PROVIDING NEWS AND INFORMATION TO MASSAGE THERAPY PROFESSIONALS IN NEW ZEALAND

MNZ MAGAZINE

massage new zealand

ISSUE 2 2020

Sustainability

Ideas for sustaining your practice, your career, and yourself.

BUILT TO LAST • SHARED DECISION-MAKING IN THE MANUAL THERAPIES • BUILDING SUSTAINABILITY IN PRACTICE THROUGH THERAPEUTIC ALLIANCE • PART OF YOUR SUSTAINABLE PRACTICE IS PERSEVERANCE • RESEARCH ON OUR DOORSTEP – A NEW ZEALAND MASSAGE THERAPY RESEARCH PROJECT • PATIENT CENTRED ONLINE CONSULTATION • STAYING SUSTAINABLE IN YOUR CLINIC PRACTICE WITH CLIENTS DURING COVID-19 LOCKDOWN • HANGING FOR SHOULDER HEALTH AND FUNCTION • BUILD BACK BETTER: A NON-PARTISAN COVID-19 RECOVERY FRAMEWORK FROM RECOVERY TO RESILIENCE

Dear MNZ Members,

Due to the recent COVID-19 situation it has been decided to cancel the 2020 MNZ Case Study Report Contest. The contest will resume as usual in 2021. Further information for the 2021 contest is due to be published early next year.

For general information about the contest please follow this link:
https://www.massagenewzealand.org.nz/Site/news/case-report-contest.aspx

We look forward to receiving new entries in 2021.

Kind regards, MNZ Executive Committee

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EDITORIAL ISSUE 2 2020

One word that should be on all of our lips – ***Sustainability***. In this issue we aim to inspire you with ideas to sustain your practice, your career, and yourself.

We have wonderful articles from Tania Velasquez who discusses sustaining ones practice during and beyond COVID-19 in *Built to Last,* and Walt Fritz who looks at how clinical decisions might impact the sustainability of our manual therapy interventions in *Shared Decision-making in the Manual Therapies*. Jamie M Johnston explores therapeutic alliance and the eight themes that are part of this in his article *Building Sustainability in Practice through Therapeutic Alliance* and Heather Thuesen acknowledges the deep psychological values of grief in order to be resilient in her contribution, *Part of your Sustainable Practice is Perseverance.* We truly appreciate these inspiring words in these tough times.

Research on our profession is being conducted on our doorstep and SIT BTSM student Sarah Rule provides readers with a summary of her research topic - *What are the demographics, practice patterns and industry opinions of people that have a NZQA or equivalent qualification in massage?* Sarah has been trying to access as many Massage Therapists as possible for her sample. We believe that it is important we get behind her and others like her doing valuable research on our profession. By the time we go to print, we hope Sarah has obtained her intended response rate.

Online consultations could become the norm, NOI and Odette Wood share their experiences. These may inspire all of us to maintain a level of sustainability in future challenging times, and to develop the "soft skills" that are so vital in working with clients in person and in the digital space.

We bring you three new columns too. Carol Wilson pens two of these - **Pathology**, with the first topic being *Covid-19 Associated Coagulopathy (CAC)*, and **Anatomy** which in this issue looks at the *Immune System*. These two topics are useful to understand in more depth to (re)educate ourselves and educate our clients. The third new column is **Business Matters**, and in this issue Steve Hockley of BNI looks at *Sustaining Your Practice and Drive in Difficult Times.* Having access to Steve's knowledge is a bonus for our magazine.

Finally, Ruth Werner continues to write with the benefit of her vast knowledge in our regular column, **Massage Therapy Research Update.** She has cleverly reported on three research articles and looked at the topic of *Sustainability of Massage Therapy Benefits* in three scenarios: chronic headaches, perinatal care and pre-hypertension. We always appreciate Ruth's contribution, especially when she is writing so much on pathology for the international massage community as well.

We are proud of this issue and the many facets of sustainability we cover, especially as it was bought together during a challenging time for us all. We would particularly like to express our gratitude for the input of our valued overseas colleagues at this busy time. Our thoughts are with you all as COVID-19 continues to have such an impact. Kia kaha, kia maia, kia manawanui. Be strong, be brave, be steadfast, dear friends.

As always members, we hope you take time to have a thorough read. Remember, MNZ Magazine is part of your annual fees – make the most of it!

Carol and Odette

ARTICLE SUBMISSION AND ADVERTISING SPECIFICATIONS

SUBMISSION DEADLINES

The MNZ Magazine will be published:

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

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.

ADVERTISING RATES AND PAYMENT

MNZ Magazine now ONLINE only.

For current advertising opportunities and pricing please see:

https://www.massagenewzealand.org.nz/Site/about/advertise/advertising-opportunities.aspx

Advertisements must be booked via the online booking form and paid online.

https://www.massagenewzealand.org.nz/tools/email.aspx?SECT=advertise

ADVERTISEMENT SPECIFICATIONS

Advertisements must have good taste, accuracy and truthful information. It is an offence to publish untruthful, misleading or deceptive advertisements. Advertisements for therapeutic goods and devices must conform to New Zealand therapeutic goods law.

Only a limited number of advertisements can be accepted. Advertising availability closes once the quota has been filled.

Magazine Page Sizes

- Full page is 210mm wide x 297mm high
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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

Hey Team,

At the time of writing this, we are one week into alert level 1, after a very different take on our previous lifestyles. Well done on making it through these challenges, hopefully everyone is far more resilient and prepared for any future adaptions that come into our lives.

As a reference of the experience encountered, COVID-19 alert level dates are listed below. Taken from the official NZ COVID-19 website:

DATES WHEN DIFFERENT ALERT LEVELS CAME INTO FORCE

- COVID-19 Alert Level 4 came into force at 11:59pm Wednesday 25 March 2020.
- COVID-19 Alert Level 3 came into force at 11:59pm Monday 27 April 2020.
- COVID-19 Alert Level 2 came into force at 11:59pm Wednesday 13 May 2020.
- COVID-19 Alert Level 1 came into force at 11:59pm Monday 8 June 2020.

With weekly, sometimes twice weekly president emails through the COVID-19 alert levels, there is not much you aren't already up to speed with. Previous Massage New Zealand (MNZ) Executive Committee priorities were put on hold, as we rallied around collecting COVID information and guidance to distribute. As we normalise further, we will continue to work on priorities that lift our policy depth whilst increasing professional practice. It is important that we all think about what it is that promotes our professional reputation/practices, and action them. Our current policies have the basics and are a great starting point, but not an absolute. If we choose to go over and above because it is a more professional thing to do, then do so. We will be asking for volunteers to assist in creating some more in-depth work on policies, please help where you can.

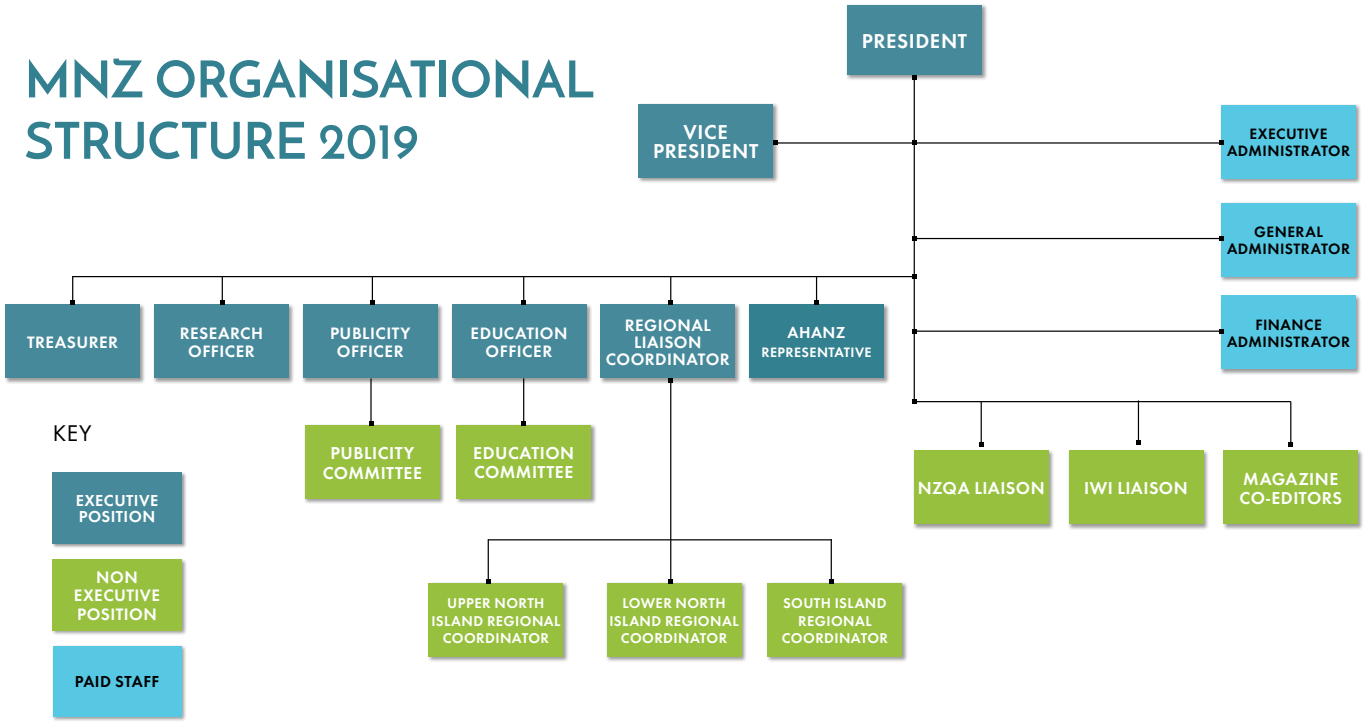
We have negotiated a deal with Massage & Myotherapy Australia regarding their online learning modules (HALO). This means that MNZ will be able to access content at members prices, so keep an eye out for further details.

