AROMs pain-free and almost within normal limits.

Table 2. Overview of Shield and Smith's (2017) treatment protocol and each session's progress, delivered treatment, and outcome.

RESULTS

Positive affect was increased at every MT session with the client declaring "I can actually think now. . . I was losing some of my brainpower before" after the first session. At the conclusion of treatment, the client reported a clinically meaningful improvement in the intensity and frequency of her headaches, her treatment goals. These improvements were sustained five weeks post-treatment during reassessment and six months post-treatment during a follow-up phone call despite not receiving any MT since treatment ended. Her reliance on pain medication decreased from five days per week to one day and she has reported more vitality and quality of life since treatment commenced. She no longer experiences related symptoms such as nerve pain in her arm or referred pain to her face and forehead. The headaches no longer distract her from her activities and she only thinks about headaches when she has one, approximately one day per week. She does not meet IHS's (2019) diagnostic criteria for CTH (less than 15 days per week) and is now considered to suffer from episodic tension headaches. Table 3 illustrates the changes to the completed SOCRATES mnemonic, with most symptoms experiencing positive change. The client adhered with the treatment's limited self-care advised (hydration, heat packs, and stress management) during treatment and had continued at the six-month follow-up.

Table 3. SOCRATES mnemonic for assessing the symptoms of clients with headaches, pre- and post-treatment.

Characteristic	Pre-Treatment – Day 1	Post-Treatment – Day 28
Site	Bilateral top of the head, extending to temporalis and frontalis muscles.	No change.
Onset	Gradual onset (30 min – 2 hours).	Gradual onset (1-2 hours).
Character	Pressing.	No change.
Radiation	Bilateral forehead.	No change.
Associated Symptoms	Photophobia during headache, but no vomiting or nausea. "Nerve pain radiating down [her] right arm."	Photophobia during headache, but no vomiting or nausea. No nerve pain after treatment.
Timing	5-6 days per week for 2 hours-2 days.	1 day per week for 1-2 days.
Exacerbating and/or relieving factors	Aggravated with slouching, sedentarism. Relieved with painkillers, sleep, shoulder massage, compression to top of the head.	No change.
Severity	7/10 on NPRS.	2/10 on NPRS.

AROM neck test results were mixed, with testing indicated that although the massages helped, other muscles were involved in the pain and restricted range of movement. After the final session, AROMs were once again pain-free and full range of movement was achieved on all tests except right and left lateral flexion. The headache area (illustrated in Figure 1), right and left upper trapezius, and bilateral SCM and scalenes all had less muscular tension and were less touch tender. The upper trapezius and levator scapula tests were both negative for the right and left muscles indicating the muscles were no longer considered "tight" however the ULTT1 test was still positive for median nerve entrapment in the upper limb.

The HDI score decreased from 64 to 42, a change described as moving from severe disability to moderate disability. However, Jacobson et al. (1994) state that there must be at least a 29-point change in order to attribute any changes to the treatment effects, and there was only a 22-point change. Headache frequency, from her self-reported headache diary, went from a baseline of six headaches per week to one in the post-treatment phase, a reduction of 83.3% (Figure 2). The severity of a headache was measured by the DVPRS 24-hour pain-impact score but was missed between the second half of week two and week four of treatment (the client only recorded when she had a headache), so there is a large hole in the data. But there were minimal changes from the baseline week (3.7) to the runout week (3.5). As the client now only experiences one headache per week, it can be inferred that her DVPRS 24-hour pain-impact score is significantly lower.

DISCUSSION

This case report aimed to investigate the effects of targeted neuromuscular therapy on a client with CTH. Current literature suggested that individuals with TTH may benefit from remedial MT due to their myogenic mechanisms (Abboud et al., 2013; Fernandez-de-las-Penas, 2015; Montalva, 2006; Moraska et al., 2015; Shield & Smith, 2017). This study appears to support the literature and the client reported several benefits from treatment, including increased quality of life. The results suggest that the treatment plan had a positive effect on the intensity and frequency of the client's chronic headaches. Most notably, substantial improvement was experienced by the client in her reduced need to use painkiller medication (from six days to one day per week) and that she no longer meets the diagnostic criteria for CTH. The results correlate with the client's treatment goals and the therapist's hypothesis. With the 83% reduction of headache incidence maintained six-months post-treatment, this is indicative that treatment effects may be semi-long-lasting. However, the original study recorded an average reduction of HDI values by 40%, this case report observed a 34% decrease. No explanation is given for this but as both studies are case reports, the results can only show correlation and are not suggesting causality.

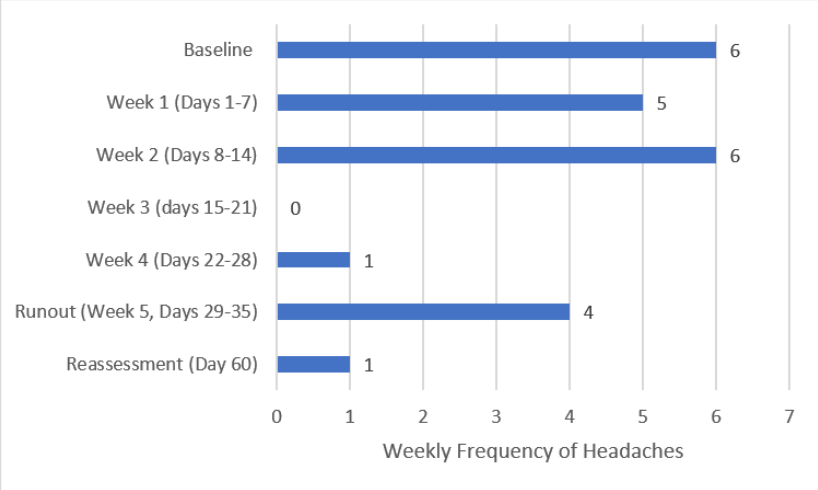

Figure 2. Weekly frequency of headaches from the client's self-reported headache diary.

Following a set treatment plan was difficult but proved instrumental in helping to achieve tissue change and a positive treatment outcome for the client; I do not know if I would have considered all the muscles if not for the original study. Additionally, attempting to treat all the planned muscles within 45 minutes was challenging and a better treatment outcome may have been achieved if the massage component was 60 minutes. However, this may be a personal limitation of the therapist and a 45-minute massage may be more in alignment with current clinical practice. Treating MFTPs in the SCM and trapezius muscles appeared to provide the client with pain relief and align with current literature (Chaitow & DeLany, 2008; Davies & Davies, 2013). Additionally, treating MFTPs may have helped to calm the hypersensitive central nervous system if central sensitization phenomenon had occurred (Woolf, 2011).