We are currently working through dates and logistics for this year's Annual General Meeting (AGM), as there is no conference. Hopefully at time of reading this, dates will have been delivered. 2020 has been a year of firsts so far, and as expected there will be more time and thought needed to create a useful experience. With more technology practice, there may be options for this inclusion, which will allow many more to attend. Watch this space.

Enjoy this edition of the magazine, keep safe, and happy massaging.

Clint

MNZ ORGANISATIONAL STRUCTURE 2019



ADMIN REPORT

This report is being written on the first day of Alert Level 1 in New Zealand, and what a fine day it is! There is a strong feeling of pride amongst us. We have all worked hard at doing the right thing, sticking together as a nation, community, and profession. It has paid off and now it is time to move forward but let us not forget what we have learnt through this experience. It has certainly been a strange and worrying time, yet it has allowed some extra time for self-reflection. And, perhaps the opportunity to gain focus on what is most important in personal life and work. Getting back to "normality" is a fluid process.

When life gives you lemons, make lemonade. This expression has never felt so challenging and essential. Have we been asking ourselves the right questions? What have we learnt from this experience? How can we use this new knowledge and experience to improve ourselves as therapists and improve the experience for our clients? As we recover emotionally, physically, financially, believe that we will come out the other end stronger, smarter, and more resilient.

The MNZ Admin team and Executive Committee have been under considerable pressure recently. There has been a huge amount of new information to take in and work with. The process of shifting priorities and working under time pressure has been challenging to say the least. A BIG thank you to everyone in the team. At times like these it shows you how important it is to have strong teammates who support each other and work harmoniously.

We would also like to thank MNZ members. We have received a great deal of support and encouragement from you, and this has helped to keep us going! We will continue to do our best to respond efficiently and in a timely manner to your queries and concerns. Please do give us a call though if you have not seen a response in a while or if it is a matter requiring more urgency.

It was great to see members making use of the MNZ Forum recently on the website. Let's keep communication open, flowing and supportive out there - https://www.massagenewzealand.org.nz/tools/discussion/topics.aspx?SECT=forum

Keep up the great work everyone!

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

MEMBERSHIP UPDATE

Figures for this period show a total of 333 members, made up of 274 RMTs (6 of these are new graduate members), 48 students and 11 affiliates. This year MNZ extended the membership renewal period until 31 May 2020 given the unprecedented COVID-19 epidemic. The membership numbers have started to climb after this extension and once New Zealand entered alert level 2.

If you are a student please encourage your fellow students to become MNZ members too. They will receive a free membership with benefits and not to mention the graduate fee of $100 the year following their studies. We have quite a few new members coming on board and a few that have had a break from massage but just getting back into it. 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.

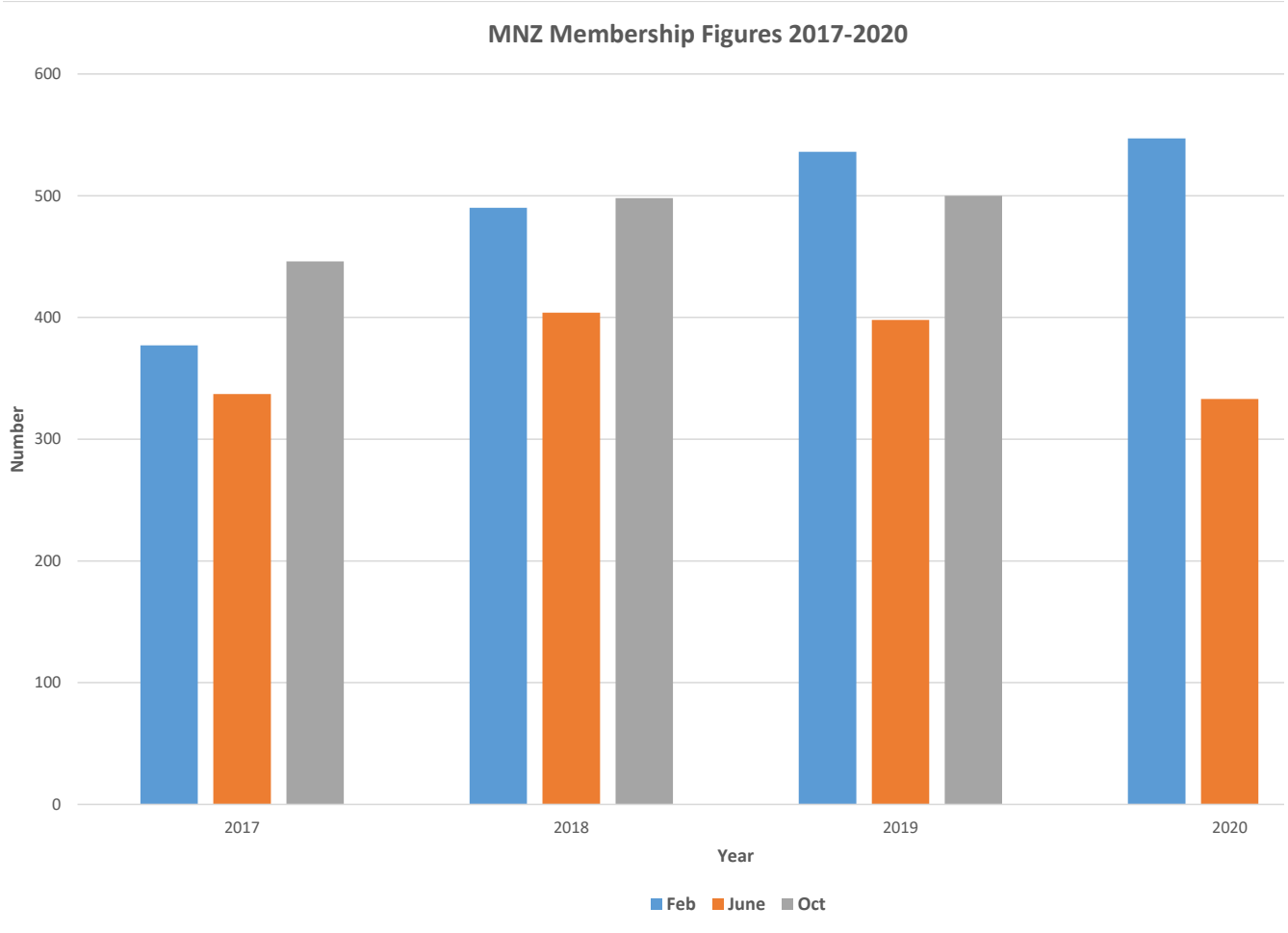


Figure 1. MNZ Membership Figures 2017-2020 as at June 2020

WHAT'S ON...

EVENT	WHAT/WHEN/WHERE/HOW TO REGISTER
Northland MNZ Networking	Sambur, 11 Maraenui Drive, Kerikeri **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
Auckland Northshore MNZ Networking	Kawai, Purapura **Contact**: Kristin Carmichael upperNIrep@massagenewzealand.org.nz
Auckland MNZ Networking	NZCM Auckland, Greenlane Tue 18 August with James Stitchbury presenting on "Craniosacral Therapy" **Contact**: Jeannie Douglas jeannie@biodynamicmassage.nz
Hamilton & Surrounds MNZ Networking	The Cancer Society's Lions Lodge, Hamilton 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	**Contact**: Janita Dubrey lowernirep@massagenewzealand.org.nz
Wellington MNZ Networking	NZCM Wellington, Level 1, Railway Station **Contact**: Ali Sullivan ali@bodyofwork.co.nz or Allison Anderson 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
Massage Therapists Discuss!	A virtual discussion group space for Massage Therapists via Zoom bi-weekly Tuesday 11th August Tuesday 25th August **Contact**: Christy Munro cmunro.rmt@gmail.com

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

BUILT TO LAST

By Tania Velásquez, LMT, Founder of PinpointEducation.com

It would be impossible to discuss career sustainability without addressing the fact our world has been violently shaken and we're still reeling from it. These recent months have brought about global upheaval at every level imaginable. I write this from New York City, where coronavirus has torn through communities and scarred tens of thousands of lives, and counting. This pandemic has impacted everyone in some way and in ways we could not have ever imagined. As a massage therapist whose life's work revolves around the very contact we've been required to avoid, it's definitely impacted mine. Talk about a kick in the pants.

Everyone is fumbling to find solutions in unfamiliar territory for a multi-faceted problem that continues morphing. Every week is an updated version of "what do we do now?", and no one seems to know what to do with massage therapists. I keep hoping the science gods will alchemize the vaccine by next week so we can all just go back to paying a normal amount for hand sanitizer again. But we know those are slim Vegas odds, at least for the immediate future.

Moving forward as massage therapists has become a complex game of chicken with an invisible opponent. We're certain we want to move forward, but how do we proceed ethically and morally as a profession whose service is needed more than ever? And how can we reinvent ourselves, as professionals, in ways that do not leave us blindsided again?

First and foremost, we need to accept that coronavirus will be with us for a while. We need to make peace with the idea nothing may ever be as it was before. And if one day we do return to a semblance of our former "normal", anyone with consciousness will be processing the reverberations of this collective trauma for a long while.