This study would have benefited from measuring the intensity of pain from range of motion tests as well as including isometric and passive range of motion tests. The AROM test findings were inconclusive and isometric and passive tests may have helped to identify implicated structures. Self-care advised was limited due to the parameters of Shield and Smith's (2017) research and it is likely that expanded self-care would produce a better therapeutic outcome. For instance, the client has moderate scoliosis in her thoracic and lumbar spine. Adapting the general therapeutic massages to target her spinal muscles would be an example of a more holistic treatment plan. Additionally, in today's digital era, monitoring screen time would be prudent as excessive screen time is known to exacerbate symptoms of postural imbalances such as forward head posture, present in many individuals with TTH.

Pertinent health psychology factors were considered under the biopsychosocial model and its subset, the DVPRS (Fritz, 2013; Munk & Harrison, 2010). Most salient was the client's emotional state as "anxiety, depression, and fear will tend to exacerbate the pain experience" (Stark, 2017, p. 9). She was worried that she would have to live with the headaches forever and occasionally did exhibit fear avoidance behaviour such as choosing to be sedentary as opposed to completing her daily chores and activities. It was explained to the client during the first session that chronic pain cannot always be eliminated, but I hoped to remove some of it and during the reassessment phone call, the client was happy,

satisfied with the results, and excited for the future. However, stress is a major trigger for CTH and can exacerbate perception of pain in people with central sensitisation phenomenon (Gatchel & Howard, 2008). A limitation of this study was not further exploring the influence of stress on the client's health status.

The headache diary was a useful measurement tool, especially as it incorporated the DVPRS, however, regular text reminders and a digital version (e.g., private Google spreadsheet) may have reduced barriers and led to increased compliance. Other case reports on the effects of neuromuscular therapy on temporalis, masseter, suboccipitals, SCM, and scalenes on CTH could lead to a case series that strengthens the state of current MT research. Future studies may benefit from including the DVPRS within the headache diary, expanded self-care and a long runout period.

CONCLUSION

Chronic tension headaches affect millions of people worldwide. The application of NMT protocols on temporalis, masseter, suboccipitals, SCM, and scalenes may facilitate improvements in CTH frequency, intensity, and duration of headaches. Treatment was successful at helping the client achieve her goals of reduced intensity and frequency of headaches in order to participate more in her life however as a case report, causality cannot be shown. Robust research is warranted to determine if the results are generalizable to the wider population. With limited evidence-informed research on MT and TTH, this case report has discussed how this approach may be beneficial and contributed to a case series on the efficacy of MT on headaches. Massage therapists may wish to consider the inclusion of temporalis, masseter, suboccipitals, SCM, and scalenes as a valuable treatment approach for clients with TTH. It may be a useful, cost-effective non-pharmacological complementary and alternative therapy for clients who have tried conventional treatment without success.

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INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH (ICF)

Abridged from WHO: Towards a Common Language for Functioning, Disability and Health

The ICF belongs to the WHO classification family of international classifications. Using a medical diagnosis alone does not predict outcomes and therefore we do not have the information required for health planning and management purposes. The ICF makes it possible to collect data on functioning and disability to measure health care needs and to measure effectiveness of health care systems.

The advantage of the ICF lies in its focus on the participation and activities rather than disability per se. It emphasises that social participation is vital, as are the goal-directed activities. More importantly, the framework emphasises the significance of one's environment.

Because the ICF highlights and incorporates the complex interactions of environment and personal factors through a biopsychosocial lens, the impact of these factors provides a new framework for massage therapists to measure change in a client, based on body structure, activity, and participation. This interaction would be particularly useful in recording outcomes as part of standard practice, in the context of carrying out case reports for learning purposes (either as part of formal massage therapy education or self-directed learning), and for massage therapy research. (Munk & Harrison, 2010)

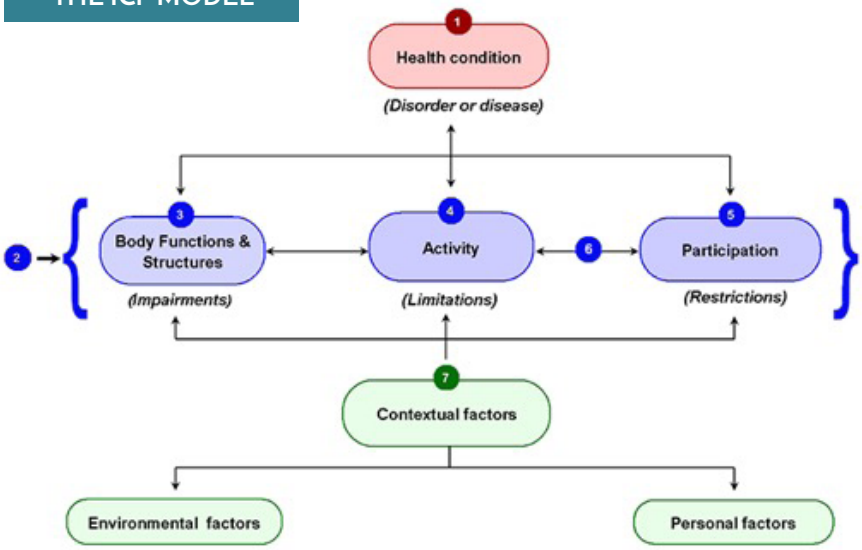
ADDITIONAL INFORMATION

Munk, N., & Harrison, A. (2010). Integrating the international classification of functioning, disability, and health model into massage therapy research, education, and practice. International journal of therapeutic massage & bodywork, 3(4), 29–36.

World Health Organization: International Classification of Functioning, Disability and Health (ICF) – Geneva. 2001. http://www.who.int/classifications/icf/en.

For more information see the full guide: https://www.who.int/classifications/icf/icfbeginnersguide.pdf?ua=1

THE ICF MODEL



	THE ICF MODEL EXPLAINED
1	This box describes the medical diagnoses, diseases or injuries that a person can experience.
2	This row describes the **life-related impacts** that result from health conditions. Rehabilitation addresses these impacts.
3	**Impairments** are problems in **body function** (physiological or psychological functions of body systems) or **structure** (anatomical body parts), e.g., weak abdominal muscles, memory loss, right-sided hypertonicity, congested lungs
4	**Activity limitations** are problems executing a task or action (e.g., getting dressed, walking to a clinic, carrying one's child, communicating with a neighbour)
5	**Participation restrictions** are problems an individual may experience with involvement in life situations (e.g., being excluded from school, difficulty participating with one's church, feeling stigmatised at work, challenges with parenting)
6	Note the arrows are bi-directional. This means that a challenge at one level can affect any other level. For example: • Peripheral neuropathy (**health condition**) causing bilateral leg pain (**impairment**) can limit one's ability to walk to one's bank (**activity limitation**) which in turn can limit one's ability to manage her/his household finances (**participation restriction**).
7	**Contextual factors** influence or shape people's experiences with these life-related impacts of health conditions. • **Environmental factors** are the physical, social and attitudinal environment in which people live and conduct their lives These contextual factors include the social determinants of health • **Personal factors** are internal to each individual (e.g., gender, age, coping styles, education, past medical history).

As health professionals bound by the HDC Code of Rights, all Massage Therapists should be displaying this poster in clinic where clients can see it. It is worthwhile getting informed about the Code and knowing your obligations.

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Your Rights when receiving a Health or Disability Service

Respect
You should be treated with respect. This includes respect for your culture, values and beliefs, as well as your right to personal privacy.

Fair Treatment
No one should discriminate against you, pressure you into something you do not want or take advantage of you in any way.

Dignity and Independence
Services should support you to live a dignified, independent life.

Proper Standards
You have the right to be treated with care and skill, and to receive services that reflect your needs. All those involved in your care should work together for you.

Communication
You have the right to be listened to, understood and receive information in whatever way you need. When it is necessary and practicable, an interpreter should be available.

Information
You have the right to have your condition explained and to be told what your choices are. This includes how long you may have to wait, an estimate of any costs, and likely benefits and side effects. You can ask any questions to help you to be fully informed.

It's Your Decision
It is up to you to decide. You can say no or change your mind at any time.

Support
You have the right to have someone with you to give you support in most circumstances.

Teaching and Research
All these rights also apply when taking part in teaching and research.

Complaints
It is OK to complain – your complaints help improve service. It must be easy for you to make a complaint, and it should not have an adverse effect on the way you are treated.

If you need help, ask the person or organisation providing the service. You can contact the local advocacy service on 0800 555 050 or the Health and Disability Commissioner on 0800 11 22 33 (TTY).

https://www.hdc.org.nz/media/2715/your-rights-poster-english.pdf

Better health for people with disabilities

World Health Organization

Over **1 BILLION** people globally experience disability

1 in 7 people

People with disabilities have the same general health care needs as others

But they are:

2x more likely to find health care providers' skills and facilities inadequate

3x more likely to be denied health care

4x more likely to be treated badly in the health care system

1/2 of people with disabilities cannot afford health care

They are:

50% more likely to suffer catastrophic health expenditure

These out-of-pocket health care payments can push a family into poverty

Rehabilitation and assistive devices can enable people with disabilities to be independent

970 MIL people need glasses and low vision aids

75 MIL people need a wheelchair; Only **5-15%** have access to one

466 MIL people have disabling hearing loss

Production of hearing aids only meets:

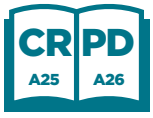
10% of global need

3% of developing countries' needs

Making all health care services accessible to people with disabilities is achievable and will reduce unacceptable health disparities

remove physical barriers to health facilities, information and equipment

make health care affordable



train all health care workers in disability issues including rights

invest in specific services such as rehabilitation

Source: World report on disability: www.who.int/disabilities/world_report

OPINION PIECE:

MASSAGE IN SOUTH EAST ASIA

by Grant C. Jones, RMT Wellington

Having travelled to a number of countries in South East (SE) Asia, 2013-2019, I have received more than one hundred and twenty relaxation massages: Philippines, (Manila, Boracay, Palawan) Taiwan, South Korea, Brunei, Thailand (Bangkok, Pattaya, Phuket), Hong Kong, Vietnam, Cambodia and Laos.

Relaxation massage varies in its style and delivery in these countries. If you are travelling to SE Asia, you may be interested in how to best prepare, before having a relaxation massage in these countries.

SOME COMMON FACTORS OF RELAXATION MASSAGE EXPERIENCED IN SE ASIA

- As a receiver, the quality of the massage, varied from a very mediocre experience (in a small number of cases) to excellent experience (approximately thirty percent) of the relaxation massages which I received.
- Relaxation massage, which is offered, appears to be dependent on the high number of tourists who want this service.
- In my experience, no pre assessment is given prior to the massage and any details relevant to the client were not recorded.
- Massage in almost all cases is "one size fits all." The style and delivery are not modified to meet individual needs unless an intending client, gives clear instructions on what they want, and one ensures that the instructions are clearly understood. This technique ensures that your needs are met for massage.
- The charges for a one-hour massage, vary between NZ$11-$20, but double or three times this price in four or five-star hotels, or at salons near such a venue.
- Quality oil appears to be used (often olive) with all massages, but oil is used sparingly with traditional Thai Massage.
- In all cases as a receiver of massage, it was indicated that the person giving the massage had at least received a basic course in the modality of their massage. I am not aware of any training being given in remedial or sports massage, and it is best to avoid requesting this.
- Client privacy was respected with the use of body coverings. There were properly screened massage rooms or in some cases sliding curtains were used between clients.
- Rooms used for massage were clean, as was the linen, and in most cases air conditioning was used with the temperatures outside often over 30 degrees.
- In all cases, massages therapists were well presented, often they were dressed in the uniform of their massage salon, evenly balanced male and female, and usually 18 - 30 years of age.
- Relaxation music prevailed, and therapists were happy to supply this if requested.
- In Bali and Thailand especially, the culture is for the massage therapists to promote their service to clients by standing outside their salon, giving verbal calls to people who pass by.
- There appears to be an oversupply of massage therapists in Bali and Thailand, with many therapists giving only two massages in a day.
- Booking a massage in SE Asia (other than at a hotel) is not the norm, or even possible in most cases - one just turns up any time between about 10.00 am and midnight or when the massage venue is open.
- There is a definite advantage in getting someone who is fluent in the language

Therapists outside a Balinese massage salon

of the country (often hotel reception) to translate from English to the language of the country: bullet points which state any relevant muscular/skeletal and medical conditions, and goals for your relaxation massage.

INDONESIA

Balinese Massage

Balinese massage originated in Bali, which is one of the several Indonesian islands, and Bali has many tourists. Massage is very relaxing and includes a range of mild stretching, acupressure, reflexology, stroking, kneading and the use of aromatherapy oils: in most cases jasmine is used.

It is common in public areas, outside of the salon, for the older therapists to walk up behind you and give you a neck and shoulder massage for 2-3 minutes, to promote their service.

On one of my visits, I did an exchange of massage training. In return for five sessions with a Balinese man who trained therapists for massage spas, I taught some of the basics of Swedish remedial massage. We used a "body" to teach and practise what we learnt. I found some of the Balinese stretching and acupressure I was shown, very useful, and I sometimes use this in my current massage. I was however unable to encourage or persuade this massage therapist to learn the importance of pre assessment and communication before a massage.

SURABAYA

This is the second largest city in Indonesia. I found the trend was to link reflexology within beauty therapy outlets. Because this is a Muslim sector of the country, I learnt that body massage is not at all common. Although I did come across a massage therapist who visited hotels with a portable table. The massage which I received was similar to Balinese, mainly stretching and acupressure and it was very well done, for the price NZ$20.

PHILIPPINES

I was unable to locate any indigenous massage, on my two visits to the Philippines (2016 and 2018), to Manilla, Boracay and Palawan. The following styles were predominant: Swedish, Thai, Balinese, Shiatsu massages and Acupuncture. Philippines has one definite advantage for visitors in that English is widely spoken.