Loved ones have been lost, lives forever changed and entire livelihoods shattered. Nature has forced each of us to confront our evolutionary interdependence on one another. The world is seeing that the negative effects of touch deprivation can be as devastating as the havoc this virus has wreaked around the globe. Mental health crises are at an all-time high. Medical teams and essential workers are overwhelmed by unfathomable physical and emotional stress. This is piled on top of having to contend with the stresses and irrationalities of the public they are working to save.

This has taken an enormous holistic toll on society. It's been exacerbated by needing to suppress our instinctual need to be with each other. Everyone is feeling the deep ache that emerges when we cannot extend a hand of support to comfort a person in pain; or receive a hug to help heal during life's most difficult moments.

In the history of the world, we've never experienced such a profound deficit of tactile human interaction and it's brought us back to recognizing who we are as a species. It's reminded us of what matters most. It's why clients still call and it's why we need to figure out how to move forward in a way that is safe, honest, and built to last.

Massage therapists have a broad range of personalities. We generally work in one or more of the following capacities: the rehabilitative and therapeutic, health and lifestyle, and/or the traditional cultural arena. Some work independently, others as part of a team. Some lead, advocate, and educate. There are those who have 3000+ hours of serious credentialed training and others with no training at all, and one isn't necessarily more talented than the other. There really isn't a more eclectic bunch of professionals required to arrive at a consensus on how to forge ahead wisely in the times of coronavirus. Herding cats would be much easier.

We're a profession rife with enormous inconsistencies across borders. There are professionals who work towards legitimising the industry and representing it with excellence, and then there are those who perplexingly superimpose fantasy over physiology. To each their own, but right now the public needs reassurance they can google a random massage therapist and trust us with their literal lives. So far, it's a roll of the dice. Massage therapists who don't value science literacy may find themselves in hot water.

These times demand unity in our common desire to help others and clear messaging about how we roll. Whether we care to admit it or not, our profession is still all over the place and now isn't the time to wave a sage wand and hope for the best. We must get on the same page as epidemiologists and follow their lead in order to be worthy of public trust.

True character shows itself in times of crisis and not all massage professionals are woven of the same high-quality standards. We're discovering which therapists are made of fine silk. They're pausing to think critically about what reopening may truly entail. Even if it means taking a financial hit for an unknown amount of time to make sure it can be done at the top level. These are the professionals who embody what it means to "do no harm", above all else. These are the ones who can be trusted unequivocally with the well-being of another once we get back into the swing of things. These are the ones who are passing the ultimate test of professional integrity.

And then there are the polyester-acrylic blend MTs (and government officials, to boot). These are the ones who ignore rudimentary science and community safety procedures. These are the ones who choose to act from a place of desperation rather than grounded education and will cut corners for any pittance. These are the ones I would not trust to care for the general public. They give the profession a bad rap.

I understand needing and wanting to get back to business as usual. People have families to support, bills due, and lives to continue cultivating. I understand things are complex and not so black and white. Some regions are more affected than others, and with that, urgency and acute precautions vary. There is basic economics. There's

nuance. There is hope for a miracle. All of that considered, we still can't move forward sustainably as a profession under an illusion of safety or conveniently forget coronavirus behaves like a wildfire. There are clear facts telling us that it ain't over yet.

It's not kosher to mislead clients with sterile fantasies such as, "I sanitize everything for 30 minutes and wear an astronaut's suit the whole time. You're safe here", even though it's well known surface contact isn't the primary means of coronavirus transmission. All you need to do is breathe to be at risk. "Well, I also take temperatures", even though we know popping a couple of aspirin will lower temperatures and standing outside in the summer will raise temperatures. I guess we can expect plenty of false positives as well as false negatives. And what about our own temperatures? The most complicating factor of all is that whole asymptomatic thing. Who wants to be the MT who tells the client "come on in, everything's peachy", and then passes the virus onto them? That's a tough one to live down.

It's our job to let the public know that no matter how much sanitising we do, there's still a very real risk of transmission as long as we are breathing. I don't know about you, but I'm not able to hold my breath for 65+ minutes at a time while performing physical labour. To be fair, some won't mind that risk and that's entirely for them to accept with open eyes. My point is that it's not for us to put rose-coloured glasses on it.

Let's not play Russian Roulette by pretending masks and bleach-wipes are 100% full-proof. Just because surfaces are being wiped and masks are being worn does not mean the gun isn't loaded. That's something everyone needs to internalize before reopening. Perhaps the only way to move forward is with that explicit communication and well-informed consent. Clients need to understand we can engage as safely as possible but are each still potential spreaders. With that, mutual respect and consideration should be honoured from their end, also.

This isn't a matter of never being able to work again. Of course, we will figure out a way forward. I mean, how many epidemics and pandemics has massage weathered since the dawn of time? All of them. And it will weather this one, too, because touch is humanity's first medicine, and right now one of the most sorely needed. Manual therapy isn't going anywhere, it's just a matter of pausing so we can rise to the occasion as the light turns from red to yellow to green.

THE PUBLIC WILL LIKELY BE MORE DISCERNING WHEN SEEKING MASSAGE, AS THEY SHOULD BE. THERAPEUTIC ALLIANCE WILL BE CRUCIAL

The public will likely be more discerning when seeking massage, as they should be. Therapeutic alliance will be crucial. Our work will have a different caliber of demand. The next question is, what will the supply be like?

Many are leaving the profession entirely for valid reasons. Businesses are being restructured. Some therapists are incorporating other skills or diversifying into areas like telehealth, personal training, computer programming, or nursing. Many are still figuring it out. We do our best. And then there are the flat-earthers who do whatever, facts be damned, and continue operating risky businesses. When people call to make appointments it breaks my heart to have to say "at another time", for now. Yes, I'm fully aware that an MT who doesn't care for their well-being at the same level I do will see them, regardless of ethics. But that's the difference between silk and polyester.

Thankfully, things are moving into the yellow light phase in New York City, but much still remains to be seen. A couple of days ago I "bumped" (from six feet away) into a wonderful client who lives in my neighbourhood. We had a rejuvenating socially distant chat for a few minutes. She empathised with me having to pause my practice until mandates change, but made a very insightful comment. She said, "Thanks for doing the right thing. It's not always easy, but this is how I know I can trust you. There's a new economy arising out of all of this and the most important currency will be the currency of trust". She's right and I trust water will seek its own levels.

AUTHOR BIO

Tania Velásquez has been a licensed massage therapist since 1994 and is the founder of PinpointEducation.com. She also serves as adjunct faculty in the Massage program at Pacific College of Health and Science-NY, where she teaches kinesiology, orthopedic pathology, and manual therapy.

Besides Tania's passion for learning, she also practices somatics and embodied self-care. Her movement background is in martial arts, contact improvisation and yoga. She combines the leveraging principles of these dynamic forms and the most current touch research into OPEN Bodywork, an approach she designed to assure the well-being and career longevity of her fellow massage therapists.

Tania enjoys developing exciting science-based content for MTs and tinkering with ideas. Above all, she's an eternal student who loves helping people find peace and comfort in their bodies. She's a Brooklyn native, an animal lover, and has a trauma-informed care practice in New York City.

SHARED DECISION-MAKING IN THE MANUAL THERAPIES

HOW YOUR CLINICAL DECISIONS MIGHT IMPACT THE SUSTAINABILITY OF OUR INTERVENTIONS.

By Walt Fritz, PT

Under the broader topic of sustainability comes the concept of how to achieve and sustain outcomes in our manual therapy practices. Such concepts of sustainability have become some of my favorite topics on which to comment, as they can be seen to align with core aspects of the evidence-based model (EBP), the biopsychosocial (BPS) model, and shared decision-making (SDM) between clinician and patient. Like many health professions across the globe, the expectation of adhering to the EBP model is becoming more common for massage therapists. How might these three acronym models apply to improve the sustainability of therapeutic outcomes?

Since jumping into the manual therapy side of the physiotherapy (PT) profession in 1992, I've gone full circle. Prior to taking my first full-scale continuing education seminar in myofascial release (MFR), armed with rather limited critical-thinking skills as a relatively new graduate, I was skeptical of the claims being made in the advertisements that I read on this particular MFR training. Though skeptical, after some arm twisting by a co-worker and as my employer fully paid the tuition, I jumped in. With the benefit of hindsight, I can see myself being immersed in an environment that discouraged critical thinking and encouraged groupthink (Janis, n.d.) and groupspeak (groupspeak, n.d.), and emerging from those multiple trainings having efficacy based upon knowing what others did not, which was the fascial narrative. Negatives aside, I did learn some wonderful ways to engage my patients, with interventions that seemed quite helpful. My PT career took off on a trajectory strongly influenced by this MFR training and mindset, first in a home-care setting followed by a private practice. Over time my identity became MFR, to the point where if someone came to see me for a problem, my only offering to them was those MFR interventions.

Lars Avemarie is a Swedish physiotherapist who lectures and writes about pain from a neuroscience perspective. He, like myself, believes strongly in providing intervention from a patient-centered perspective. Though our definitions differ, I see similar messages being conveyed. Lars described the evaluation process and resulting treatment choices based on a wide variety of factors. He sees an all-too-common pattern of treatment decisions being based upon the therapist's bias and expertise, rather than truly being based upon the patient's distinct needs (Avemarie, 2019). As a patient enters your room, seeking help for a problem, are your evaluation findings and intervention strategies unbiased, or are do they swing toward your treatment of choice? Does your preference for a modality colour your decision-making, or are treatment choices truly a shared decision-making process? How does this distinction influence the sustainability of treatment results and outcomes?