I was delighted in Boracay where I had my first massage, to be asked to fill in a form which required information on medical conditions and whether I had a professional massage previously. Much to my surprise, the therapist did not look at the form or discuss it with me before the massage started. I did however give instructions, on my goals. It was an excellent massage, which I had on more than three occasions.

I took the opportunity to discuss the pre assessment/medical form with the manager of the venue and to congratulate her on having a preassessment and medical form for clients to complete.

I freely offered my services the next day to give two, one-hour sessions, to two groups of therapists on pre assessment, using the medical conditions form as a good starter. Followed by ascertaining what the intending client wants to achieve from their massage, and the value of getting feedback from the client after the massage.

THAILAND

My comments are based on two recent visits to Thailand - Bangkok, Pattaya, and Phuket. The last one in September 2019. Charges are varied but there is expectation to tip the therapist 10% of the massage if you are satisfied.

Traditional Thai Massage - requires a higher degree of training than oil massage. Thai massage uses pressure and stretching techniques to relax the whole body. This is an ancient healing practice that originated in India. This style of massage can be very painful unless you stress to the therapist at the start that you want comfortable and relaxing pressure. It is usual for this form of massage to be done on a floor mat. It is best to give this instruction written in Thai, at the start. Having done this, I then experienced some very good massages.

Foot Massage - This is based on reflexology, but it appears to be at very basic level from my experience and is given with the client sitting on a chair.

Thai Oil Massage – This is Swedish massage and it appears to be the most relaxing and popular of the services offered for massage. Regretfully the professional standard has slipped considerably in recent years and it is now often used as a popular prelude to a sex service for an extra fee. This is regrettable as not only does it lower the professional image of massage, but it tends to encourage the type of client who wants and expects this type of service.

AUTHOR BIO

Grant C. Jones RMT (L6), M.Ed. (Liv) MA Hons, Adv Dip PE (Leeds) Dip Tchg, N D Adult Ed & Training, PENZ (Fellow)

Grant currently works as a Massage therapist from his home clinic in Wellington, as well as being a health consultant dealing with stress management. He has worked as a tutor at the NZ College of Massage when it began in Wellington in 2000, and more recently worked part time at a Musculoskeletal Pain Specialist clinic. Grant was also on the Massage Advisory Group which developed the massage unit standards in the NZQA national framework.

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www.mfrworkshops.com

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- **Advanced Lower Body** - Delves deeper into treating conditions for back, hips, diaphragm, abdomen, legs & feet
- **Micro Fascial Unwinding** is a subtle yet profound way of working with clients on a body, mind and consciousness level. Through hand holds and deep listening skills we will unwind the body from the inside out. The work invites practitioners to sense deeply into the body, the tissues, stored memories and body consciousness, to create change on a truly holistic level.

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Videos Available

New Zealand College of Chinese Medicine

Massage Programme Leader

The New Zealand College of Chinese Medicine has a vacancy for a Massage Programme Leader.

This position is responsible for: Programme coordination for the NZ Diploma in Wellness and Relaxation Massage L5 and NZ Diploma in Remedial Massage L6); includes; supporting and coordinating teaching faculty for mixed mode of delivery - distance and face-face teaching, learning and assessment; developing course material and academic support etc.

The role can be part-time or full-time with teaching role; flexible location with willingness to travel; desirable Auckland based.

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www.chinesemedicine.ac.nz

USEFUL SITES AND ONLINE RESOURCES

The purpose of this column is to provide readers with a list of useful online resources, from websites, pdfs, facebook groups and other forums, to podcasts, youtube videos and webinars that are of interest to massage therapists. We aim to cast the net wider than just massage therapy – to other manual therapy disciplines, other fields of health and wellbeing and other areas such business, marketing and more. Anything we find that we believe will be of relevance to massage therapists can be found here, with a brief description. We try to relate each issue's selection to the theme, so for this issue you will find the focus ties in to the topic of diversity. We have grouped them into different areas.

MĀORI

Tikanga Māori A Guide for Health Care Workers (Kaimahi Hauora)

https://www.ccdhb.org.nz/our-services/a-to-z-of-our-services/maori-health/43875-tikanga-maori-web.pdf

These guidelines are put together by the Wellington Capital Coast DHB and are underpinned by Māori values, protocols, concepts, views on health and Te Tiriti o Waitangi. They may be useful as a starting point for Massage Therapists.

Māori Health Models

https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models

This Ministry of Health resource looks at three different Māori health models – Te Whare Tapa Whā, Te Wheke and Te Pae Mahutonga. For Māori, the philosophy towards health is based on a wellness or holistic health model and for many Māori, the major deficiency in modern health services is taha wairua (the spiritual dimension). These models are worthwhile knowing about, to help health professionals understand health and wellness from a Māori perspective.

REFUGEE AND MIGRANT

Refugee Council of New Zealand

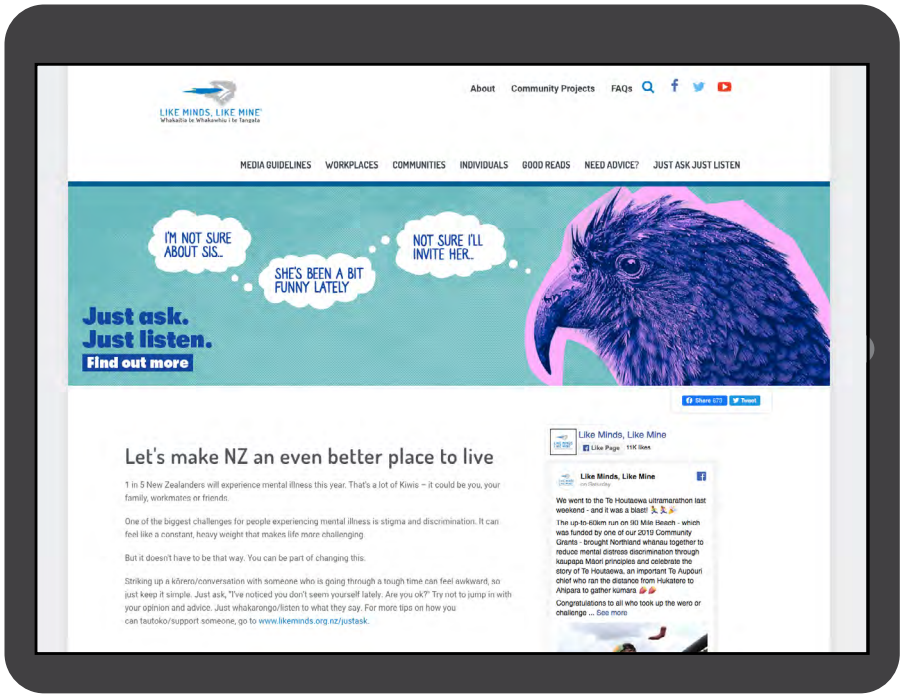
http://rc.org.nz/

The Refugee Council of New Zealand (RCNZ) is a national organisation whose purpose is to provide advice, information and assistance to asylum-seekers and refugees in New Zealand; promote a strategic response to the needs of refugees and asylum seekers; and to campaign to ensure that New Zealand meets its legal and humanitarian obligations under the 1951 United Nations Convention on Refugees.