The evidence-based practice model embodies three separate but linked concepts to form what is seen to be the current best-practice view on the delivery of health services. Below, the basic three components of EBP are diagrammed. While few seem to question the importance of the evidence that supports our work, the other two aspects of EBP remain a bit unclear, at least as I observe this model being both discussed on social media as well as being put into action. Categorising "clinician expertise" requires an accepted definition, which appears. Some view this expertise as a narrow tunnel; how does one apply the evidence in making treatment decisions based not on clinician's bias but from how the actual evidence guides us, while others feel that their expertise allows them to insert what they feel is most effective. Avemarie writes that our choice of intervention should not be based on our bias, but from how the evidence (should) form our decisions. Every problem should not be treated with the same tool (modality), as the evidence does not support such a practice (Avemarie, 2019). Where I see my interpretation of a patient-centered model differing from Avemarie's is that I am primarily a therapist who uses manual therapy as my primary intervention model, supplemented by recommendations for movement and exercise to assure, that functional goals are indeed met. Though within that framework, my manual therapy tends toward what I deem a "non-denominational" approach, avoiding tissue or biomechanical causation-blaming and shifting the focus onto patient-perceptions of that manual therapy intervention. It is the third aspect of the

EBP model, "Patient Values," which is the component that I feel is underserved.

Lebert 2017

Patient values and perspectives, as other EBP models include (ASHA, n.d.; APTA, n.d.), seem subject to even broader clinician interpretation. When I talk with other clinicians and ask how they include this component into their interventions, many will report that they comply with this mandate by checking in with their patients regarding pressures. If the patient answers that the pressure is fine, then the clinician has met the requirement that interventions be based on the values of the patient. I believe that patient preferences and values should be incorporated throughout the interview/evaluation/intervention cycle to the point where that input, coupled equally with the evidence and clinician's expertise applying that evidence, forms the basis for equal weighting of all three aspects of the EBP model.

While often misrepresented as a requirement that all interventions be based on protocols proven in published studies, current understandings allow flexibility in the interpretation of the evidence to allow a personalised experience for each patient. In a 2014 paper published in the British Medical Journal titled, "Evidence based medicine: a movement in crisis?" the author breaks down limitations in the current model and in conclusion writes, "contemporary healthcare's complex economic, political, technological and commercial context has tended to steer the evidence based agenda towards populations, statistics, risk, and spurious certainty. Despite lip service to shared decision making, patients can be left confused and even tyrannized when their clinical management is inappropriately driven by algorithmic protocols, top-down directives and population targets.

Such problems have led some to argue for the rejection of evidence based medicine as a failed model. Instead we argue for a return to the movement's founding principles—to individualise evidence and share decisions through meaningful conversations in the context of a humanistic and professional clinician-patient relationship. To deliver this agenda, evidence based medicine's many stakeholders—patients, clinicians, educators, producers and publishers of evidence, policy makers, research funders, and researchers from a range of academic disciplines—must work together" (Greenhalgh, 2014).

Greenhalgh (2014) speaks earlier in the paper about relationship care: "Real evidence based medicine builds (ideally) on a strong interpersonal relationship between patient and clinician. It values continuity of care and empathetic listening".

Learning at all levels of healthcare typically follow the lines of a hierarchical model of learning, both from the perspective of the clinician/professional as well as the patient/client. In both the medical as well as the pedagogy models, education and experience build skills and reputation. Many brands of manual therapy, be it massage, or other modalities or strategies utilized by MTs, physios, and others, tends toward learning styles that guide the clinician into an environment cushioned from the outside world and into a rabbit hole occupied solely by those who work from the same perspective. Groupthink and groupspeak are common, and as the therapist takes additional training, their view that they have a deeper understanding of pain and movement-related problems increases. While this learning curve is a natural one, the effects of learning in a closed environment, removed from the dissonance that critical thinking can insert onto the learned concepts, can blind one to the views of others. This blinding often includes the patient. As pain and movement-related experts, people come to see us for our expertise, with hopes that we can help them when, possibly, others have not. As such, they often allow themselves to assume a passive role, deferring to our greater knowledge. However, given the breakdown of EBP model with regards to evidence, clinicians' expertise applying that evidence and patient preferences and values, have we, as the professional, taken on too much of the decision-making process? Have we shifted the power away from the patient and toward ourselves?

Lederman (2015) contrasts this traditional model in use in physical and manual therapies with what he terms a "process approach." Moving from the traditional therapist-as-controller model, a process approach model shifts the power over to the patient to be an active participant in their own recovery. The establishment of shared goals and values is necessary for sustainable progress and growth.

Jacobs and Silvernail (Jacobs, 2011) addressed this concern over power disparity in their 2011 paper, "Therapist as operator or interactor? Moving beyond the technique". While not referencing the EBP model, their observations completely mirror my concerns, even coming up with similar suggestions for balancing out the inequities typically seen in the EBP model. Jacobs and Silvernail point to the traditional model of manual therapy, where the therapist acts as the operator, overseeing all aspects of the intervention. They put forth al alternative model, one that aligns the therapist and patient as equals or partners in the therapeutic relationship, recommending that the "the context of the treatment including the technique, the provider, the participant, the environment, and the interaction between these factors may contribute to patient outcomes." Their views are stated to align with the current and emerging "explanatory model of the multifactorial, biopsychosocial pain experience."

To further cement the need for the clinician to be a partner, not a dictator, a study was recently published in the United Kingdom looking at peoples with fibromyalgia and their perspectives on physiotherapy services. Compliance with "a mutually agreed, individualized plan of care" was found to be higher if the therapist displayed a greater awareness of and empathy toward the emotional impact of the nature of the diagnosis (Furness, 2020).

What I am proposing is to give value to what might be interpreted as the true spirit of the EBP model, reducing, though not eliminating the ego-input from the clinician. The clinician does have meaningful input, and that input is expected in most patient/client interactions. In fact, it is expected by many to be the driving force behind interventions of sessions. My suggestion would be to try to balance this expectation with demands for contribution by the patient/client. Work toward a partnership, an interactive experience. Due to pre-existing expectations as well as social/cultural differences, many patients/clients may seem incapable of assuming a partnership-type of relationship (Bialosky,2010). However, this partnership is a goal worth meeting.

SDM follows along with these topics (Coronado, 2017). In this 2017 paper, the authors speak to emerging models of manual therapy as one of embracing BPS perspectives. Included in their concepts is shared decision-making between clinician and patient. "The traditional clinical decision-making process is one in which the provider is authoritative, while the patient is expected to agree and adhere to the prescribed intervention. SDM describes an interactive process in which the patient and provider work together to determine mutually acceptable treatment approaches" (Coronado, 2017). While one of the references in this paper (Tousignant-Laflamme, 2017) cites that regarding musculoskeletal conditions, the "true effect of this concept (SDM) has yet to be studied, despite the reality that SDM has been advocated for many years. We recognize the potential benefits of SDM in a patient-centered care approach, as it explicitly gives a voice to individuals and renders them more control towards the health care they choose to receive." They speak at-length to how SDM has been successfully included in many other aspects of healthcare, with positive outcomes found in a variety of studies. Though not yet fully assimilated into the manual therapies, there is precedent for improved outcomes in the research (Hall, 2010) and in popular massage-related articles (Lebert, 2017). SDM has been shown to be an effective tool for improving and sustaining outcomes, though with SDM in the manual therapies having incomplete vetting, I accept the limitations in the model for its inclusion in musculoskeletal conditions as we are dealing with in our practices.

Allowing an equal weighting of the three components of EBP and inclusion of SDM described above is, to me, an embodiment in a BPS approach, but we must go further in understanding the person who comes to us for help. Collecting history is standard practice, but that history must be viewed as only the beginning. Much will be stated, both before the first visit on written history forms, as well as during the initial interview/session, but other information may be released over time. Other information may be chosen not to share or may not be accessible by the patient. Cultural, social, and religious customs, sexual role expectations, language barriers, and other factors should be considered when interviewing, evaluating, setting goals, treating, and prescribing homework. Each patient should be viewed as the "N of 1" (Lillie, 2011), in that every patient encounter should be viewed as an individual with regards to determining a treatment plan solely appropriate for that person. While it is impossible to forget our past experiences and while still reaching for an evidence-based perspective on the conditions presented, efforts should be made to assure that past biases do not cloud objectivity in the present moment. The BPS model "does not recommend any particular approach but provides a framework for understanding and facilitating behavioral change" (Behlau, 2019).

With this theoretical background, how might you begin to be able to promote sustainable outcomes in your practice?

1. Begin by assessing your interview style. Do you allow sufficient time for your patient to tell their story? If your practice is set up to charge for "time on the table" only, is there a rush to conclude the interview? If so, how might you modify your situation to allow the patient to more-fully express their history and concerns?
2. Use open-ended questioning to find out why your patient is seeking your services. Pain is a common reason for referral, but I like to ask, "what is it that pain keeps you from doing or enjoying?"
3. Set goals that have meaning to the patient, which makes finding interventions and possible home carry-over to be more sustainable than interventions and homework prescribed based solely on your judgment and bias. If there is no "buy-in," you stand less of a chance of being impactful in a lasting way.
4. During the interview and evaluation, do you tend to steer your patients into your bias?

   While patients will frequently defer to our knowledge and experience, encourage equality in decision-making. When presented with a patient telling me, "you know more about this stuff than I do," I will turn it around and say, "Yes, I know a lot, but I don't know what you are feeling, hoping for, and fearing." This type of statement will open up a dialogue that may allow them to contribute more.
5. When asking questions, patients will often say, "how do I say this to make it make sense?" This may come from past experiences where they were made to feel foolish or ill-informed. I will ask them not to "make it make sense," but to say what they are thinking or feeling, unfiltered. It is up to us, after a conversation, to make it make sense.
6. When responding to questions regarding physiological causation of the problem or what it is that you feel when you palpate/treat, try to understand that your responses are strongly dictated by your training and that those beliefs may not align with current evidence. For instance, if you were trained in a trigger point model, your explanation for why a person is having pain will tend to be explained from that trigger point perspective, as will be your response to, "what do you feel?" To add even more to this problem is that many patients come to us, repeating what someone has told them about their

problem. Let's continue along with the assumption that you work from a trigger point perspective, and your patient comes in being told they are having difficulties due to weakness. How do you move forward? Should you negate the patient's beliefs as being less-than your beliefs? Try allowing multiple correct responses. "Well, it could be a weakness, as your doctor told you, or it might be trigger points. But no matter what it is or caused the problem, can we look at how you feel right now? As I press here, what do you feel? Does my pressure feel like it replicates or reduces your symptoms? Does it feel like what I am doing right now will be helpful or harmful? I want to do something that to you, not to me, feels like it is a useful intervention." This way of responding allows uncertainty to be acknowledged for the fact that it is (Bialosky, 2009; Bialosky, 2018; Bishop, 2015), despite how we were trained.

7. Won't admitting uncertainty make me, the clinician look less knowledgeable? I see the opposite to be true. Let your patient know that you know enough about manual therapy and pain to know that there are many theories, so many so that it is impossible to know with certainty what is wrong with them and also that the full effects of any intervention are not fully known. From the interview, goals set by the patient, which stemmed from their own values and preferences, and the results of your therapeutic interaction, can you come up with home activities (as allowed by individual practice acts) that align with their values and not your own?
8. Poor outcomes are often blamed on the patient for not following through on the recommendations of the clinician. However, the greater that the homework aligns with core patient values and perspectives, the greater the chance of having meaningful follow-through. "Research has shown that patients who are more informed and more involved in their own decision-making are more accepting of their treatment regimens and experience better health outcomes" (Bainbridge, 2006). This principle is now even being seen as a reason why patients do not always comply with medication recommendations by their physician (Lauffenburger JC, 2018). To best create sustainable outcomes, learn to craft homework recommendations that align with patient values and perspectives.

Creating a practice that promotes sustainable results may require some major changes in the way you view your role and the role of your patient. However, with time and practice, the suggestions above will become your go-to way to work.

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BUILDING SUSTAINABILITY IN PRACTICE THROUGH THERAPEUTIC ALLIANCE

By Jamie M Johnston (LMT), Founder of The Massage Therapist Development Centre

As different parts of the world start to come out of isolation and begin pondering what work will look like, we have to acknowledge that things are going to be different...forever.

I've seen the question asked, "Who in this profession is going to make it?" There was some debate around this and a few comments I've seen are things like:

"Massage is a luxury, only those who have money are coming back"

"Only remedial therapists will pull through"

"Only those who work in a clinical setting will be able to recover"

Well, the reality is, none of that is true and it quite frankly doesn't matter what setting you work in. What truly matters most is how you're going to treat your patient. No, I don't mean what modality are you going to use, I'm referring to the relationship you have built, and will continue to build. This is what determines who will be successful after this pandemic, or any other one we may face down the road.

USING TRUST TO CREATE SUSTAINABILITY

It's not often I say this, but I have to give some kudos to our regulatory body, the College of Massage Therapists of British Columbia (CMTBC). While they put in the effort to put together a return to work document[1] for our reference and gave us some direction on how we should handle things, there was a central point they made in the direction.

Build trust with your patients.

They outlined cleaning procedures, PPE protocols, and new consent instructions, yet at the heart of it all was direction to do, or wear these things in front of your patient, if for no other reason than to build their trust in you as the healthcare professional. It's honestly the first time I've seen something like this from our regulatory body, and I applaud them for it.

Along with this was a perspective piece written in the New England Journal of Medicine[2], although it was written from a doctor's perspective, I couldn't help but see how this is applicable to us as therapists. In this article they talk about the importance of relying on an evidence-based practice. While this is always important, at a time like this that importance is amplified as patients and therapists alike could be making decisions based on fear and emotion, which in turn can result in falling prey to cognitive bias and making therapeutic errors.

Since our role as therapists is to provide safe, effective care we need to have what this article calls a "healthy skepticism" and keep our clinical equipoise when considering any intervention. If we don't retain this healthy skepticism, we run the risk of relying on personal anecdotes where all too often in our profession we see people saying things like "I know it works because I've seen it work" while at the same time refuting and even sometimes refusing to accept research into their practice.

When things like this happen, it is usually a result of what the article calls "the intense desire to try new and unproven remedies". Think about how this applies to many of the continuing education courses we see in our profession. Many of them don't have research to prove their unsubstantiated claims and yet we look to try this new intervention possibly making therapeutic errors. Of course, all done with the absolute best of intention trying to help our patients.

If we are going to be successful once this is all over and we want to build sustainability in our practice, this has to change. As tough as this whole shutdown has been, it has also created an opportunity for change. As we move forward trying to build trust with our patients while also gaining sustainability in this profession, there's one other golden nugget we need to look at.

THERAPEUTIC ALLIANCE

There are many things that influence our treatment outcomes that go well beyond whatever our favourite modality is. Some of these are referred to as non-specific or contextual factors3. Part of these factors is the therapeutic alliance we have with our patients which can be defined as:

"The working rapport or positive social connection between patient and therapist"[3]

And,

"Established between therapist and client through collaboration, communication, therapist empathy, and mutual respect"[4]

This systematic review4 showed there were eight major themes associated with therapeutic alliance:

- Congruence
- Connectedness
- Communication
- Expectation
- Influencing factors
- Individualized therapy
- Partnership
- Roles and responsibilities

Now, we could probably write an entire article on each one of these 8 themes, how it applies to us in practice, and how we could effectively use them, but let's leave that for a later date. For now, let's just consider what was most important to the patients.

Of those eight themes, the most important determinants of a therapeutic alliance in the eyes of the patient were:

- Communication
- Interpersonal aspects
- Partnership
- Roles and responsibilities

Another thing the review showed was both patient and therapist agree that effective communication improved treatment adherence. They also found that agreement on goals and tasks, sense of connectedness, positive feedback, genuine interest, individualized care, trust in the therapist, and feeling empowered were all important predictors of exercise or homecare adherence.

The way we communicate, listening, sending appropriate messages and words of encouragement actually has an influence on reduction in pain4. However, it's important to note that making inappropriate comments can actually make a patient's symptoms worse (which also demonstrates why communication is so important in the patients eyes).

They also came to understand a few more sub-categories important to build this alliance. Included are humour (I can only use a limited supply of this as my sense of humour is pretty offside), emotional intelligence, appreciation, honesty, clarity of information and feedback, support and follow up.

Are you as excited as I am when looking at these lists? We are in a place of HUGE opportunity for sustainability in our practice by simply communicating, creating a partnership, showing genuine interest in our patients, providing individualized care, and just simply being genuinely good people!

I'm sure most of us are already doing many of these things in our practice, but how often do we practice them, get better at them, or take a course on them? While they are deemed "soft skills" the research is showing us these things should be at the forefront of our practice.

And the great thing...we get to spend more time with our patients than most other manual therapists and we can literally practice most of these things during our treatments. This was another one of the things that positively influenced outcomes, the amount of time spent with the patient along with warm, empathic interaction4! So while there was no way for us to predict this pandemic, there are ways for us to create sustainability in our career. Massage therapy as a profession isn't going anywhere, people will still need help, and still want to be touched in a therapeutic way. Unfortunately, some clinics won't recover from this which is an absolute travesty that no one deserved to go through. But the best way to create sustainability is by enhancing and developing strong therapeutic relationships with our patients. With that strong relationship, should something like this ever happen again, those patients will be waiting for your clinic doors to open again because they trust you will do what's best for them. As we start our clinics up again, while it won't be the same, there is a genuine opportunity to start building that trust again while creating sustainability in your practice.

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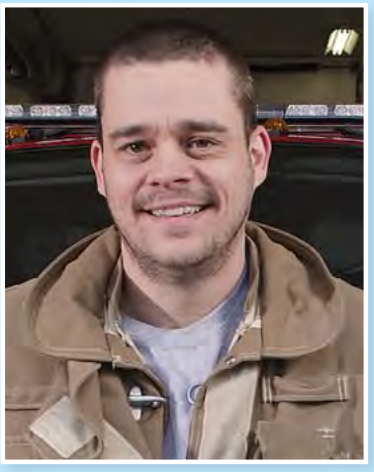

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Jamie is a Registered Massage Therapist in Victoria, British Columbia, Canada. He is also a former Massage College Clinical Supervisor, First Responder instructor, hockey fan and firefighter.

Currently, he works with Hockey Canada in the women's development program. As a continuing education instructor, Jamie teaches other Massage Therapists how to incorporate therapeutic movement and pain science into their treatments and still can't believe he gets to be part of other RMT's learning process. He gets excited to meet new colleagues and still learn something from them every time he teaches a class.