Refugees As Survivors (RASNZ)

https://rasnz.co.nz/

RASNZ is the leading mental health service for people from refugee backgrounds. RASNZ promotes programmes and policies that respect and advance the health, wellbeing and human rights of people from refugee backgrounds. RASNZ works to provide people from refugee backgrounds with access to quality, culturally-sensitive mental health and wellbeing services to assist with positive resettlement in New Zealand. Their services include Psychological assessment and therapeutic interventions, body therapy (see the article by MNZ member Barry Vautier in this issue), community programmes and initiatives for people from refugee backgrounds and tailored support for young people from refugee backgrounds.



Migrant Action Trust

http://www.migrantactiontrust.org.nz/

The Migrant Action Trust run services by migrants for migrants. They work to support migrants from their arrival to meaningful employment and healthy integration, promote migrants and refugees as valuable stakeholders in New Zealand society and inform migrants of their role and responsibilities as residents.

Refugee Health Care: A handbook for health professionals

https://www.health.govt.nz/system/files/documents/publications/refugee-health-care-a-handbook-for-health-professionalsv2.pdf

Published by the Ministry of Health, this booklet discusses new refugee communities settled in New Zealand, emerging trends in the health of refugee groups and current therapies, and adds new service providers. Written in consultation with health providers, experts in the field and people from refugee backgrounds, it is designed to support health workers in primary, community and secondary health care settings in the delivery of safe, effective and culturally appropriate care for their refugee clients. While it is several years old it still provides valuable information for health professionals and may be useful for therapists who are working with clients who have a refugee background or are interested in working in this area.

MENTAL HEALTH

Like Minds, Like Mine

https://www.likeminds.org.nz/

Like Minds, Like Mine is a public awareness programme to increase social inclusion and end discrimination towards people with experience of mental illness or distress. They do this through public awareness campaigns, community projects and research. Their target audience is people who have the potential to exclude, particularly in workplace and community settings. Information they provide is useful for therapists and massage business owners.

In Safe Hands: Massage & PTSD

https://www.amtamassage.org/articles/3/MTJ/detail/3484/in-safe-hands-massage-ptsd

This resource from the American Massage Therapy Association discusses PTSD, symptoms, treatment, how massage therapy can help and what massage therapists need to know. It is a good introduction to PTSD.

Mental Health first aid training providers

1 in 6 New Zealand adults experience mental illness at some time during their life, this means that for every 6 adult clients you see as a massage therapist, one will have experienced or may be currently experiencing mental distress. It is therefore really important to have a good basic understanding of mental illness and be able to recognise developing mental illness, respond appropriately and guide clients to professional help, know how to avoid stigmatisation and know how to keep yourself well. Two mental health first aid course providers are:

St John

https://buy.stjohn.org.nz/first-aid/first-aid-courses/mental-health-first-aid

Coliberate

https://coliberate.co.nz/

SENIORS

Massage for seniors: what the research says

https://www.amtamassage.org/articles/3/MTJ/detail/2318/massage-for-seniors-what-the-research-says

This article from the AMTA looks at the benefits of massage for older people, focusing on two conditions – OA and Alzheimers.

Age Concern

https://www.ageconcern.org.nz/

Age Concern works to promote dignity, wellbeing, equity and respect and provide expert information and support services in response to older people's needs. There are local Age Concern branches throughout New Zealand. Their services include elder abuse and neglect intervention, an accredited visiting service to address social isolation and information on a range of subjects affecting older people. A great service to know about if working with older clients.

LGBTQI COMMUNITY

A number of online resources aimed at massage therapists, covering how you can ensure your practice is supportive and inclusive to clients from the LGBTQI community.

10 things you can do right now to welcome LGBTQ people to your massage practice

https://www.massagemag.com/10-things-you-can-do-right-now-to-welcome-lgbtq-people-to-your-massage-practice-41099/

Supporting transgender clients part 1

https://www.massagebusinessblueprint.com/supporting-transgender-clients-massage-practice-part-1-trans-101/

Supporting transgender clients part 2

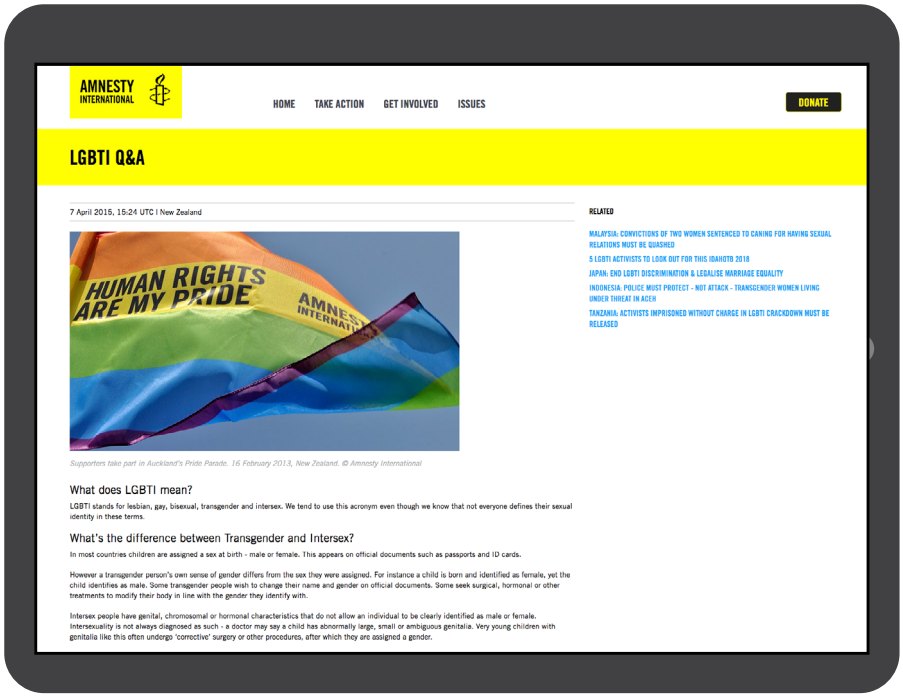
https://www.massagebusinessblueprint.com/supporting-transgender-clients-part-2-better/

Amnesty International LGBTI Q&A

https://www.amnesty.org.nz/lgbti-qa

This Q&A info from Amnesty International covers a range of questions about the LGBTI community and the work Amnesty International is doing to address discrimination against people for their sexual orientation or gender identity.

Every day across the globe, sexual orientation or gender identity leads to abuse in the form of discrimination, violence, imprisonment, torture, or even execution.