When not at work you can find him at the gym, at the ice rink, on the golf course or at the firehall.

You can connect with Jamie via The MTDC facebook page, where Massage Therapists can share ideas about how to improve the perception of the Massage Therapy industry.

PART OF YOUR SUSTAINABLE PRACTICE IS PERSEVERANCE

By Heather Thuesen, LMT, USA

The world as we know it has changed with the COVID-19 pandemic. Not a single person around the globe has remained unaffected by SARS-CoV2 as it has ravaged its way across the planet. Whether in the form of a physical, emotional or economic toll, there has been a weight added to the world. We know currently there is nothing absolutely certain about this virus; there is no vaccine, no clear understanding of its full capabilities, no complete understanding of how long its effects will continue.

Our loss is a collective one; the sanctity in the feelings of safety, whether imagined or real, are now damaged, and many people are swimming in a mire wondering, "What's next? What do we do? What does this mean?" With the requirements of lockdowns, quarantines and 6' social distancing, we have in effect, temporarily lost one of our primary senses: touch.

For massage therapists, this is who we are. It is by deft use of the sense of touch that we engage with our clients, offer them comfort and solace, and help facilitate a decrease in their pain. When people grieve, we want to comfort them. Touch, the very thing that people need the most right now, is the one thing that is essentially forbidden. Many of us find ourselves plunged into the debate of trying to figure out just what kind of touch is safe touch, and explore how is it possible to work skin to skin with someone whilst being six-feet apart. What a paradox to experience, that perhaps the safest, most compassionate thing we can do right now is to keep our practices closed!

It is nothing new for massage therapists to develop ways to commit to sustainable business practice for ourselves, but in the era of COVID-19, it won't be enough to only develop more stringent sanitation practices. We will need to acknowledge the deep psychological values of both grief and grit in order to be resilient in the face of the uncertain free-falling that this virus has spun down. In a lot of ways, this is a marathon of mental stamina that exceeds a new set of disinfection and hand washing protocols.

Adopting a sustainable mindset that is grounded in resilience will not only help our clients navigate through the new era of session changes, but most importantly, this mindset will help us find a new endurance as our practice paradigm continues to shift with new information.

In an interview with Jim Collins that discussed how he survived being a POW in North Vietnam for nearly 8 years, Admiral James Stockdale said this: "This is a very important lesson. You must never confuse faith that you will prevail in the end—which you can never afford to lose—with the discipline to confront the most brutal facts of your current reality, whatever they might be."

Let's face our reality: this pandemic sucks. It sucks the life out of our loved ones, sucks

the marrow from our economic welfare, sucks the feeling of stability out of our daily lives. It has revealed economic disparities, torn through weak healthcare and social systems, and for many has upended day-to-day lives.

Each and every nation has had its unique struggles, successes and failures in dealing with this virus, and the guidelines for massage therapists have also been uniquely different. There comes with these experiences a bit of information burnout about how to proceed. Uncertain can come with a feeling of vulnerability, and for massage therapists, this vulnerability might be in how we view the safety of practicing both to ourselves and our clients, the worry of whether or not people will be able or willing to pay for our services, and what the inevitable changes to our practices look like. There is a lot of "I don't know" involved in the decisions we have to make.

Having perseverance and adaptability will be a huge asset for our clients as well, even when we are not offering hands-on sessions. It demonstrates that we are not only capable massage therapists in a session, but also that our practice as a whole is reliable, evidence-informed and this is what lets clients trust our services for the long-haul. This allows us to be adaptable in how we implement new policies into our practice as the healthcare guidelines change, and be able to offer our clients confident guidance as time goes on.

Once we have acknowledged the collective grief we may be feeling over our individual and collective losses, we are able to gain a more clear perspective over what we do have control over during these pandemic times.

In an interview with Harvard Business Review on the global pandemic grief, David Kessler said this: "Understanding the stages of grief is a start. But whenever I talk about the stages of grief, I have to remind people that the stages aren't linear and may not happen in this order. It's not a map but it provides some scaffolding for this unknown world. There's denial, which we say a lot of early on: This virus won't affect us. There's anger: You're making me stay home and taking away my activities. There's bargaining: Okay, if I social distance for two weeks everything will be better, right? There's sadness: I don't know when this will end. And finally there's acceptance. This is happening; I have to figure out how to proceed. Acceptance, as you might imagine, is where the power lies. We find control in acceptance. I can wash my hands. I can keep a safe distance. I can learn how to work virtually."

ACCEPTANCE, AS YOU MIGHT IMAGINE, IS WHERE THE POWER LIES.

For massage therapists, we are seeing what we can't do, but there is so much opportunity in what we CAN do. This may look a little different than other healthcare professions, but there are plenty of opportunities for reorganizing and reframing our priorities with our business.

Perhaps this could be a great time to increase how we give our information to clients, either through more focused marketing or blogging or surveys or that website overhaul that's been on the "to do" list for ages. Maybe with the increased stringent sanitation procedures, this may be a great time to overhaul our current protocols and see which treatments we offered weren't really serving our business in the best way. By taking the time to reflect on what we really can offer our clients better once we open our doors, we focus less on things we currently cannot.

This pandemic absolutely has affected each of us in unique ways, and our practices will certainly look different once we return to them. But, with the right mindset of courage and perseverance, "different" can be a very good opportunity for our long-term practices.

This current state of the pandemic is temporary. As time moves forward we will have more data to have a clearer understanding of COVID-19, as well as more effective treatment options. In the interim, with a little grit and polish, our ability to compassionately and safely serve our clients in our practices will indeed "prevail in the end."

AUTHOR BIO

Heather Thuesen is an experienced licensed massage therapist in Fort Collins, Colorado, USA.

Her passion is to help people, and she could not be more proud of her career. Heather's mission includes helping athletes and those experiencing chronic pain, anxiety, depression and stress to find effective bodywork that uses positive, evidence-based practices.

CO-EDITOR'S NOTE: At the time of writing this article for MNZ Magazine, the number of active cases in the US was still very high and not showing any sign of decreasing. Massage therapists in the US are facing some major challenges affecting their ability to continue to practice safely. Here in NZ, we must remember that being prepared for any kind of pandemic may be the way of the future and Heather raises a number of very valid points that may assist massage therapists to remain prepared.

RESEARCH ON OUR DOORSTEP - A NEW ZEALAND MASSAGE THERAPY RESEARCH PROJECT

By Sarah Rule, MNZ RMT

I am doing year 3 of the Bachelor of Therapeutic and Sports Massage (BTSM) at Southern Institute of Technology (SIT) by block and distance learning over 2020. This is the first time year 3 of the BTSM has been offered in this blended delivery format. This means three trips and 15 days study in Invercargill. I am impressed by the scope, diversity and focus of the other students in my class, half like myself returning to study to complete the degree after some time.

Throughout my experience as a qualified massage therapist and more specifically, as a lymphoedema therapist, trained in Manual Lymphatic Drainage (MLD) and Combined Decongestive Therapy (CDT), I have found interfacing with the healthcare system around lymphoedema patient care interesting and at times challenging. These challenges have led me to explore the area of professionalisation of massage therapy, particularly, its potential benefits of credibility and engagement in the healthcare system interface.

One of the third-year papers of the BTSM degree is a research project. I shaped the study to explore "What are the demographics, practice patterns and industry opinions of people that have a NZQA or equivalent qualification in massage?" I had hoped to share the findings at the New Zealand Massage Stakeholder Hui, to bring to the table information from massage therapists as stakeholders about the future direction of the industry. However, with this event now cancelled, the findings will still be valuable to the New Zealand massage therapy industry.

Yes, it is ambitious for an undergraduate project. Unlike previous studies by Smith and colleagues in 2008 and Cottingham and colleagues in 2018, who focused on MNZ massage therapists, this study hopes to record the views and information from a wider population of massage therapists, including those who are not MNZ members. NZQA qualifications or equivalent were selected as a criterion to provide a known population size. There are around 5520 individuals with NZQA qualifications in massage since 1999. At the time of writing this article, I am still in the data collection phase and hope that many massage therapists participate in the study. MNZ has a wide range of training levels and business cultures represented within its membership that all need supported by any decision going forward. To be able to produce a publishable research paper from the survey information collected it needs to be clear that it is a good representation of the population being surveyed.

It is my hope that this research will help inform the massage profession, massage educators, other health professionals, and those who develop health policies about how massage therapists work in New Zealand and what those trained in the profession see as important for the ongoing direction of the industry.

It has been an interesting and rewarding challenge to do this research project, a project that would have been difficult to do outside of an educational institute without the resources, supervision and support provided. I have developed a better understanding of the research process and have enjoyed doing it. I will encourage anyone interested in interfacing with the healthcare system more seriously to consider looking at completing the degree. We need more New Zealand based massage research on all topics.

AUTHOR BIO

Sarah Rule is the owner of In Form Health, a massage therapy practice in Wellington. She holds a Diploma in Therapeutic Massage from the New Zealand College of Massage and has degrees from Otago University in Human Nutrition, Microbiology/Immunology and Psychology. Sarah is also trained in MLD and CDT.

PATIENT CENTRED ONLINE CONSULTATION

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https://www.noigroup.com/

Telehealth is emerging to be the new standard in COVID-19 times to replace face-to-face consultation. For now. Or will there perhaps be a pre- and post COVID-19 era in healthcare? Is it a threat, does it change how we will work or will it cause some interesting changes for the better? Everyone may have their own thoughts.

This video covers working with clients in a patient-centred way in an online consultation.

https://www.youtube.com/watch?v=fYGTLFy-kRg

https://noijam.com/2020/04/29/patient-centred-online-consultation/

THE LEARNING CURVE

Since consulting patients online – which I have done for a number of years, although never in this frequency or quantity – it has been tough. It's a big learning curve.

After a day picking up on verbal cues on a screen in an unfamiliar set up – burning eyes, 'Help – I can't use my hands', engaging patients, writing down notes, helping patients to set up their webcam, sound, wifi... What a day!

IS IT EFFECTIVE?

Should you be concerned for your results in therapy? There is, in fact, no difference in goals and objectives. Even the delivery in many cases is very much the same – especially in exercise therapy. When it comes to hands-on therapy, however, things will be more challenging.

Telehealth is potentially as effective as face-to-face – depending on the quality of the online consultation. Of course, more research will provide more insight. What makes quality telehealth as close as possible to face-to-face results? We will go into this in detail.

SOME BASICS – AUDIO, VIDEO, AND A PLAN

Quality connection with your patient is critical to best outcomes. A semi-professional set up, at least, is essential. The quality is largely affected by technical specifications. Make sure you have:

- Stable internet connection (up to 5 mb/sec)
- HD camera
- Microphone (external if possible)
- Lighting plan
- If you are not fully equipped still try to do the best you can. There are many significant measures you can take to improve the set up.

AUDIO

Patients will respond well to hearing your usual crystal clear voice. Consider an external microphone, preferably not headphones because you want to look like a clinician, not an IT consultant. AirPods or similar work well (although sound quality is not great) and allow you to be hands-free, for example when demonstrating exercise. Important: be mindful of your patient's privacy if you must have your patient's voice on speaker.

VIDEO

Seeing is believing. This is why creating a comfortable setting is important. Everything in the environmental context may have an affect on treatment results: what you wear, where you sit or stand, how much space you have to move around. Be aware of yourself before and during a session. Remember, your thumbnail is on the bottom of your screen during the session. From a technical point of view, there are a few things to take into consideration:

- Experiment with distance to the screen. We seem to sit too close – spatial distance on screen is appropriate.
- Position the camera correctly. An external cam should be positioned so you are looking straight into the camera while watching the screen. Remember, your facial features can be exaggerated and distorted with incorrect camera angles.
- Keep your background clean, professional and personable. A bare background may be too clean. Find out what fits in your own setting.
- Consider your lighting. Watching someone with a light bundle in the background is very uncomfortable. Place your light source in front of you. Daylight is best but if not available utilise artificial light.
- A plan

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NOI resources will help you to create a framework that will engage your patient to their treatment plan. The Explain Pain Protectometer: Handbook (https://www.noigroup.com/product/ep-handbook-protectometer/) allows you to create a framework (curriculum) for the patients journey to recovery. Completing the Protectometer fold-out in the handbook together and encouraging them to use the Recognise App and/or Protectometer App to set challenges and experiment with context, will provide a set of treatment modalities. Pain education will be exciting and creative as you will be relying on a variety of skillsets. NOI Explain Pain resources are designed to be accessible for a broad audience and have been proven to work for many people. All they need to find is an up-to-date clinician. That might be you.

WHEN DOES TELEHEALTH NOT WORK?

Creativity and flexibility will not limit you in treating a person with a certain health issue. Limitations may come into play with screens or devices because of a patient's physical impairment. If you are feeling uncertain, reflect on your early treatment experience. Did you feel as comfortable as you do in face-to-face consultations? Probably not – it's a learning curve. Give it a chance, don't give up too soon. We are aiming to deliver high value care. It's all about the patient, we need to adapt as much and as fast as we can.

Whatever your preference may be – face-to-face or online – some forms of mobilising and coaching need your physical appearance at some point in time.

We wish you all the best and stay healthy – the world needs you ALL!

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See the original blog [https://noijam.com/2020/04/29/patient-centred-online-consultation/- April 29, 2020](https://noijam.com/2020/04/29/patient-centred-online-consultation/)

AUTHOR BIO

Bart van Buchem is a NOI instructor, NOI NL Faculty Leader, polyglot and translator, he is also a researcher and clinician. He was wearing all of these hats in writing the following that he has shared with us, along with the video to go with it.

STAYING SUSTAINABLE IN YOUR CLINIC PRACTICE WITH CLIENTS DURING COVID-19 LOCKDOWN

Odette Wood talks about her experience of using Telehealth with clients

My learnings so far for a telehealth form of service delivery during COVID-19 lockdown.

Having completed a number of telehealth sessions via Zoom and getting feedback from clients, it is important to:

- Check in at the beginning just to see how they are in themselves. I Isolation, long hours sitting if they are working from home in set-ups that are not ideal (having to make do with kitchen table etc), not being able to do usual movement routines, the stress of this very unusual situation; all are important for clients to be able to acknowledge firstly.
- Find out how physical exercise is going for them, what are their challenges? They may only have a small area to use for movement, may be worrying about not going too far from home, feeling anxious about being around other people if outside et. These can all play a part and pose challenges for clients.
- Ask them if there is anything new/ different, from session to session.
- Be flexible in your approach and work at the client's pace
- Have enough physical space in the area you are doing the online session, so you can demonstrate if need be.
- Make sure you have a quiet, uninterrupted space. You don't want your kids or others at home on lockdown with you in the same room and coming in to view. Remember confidentiality and privacy are just as important with telehealth as they are with face to face sessions.
- Have a good internet connection and check your mic and speakers first.
- Get clients to do any activities (stretching movement, self massage) in real time with you, so you can observe and give feedback.
- Draw on resources/tools you find online and direct them to these, e.g. self massage videos, stretching videos or images, mindfulness apps etc. This gives them the tools. We don't have to create our own content for everything, if someone has done something good, use it!
- Be creative! Find out what they have access to e.g. a park to walk around, Youtube, a deck or patio for some outside movement, a tennis ball (some supermarkets sell these) or massage ball, foam roller, heatpack etc.
- Have some self-massage tools e.g. spiky or tennis ball, pillow case/sock to show how to use against a wall, a rolling pin can be great substitute for self-massage to the quads, hamstrings, calves, lower back and glutes.
- Be prepared that you might be one of the few people that your client connects with during the week/fortnight if they are living alone. Sometimes just the listening and connecting is the most important thing you can do for the client.
- Check in at the end to see if you have covered everything they wanted to go over today, so they know you have listened and addressed their priorities, and you know that you have.
- Follow up with an email afterwards, recapping on anything you think would help, providing pics of stretches if needed, providing links to resources.
- Realise that it is about empowerment of clients. Sometimes in clinic work we may lose sight of the fact that it's NOT so much about what we are "doing" to the client (techniques etc.), but it IS about rapport, connection, and helping clients to build self-efficacy.

Most of my sessions are 20-30 minutes long. This seems to be a good amount of time for the client.

HANGING FOR SHOULDER HEALTH AND FUNCTION (AND OF COURSE SUSTAINABILITY)

By Todd Hargrove

If I had to pick one physical activity that is healthy for human beings, and which they don't do very much, it would be hanging. Shoulders are built for hanging and swinging, but these actions are rarely included in exercise programs. Pull-ups offer similar benefits, but they aren't as natural, simple, and easily tolerated.

Our distant ancestors lived in trees for millions of years, so they grabbed onto lots of branches. The best way to get around in trees is brachiation, which means swinging from branch to branch with long arms. Gibbons can brachiate at speeds up to 35 miles per hour, which is faster than Usain Bolt can run. Human ancestors descended from the trees long ago, but we retain many of the anatomical characteristics that evolved for brachiation, such as hugely flexible shoulders, long arms, rotating wrists, and clasping hands.

The naturalness of hanging and swinging is easily seen by watching young children, who start doing these movements spontaneously. If there is a bar within reach, they will start hanging from it, usually with the knees moved up into a position that aligns and stabilizes the trunk. Swinging comes next, which they do by pumping the feet back and forth. If kids play near a set of monkey bars, most will eventually learn to swing hand to hand, without any coaching. You won't see them busting out a set of pull-ups unless they are involved in competition or formal practice. But hanging and swinging are as natural as running around.

I do know from personal experience that hanging from a bar feels really good. I hang for at least a minute every day, and almost anytime I see a bar within reach. It makes me feel loose, strong, and ready to move, and I know many people who say the same thing. I don't think I have heard anyone say that hanging makes them feel worse. Therefore, hanging is on my short list of "stuff worth trying" if you want your shoulders to move better and feel better.

Here are some ideas about how to play with hanging and swinging. For best results, make sure to spend plenty of time exploring and getting comfortable with the easy moves before moving onto the more challenging ones. And if it doesn't feel good, don't do it!

LIGHTEN YOUR WEIGHT

Unless you have excellent grip strength and overall fitness, most of the movements described below will be easier and more productive if you find some way to reduce your effective bodyweight. This means having the feet take some of the load (if the bar is too high use a stool or chair.)

MESS WITH HAND POSITION

Experiment with different hand positions to find the one where you feel most comfortable and strong. For most people that will be the palms forward and hands shoulder width apart. You can experiment with thumb position too - try thumb with the fingers monkey-style.

PLAY WITH SCAPULAR MOVEMENT

Now that you are hanging, notice the work of the muscles that control the scapula. Are they passive, so the shoulders come up to the ears? Or more active, keeping the shoulders lower? Slowly move back and forth between these two positions, keeping the elbows straight, so

you can feel the difference between active and passive shoulders while hanging. Don't think of either position as right or wrong - they are just different ways to hang, and you should be comfortable with both. Which option would allow you to hang longer? Probably the released shoulders, because that is less work.