DISABILITIES

A range of articles aimed at massage therapists covering how to best work with clients with disabilities.

How to accommodate massage clients with health conditions

https://www.amtamassage.org/articles/3/MTJ/detail/2986/how-to-accommodate-massage-clients-with-health-conditions

Massage therapy for children with developmental disabilities

https://themtdc.com/massage-therapy-for-children-with-developmental-disabilities/

Physical disability massage

https://www.massagemag.com/physical-disability-massage-87115/

Disability Etiquette

https://www.odi.govt.nz/home/about-disability/disability-etiquette/

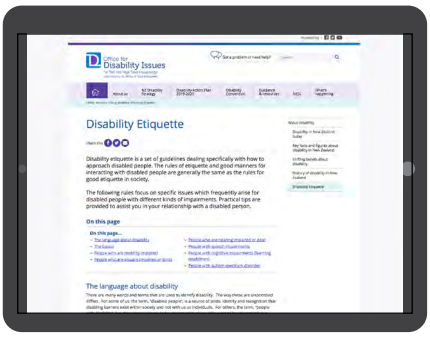
This fact sheet from provides some interesting facts.

If you work with disabled clients, this is resource from The Office of Disability Issues is worth referring to. Disability etiquette is a set of guidelines dealing specifically with how to approach disabled people. The rules of etiquette and good manners for interacting with disabled people are generally the same as the rules for good etiquette in society.

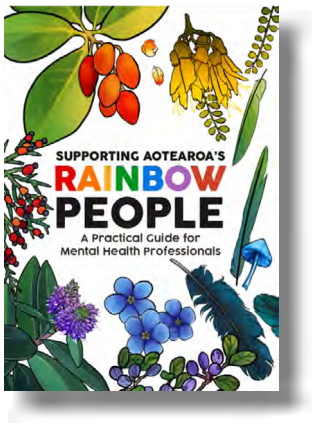
Disability Action Plan

https://www.beehive.govt.nz/release/disability-action-plan-2019-2023

If you are interested in higher level government planning, the current Labour government's action plan Disability Action Plan is aimed at working towards a more inclusive and accessible New Zealand. It consists of 25 work programmes across government agencies that have an explicit focus on improving outcomes for disabled people.



BOOK REVIEWS



Fraser, G. (2019).

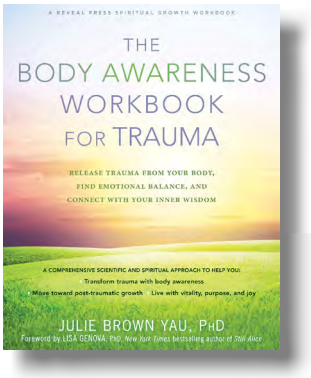
SUPPORTING AOTEAROA'S RAINBOW PEOPLE: A PRACTICAL GUIDE FOR MENTAL HEALTH PROFESSIONALS. WELLINGTON: YOUTH WELLBEING STUDY AND RAINBOWYOUTH

Based on findings from the Rainbow Mental Health Support Experiences Study and the Out Loud Aotearoa Project, this beautifully illustrated resource was created through collaboration between Youth Wellbeing Study, RainbowYOUTH, InsideOUT, and Gender Minorities Aotearoa. While it is aimed at mental health professionals, the resource has some valuable information relevant to all health professionals (including massage therapists) working with rainbow clients.

The booklet provides a good background, covering topics such as terminology and language, historical and contemporary contexts, how to provide a supportive therapeutic space, making your service rainbow friendly, and understanding the diversity of experiences among rainbow people. Rainbow people in New Zealand face a range of complex issues. Within many healthcare settings people in this community are often marginalised, subjected to misconceptions, assumptions, prejudice and discrimination, which can create barriers to accessing health care. It is just as important for massage therapists to be aware of these issues, as it is for other health professionals.

The resource helps to demystify and provide information which can help you to better understand the needs and experiences of rainbow clients, helping you to work in a supportive, inclusive and appropriate way.

The resource is available (for a donation) in hard copy booklet form, downloadable pdf and online format from https://www.rainbowmentalhealth.com/



Brown Yau, Julie

THE BODY AWARENESS WORKBOOK FOR TRAUMA

$26 NZD

Reveal Press, 2019

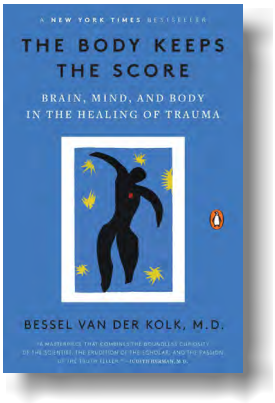
For years, we've understood the connection between trauma and mental health issues, such as depression and anxiety. But somatic psychology has recently shown that our bodies hold on to trauma, and trauma can manifest in physical symptoms, such as pain, hormone imbalance, sexual dysfunction, and addiction. In addition, we now know that developmental trauma—trauma that emerges when basic childhood needs are not met—can result in profound emotional stress and lead to serious diseases.

Building on this knowledge, this cutting-edge guide offers simple skills for connecting and calming your body, balancing your emotions, and rewiring old patterns of reactivity for better self regulation. The mind-body approach in this book is designed to guide you away from post-traumatic stress disorder (PTSD) and trauma and toward post-traumatic growth. Using these exercises, you'll learn how to reconnect and relate to your body and yourself as a whole, in a new and healthy way.

If you're ready to move past your trauma and rediscover your body's innate capacity for healing, growth, vitality, and joy, this unique guide will help light the way.

Recommended by Barry Vautier

Retrieved from https://www.amazon.com/Body-Awareness-Workbook-Trauma-Emotional/dp/168403325X



Van der Kolk, Bessel

THE BODY KEEPS THE SCORE: BRAIN, MIND, AND BODY IN THE HEALING OF TRAUMA

$19 NZD

Penguin Books, 2015

In the Body Keeps the Score, Van der Kolk, uses recent scientific advances to show how trauma literally reshapes both body and brain, compromising sufferers' capacities for pleasure, engagement, self-control, and trust. He explores innovative treatments, from neurofeedback and meditation to sports, drama, and yoga, that offer new paths to recovery by activating the brain's natural neuroplasticity. Based on Dr. van der Kolk's own research and that of other leading specialists, The Body Keeps the Score exposes the tremendous power of our relationships both to hurt and to heal—and offers new hope for reclaiming lives.

Also recommended by Barry Vautier

Retrieved from https://www.amazon.com/Body-Keeps-Score-Healing-Trauma/dp/0143127748

MASSAGE THERAPY RESEARCH UPDATE: COULD MASSAGE IMPACT THE LIVES OF ELDERS WITH DISABILITIES?

Greetings, MNZ readers!

It is exciting to be part of an edition of Massage New Zealand dedicated to the recognition and welcoming of diverse populations in massage therapy, both as providers and receivers. I started down a few pathways in pulling together some research to contribute to the mix, but I ended up deciding to shine a light on what we currently understand about massage in the context of a frequently under-served and drastically under-touched population: our elders—especially our elders with mental or cognitive disabilities.

As usual, in this Research Update I have chosen three papers to review. One is a dated and small-scale but very interesting study of nursing home residents and agitation; one is a review of massage therapy research in the context of residential care settings in general; and we'll finish with a review-of-reviews of interventions for behavioral disturbances among seniors, which places massage therapy in the context of other nonpharmacological interventions for this population.

We'll start with the small-scale study first. This article dates from 2009, but it has some clear findings that make it a worthwhile position paper on which to base further study.

HOLLIDAY-WELSH DM, GESSERT CE, RENIER CM. MASSAGE IN THE MANAGEMENT OF AGITATION IN NURSING HOME RESIDENTS WITH COGNITIVE IMPAIRMENT. GERIATR NURS. 2009;30(2):108–117. DOI:10.1016/J.GERINURSE.2008.06.016

Abstract (edited for space and formatting)

Introduction: Managing agitation in seniors with cognitive impairment is important, and pharmacological options have many undesirable side effects.

Methods: This was a prospective study designed to examine the potential of massage to reduce agitation in cognitively impaired nursing home residents. Subjects were identified as susceptible to agitation by nursing home staff or by Minimum Data Set (MDS) report. Data was collected during baseline (3 days), intervention (6 days), and at follow-up. At each observation, agitation was scored 5 times during the 1-hour window of observation.

Results: Subjects' agitation was lower during the massage intervention than at baseline (2.05 vs. 1.22, $P < .001$), and remained lower at follow-up.

Discussion: When analysis was restricted to residents with significant levels of agitation at baseline, the observed effects of massage on agitation increased. Massage is an accessible, easily learned intervention that is effective in controlling some types of agitation in elders with cognitive impairment. Massage should be studied further as a nonpharmacological intervention in such patients.

Ruth's observations:

This study was conducted in a set of three nursing homes in the upper Midwest of the United States. Fifty-two subjects were included, with a mean age of 90 years. Researchers looked for changes in five problematic behaviors: wandering; being verbally agitated or abusive; being physically agitated or abusive; being socially inappropriate or disruptive; and resisting care.

The subjects in this study all had moderate to severe cognitive impairment and a history of agitated behavior, as confirmed by the staff. They all had "control of behaviors" listed as a goal in their care plans. Consent was obtained from the families or surrogates of the subjects, and from the subjects themselves in verbal form before each session.

The staff made note of the time of day when each subject tended to be most agitated, and it was within this timeframe that each one was observed and rated on a scale of 0-6 for displaying the targeted behaviors.

Baseline measures were taken for 3-5 days before the massage intervention began. The subjects received 10-15 minute massage sessions twice a week for 2 weeks, and measures were taken during this period. Then they were taken again at 7 and 14 days after the massages were stopped. All observations were made during the subjects' most agitated times of day.

Of the 5 behaviors examined in this study, massage was associated with significant improvement for 4: wandering; verbal agitation or abuse; physical agitation or abuse; and resisting care, and these benefits persisted through the follow-up period. Interestingly, the more impaired the person was, the more improvement they had with massage.

The authors suggest that massage should be seen as a multifaceted intervention, and its physical effects for this population may be less important than the experience of focused one-on-one attention, positive nonverbal communication and connection, and simple human touch. They conclude, "We believe that at present, massage is best understood as an intervention that affects patients through both physical and psychosocial pathways."

Weaknesses?

No massage therapists were used in this study; a physical therapy assistant with some training in soft tissue technique provided all the massages. These authors also suggest that massage is safe and easily taught to others—a point I would like to argue, since elderly people often have physical restrictions that require adaptation in some types of massage—even gentle relaxing massage. I am glad these researchers got such good results, but I wonder if they might be even better if massage therapists educated in working with medically complex clients had been a part of the study.

As we will see, this is a repeating theme in research about massage conducted for the elderly, including this lovely 2016 review of studies:

MCFEETERS S, PRONT L, CUTHBERTSON L, KING L. MASSAGE, A COMPLEMENTARY THERAPY EFFECTIVELY PROMOTING THE HEALTH AND WELL-BEING OF OLDER PEOPLE IN RESIDENTIAL CARE SETTINGS: A REVIEW OF THE LITERATURE. INT J OLDER PEOPLE NURS. 2016;11(4):266–283. DOI:10.1111/OPN.12115

Abstract (edited for space and formatting)

Introduction: Globally, the proportion of people over 65 years is rapidly rising. Increased longevity means older people may experience a rise in physiological and psychological health problems. These issues potentially place an increased demand for quality long-term care for the older person. Complementary approaches such as massage appear to be needed in quality residential care. The aim of this study is to explore the potential benefits of massage within daily routine care of the older person in residential care settings.

Methods: A literature review pertaining to massage in the older resident was conducted using a range of online databases. Fourteen studies dated 1993-2012 met the inclusion criteria and were critically evaluated as suitable resources for this review.

Results: Evidence suggests massage may be advantageous from client and nursing perspectives. Clients perceive massage to positively influence factors such as pain, sleep, emotional status and psychosocial health. Evidence also demonstrates massage to benefit the client and organization by reducing the necessity for restraint and pharmacological intervention. Massage may be incorporated into care provision and adopted by care providers and family members as an additional strategy to enhance quality of life for older people.

Discussion: Massage offers a practical activity that can be used to enhance the health and well-being of the older person in residential care. Massage offers benefit for promoting health and well-being of the older person along with potential increased engagement of family in care provision. Integration of massage into daily care activities of the older person requires ongoing promotion and implementation.

Ruth's Observations:

This was a terrific review, with much to commend it. One thing I especially appreciated was that the authors reported their findings from client perspectives and nursing staff perspectives. From the client perspectives they came to 6 conclusions:

1. Massage reduced anxiety and agitation behaviors;
2. Massage improved relationships and interpersonal communication;
3. People who received massage reported better sleep and relaxation, and used fewer drugs to induce sleep;
4. The non-task touch provided by massage addressed touch deprivation and social isolation that many nursing home residents live with;
5. Massage improved mood and emotional well-being;
6. Massage improved pain and discomfort.

From the nursing staff they found…

1. Massage had sustained benefits for anxiety, agitation, and conflict;
2. Massage reduced the need for physical restraints and pharmacological restraints (i.e., tranquilizers);
3. Massage is easily taught to nursing staff;
4. Massage is well-accepted by staff, and a good fit with organizational structure.

Another feature I liked in this piece was a sidebar dedicated to appropriate actions or applications of findings. The authors recommended that massage be further studied, especially since its benefits seem to extend beyond treatment for pain and relaxation; they suggest that nurses could undertake massage, and teach friends, family, and other carers to provide it as well; and that government funding for healthy aging should include massage in the care regime for older people.

Weaknesses? Yes, a couple

While I want to promote this study from the rooftops, it is important to point out that—once again—no massage therapists were used in this project. All of the massage provided was performed by nursing staff.

The authors made an interesting and somewhat self-contradictory observation when they stated that elders need complex integrative care, especially when they have several overlaying pathologies or conditions that color their health, and in the next paragraph they said that "for a fundamental informal relaxation massage, providers can easily learn elementary techniques." Massage for medically complex patients is a whole specialty within this profession, and it is distressing to see the complexity of this skillset minimized. Further, while I don't know the situation in New Zealand, I can confidently say that in the majority of nursing homes in the U.S., nurses do not have the time to add twice-weekly 10-15 minute sessions of gentle, relaxing, non-task-oriented touch for each resident to their already overcrowded schedules.

I am delighted to see that educated touch is valued in this setting; I hope that massage therapists will likewise be valued. And I wonder if results would be even greater, leading to better quality of life for residents, lower care costs, and fewer medical complications, if appropriately educated massage therapists were part of such a program.

Our final article is a 2017 systematic review of systematic reviews. Instead of looking specifically at massage therapy for elders with disabilities, it compares all kinds of interventions, including light therapy, music therapy, massage therapy, and many others for the group of behaviors called behavioral and psychological symptoms in dementia (BPSD).

ABRAHA I, RIMLAND JM, TROTTA FM, ET AL. SYSTEMATIC REVIEW OF SYSTEMATIC REVIEWS OF NON-PHARMACOLOGICAL INTERVENTIONS TO TREAT BEHAVIORAL DISTURBANCES IN OLDER PATIENTS WITH DEMENTIA. THE SENATOR-ONTOP SERIES [PUBLISHED CORRECTION APPEARS IN BMJ OPEN. 2017 JUL 17;7(7):E012759CORR1]. BMJ OPEN. 2017;7(3):E012759. PUBLISHED 2017 MAR 16. DOI:10.1136/BMJOPEN-2016-012759

Abstract (edited for space and formatting)

Introduction: The goal of this study is to provide an overview of non-pharmacological interventions for behavioral and psychological symptoms in dementia (BPSD).

Method: Systematic overview of reviews, using PubMed, EMBASE, Cochrane Database of Systematic Reviews, CINAHL and PsycINFO (2009-March 2015). Systematic reviews (SRs) that included at least one comparative study evaluating any non-pharmacological intervention, to treat BPSD were included. Eligible studies were selected and data extracted independently by 2 reviewers. The AMSTAR checklist was used to assess the quality of the SRs. Extracted data were synthesized using a narrative approach.

Results: 38 SRs and 129 primary studies were identified, comprising several categories of non-pharmacological interventions, including shiatsu, acupressure, massage, and touch therapy (among many others).

Discussion: A large number of non-pharmacological interventions for BPSD were identified. The majority of the studies had great variation in how the same type of intervention was defined and applied, the follow-up duration, the type of outcome measured, usually with modest sample size. Overall, music therapy and behavioral management techniques were effective for reducing BPSD.

Ruth's observations:

My hat is off to the team that undertook this project—it was monumental, and it speaks to the continually rising priority of finding nonpharmacological options to care for seniors with disabilities. And in the mishmash of research on massage, cognitive behavioral therapy, horticultural activities, and dozens of others, they sought to compare outcomes and effectiveness. It is not surprising that they found tremendous variation in how each intervention was studied.

One of the problems this project points to in massage therapy research (along with other disciplines) is inconsistency in reporting. If every researcher provided information that could be compared and evaluated in a similar way, our cumulative findings would be much stronger. (The Massage Therapy Foundation has addressed this challenge with the publication of the STRICT-M checklist. This stands for Standards for Reporting Interventions in Clinical Trials of Massage, available here https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4925170) I hope that any researchers contributing to our body of knowledge is willing to comply with this checklist, because it will make future projects much more useable in systematic reviews.

The opening argument for the need for this study is deeply compelling, making the case that nonpharmacological options for BPSD are badly needed, because the adverse events associated with psychotropic drugs are serious (including poor quality of life, but also a more emergent risk of falls and mortality). The authors set out not only to compare nonpharmacological interventions to see which have the best effects, but also to create a compendium of such interventions so future research can build on this base.

They began with 4,392 studies, which were pared down to 38: still a huge number of studies to include in a systematic review. Then they pulled 129 individual studies out of the systematic reviews for further data. They created six categories of interventions. These include (italics mine)...

1. Sensory stimulation interventions that encompassed: shiatsu and acupressure, aromatherapy, massage/touch therapy, light therapy, sensory garden and horticultural activities, music/dance therapy, dance therapy, snoezelen multisensory stimulation therapy, transcutaneous electrical nerve stimulation;
2. Cognitive/emotion-oriented interventions that included cognitive stimulation, reminiscence therapy, validation therapy, simulated presence therapy;
3. Behavior management techniques;
4. Multicomponent interventions;

5. Other therapies comprising exercise therapy, animal-assisted therapy, special care unit and dining room environment-based interventions.

They discuss massage and related interventions as represented by several studies, including the Holliday-Welsh one discussed above. Their conclusions are that massage studies show consistent improvement in agitation scores, but they are highly susceptible to inclusion bias. (This was an issue in the Holliday-Welsh study, but only as a possible negative influence: the researchers specifically chose residents with high rates of agitated behaviors to be part of the project.)

The final conclusions of this review of reviews is that the most predictably effective interventions for BPSD are music therapy and behavioral management techniques, but this was influenced by vastly inconsistent reporting standards. This doesn't mean that other interventions (like massage, or dance, or gardening) are ineffective. But it does mean that our profession is under-represented in this field, and that we need more massage therapists involved in the creation of important research studies.

Again, I am forced to wonder if whether including massage therapists with specialized education in working with elders with BPSD might have improved outcomes in the studies included—especially if researchers used reporting methods that are more in line with conventional medical research.

This brief exploration of the research on massage therapy for seniors with disabilities elicits in me both frustration and optimism. Frustration, because research is being conducted and published about our profession without using our professionals, and optimism because the newest generation of massage therapists is more research literate and more likely to get involved in high-level research projects than any in history. I am closer to the end of my career in this field than I am to the beginning of it, but I plan to be around long enough to see my youngest colleagues change the landscape of our profession.

AUTHOR BIO

Ruth Werner is an educator, writer, and retired massage therapist with a passionate interest in massage therapy research and the role of bodywork for people who live with health challenges. Her groundbreaking textbook, A Massage Therapist's Guide to Pathology was first published in 1998, and is now in its 7th edition, published by Books of Discovery.

Ruth is a columnist for Massage and Bodywork magazine and Massage New Zealand. She serves on several national and international volunteer committees, and teaches continuing education workshops in research and pathology all over the world. Ruth was honored with the AMTA Council of Schools Teacher of the Year Award for 2005. She was proud to serve the Massage Therapy Foundation as a Trustee from 2007 to 2017, and as President of the Foundation from 2010-2014.

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