RELEASE TENSION

Now let the shoulders be passive, and try to release muscle tension, so your body gets as "long" as possible. Let the spine and tailbone sink down to the floor, so that every space between the ribs and vertebrae expands. Find spaces that are holding tension, and see if they can let go.

If you are interested in the slings or "trains" of myofascia that connect distant bones, this is an easy way to get a felt sense for where they are and what they do. Feel the chains of tension that connect the hands to the shoulder, and the shoulder to the pelvis, especially where they move through the armpit. Do you feel the lines of pull more clearly through the front (the pecs and abs)? Or the back (the lats and back muscles)?. Take a break from hanging, walk away and see if you can feel the effects on your shoulder mobility, posture and breathing.

PLAY WITH SUBTLE MOVEMENTS

You can vary where you feel the stretch by making slight adjustments to the positions of the feet, knees, pelvis, or head. For example, as you hang, slowly move the knees upward, so the hips and knees come into a chair sitting position. This will encourage the pelvis to move into a posterior tilt, and the spine to flex slightly. To make the pattern more clear, look down with the head toward the pubic bone. What effect does this have on where you feel the stretch of hanging? What chains of muscle are now providing more support?

Now do the opposite movement - let the feet and knees move slightly behind you, encouraging the spine to come into extension. Let the head come back and look upwards to make the pattern more clear. Note again the effects on your sense of connection from shoulders to pelvis. Now move slowly back and forth between the two positions, so you can feel the difference. You could also explore moving the knees

and feet slightly left and right to feel the effect of subtle rotations or lateral flexions. Which hand feels more pressure if the feet move left? Which armpit feels more stretch?

You can use these movements to explore the mobility and integration of almost every muscle in the trunk. Walk and away and see if you can feel the effects.

SWING

For a more dynamic version of the above movements, move the feet and knees back and forth more quickly, and with rhythm, so that you start to swing a little. Try it with the knees bent versus long and compare. If this is feeling easy, you can play with a jump dismount from the forward swing. Or jumping forward to the bar to initiate the first swing. You can also swing side to side.

REACH WITH THE FEET

While hanging from the bar, pick a target and reach with a foot to touch it. Imagine you are hanging from a branch and need to find the next foothold. Use some momentum from swinging if you want.

HANG FOR TIME

Playing with all the above movements is a surprisingly good challenge to strength. I stopped doing pull-ups for a few months in favour of just playing around with hanging and swinging, and then did a pull-up test and hit 17 (which for me is better than usual.)

Here's a way to test your endurance. See how long you can just hang with your full bodyweight. Or hang for 30 seconds, try a pull-up, then 30 more seconds of hanging, and another pull-up.

ONE-ARM VARIATIONS

You can perform similar versions of all of the above movements with one arm. And more. With one arm free, you are now free to reach for targets or imaginary branches with the free hand. Notice the rotation that happens in the hanging shoulder. Explore reaching forward and back, as if you are reaching to monkey bars. Make sure to use lots of support from the feet to stay safe. If you are feeling comfortable with all the above movements, and you are confident in your strength, mobility and coordination, you are ready for the final test: find some monkey bars at a playground, and try to get across as fast.

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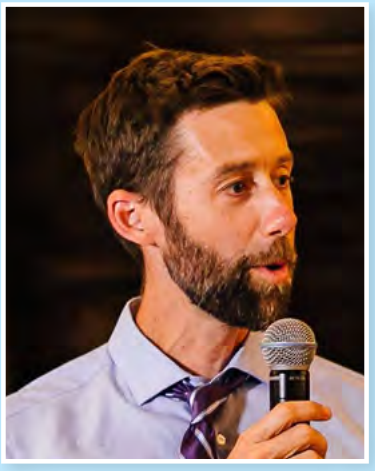
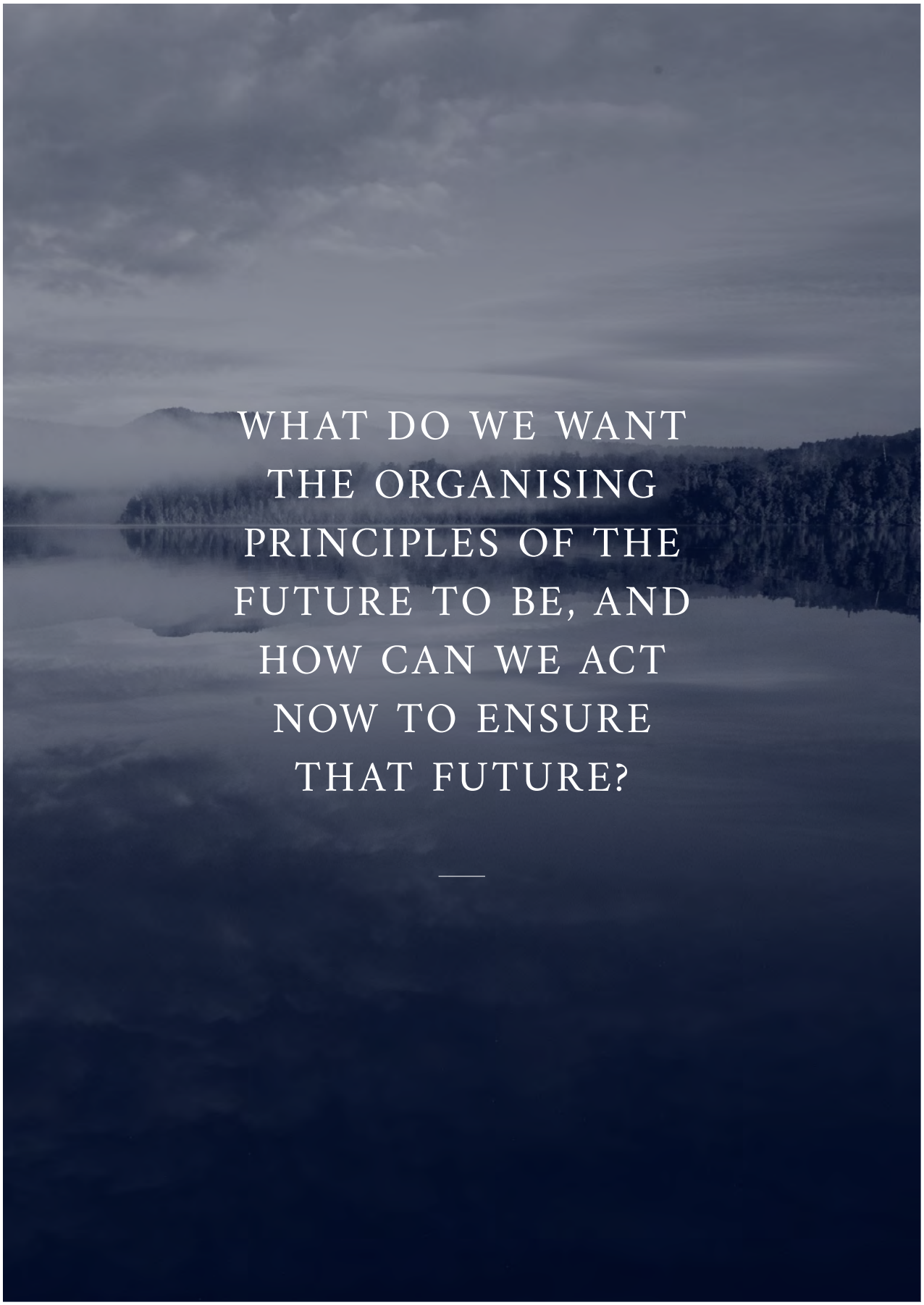


AUTHOR BIO

An author, blogger, and manual and movement therapist. His goal is to help people move better and feel better. Todd has completed training programs in the Feldenkrais Method and Rolfing and used to be an attorney.

Todd writes and speaks about science that is relevant to manual and movement therapists, such as bodyworkers, physical therapists, chiropractors, personal trainers, yoga instructors, athletic coaches.

BUILD BACK BETTER: A NON-PARTISAN COVID-19 RECOVERY FRAMEWORK FROM RECOVERY TO RESILIENCE



PRINCIPLES FOR OPTIMISED RECOVERY

Recovery decisions we make now may shape our society for many years to come. Given what's at stake and the opportunities in front of us we've drafted a practical set of organising principles, that ideally can help guide decision making creating better outcomes for New Zealand while, minimising unintended consequences. These guiding principles for decision making are based in ethics while at the same time making practical and scientific sense.

It is our hope that taken together, these principles will help us build back better, ultimately guiding us to a healthier, more resilient and prosperous society for New Zealand.

1. **GENERATE HOLISTIC WEALTH:** In a competitive global economy, New Zealand must of course continue to support wealth generation in the traditional sense and strive for higher productivity. Yet, we now need to broaden our understanding of what constitutes 'wealth'. Wealth can be defined in terms of the wellbeing of the whole, achieved through the optimisation and preservation of multiple kinds of wealth or capital, including natural, cultural, social as well as financial capital. We need to preserve capital in all its forms in order to re-emerge as strongly and quickly as possible.

2. **INCREASE PREPAREDNESS AND FUTURE RESILIENCE:** Our recovery should help future-proof our society, decrease systemic risks and increase resilience to future crises. We can use this opportunity to build our ability to respond to future shocks and crises, not just in physical infrastructure but also our systems, data, institutions, strengthening social cohesion and natural capital protection and restoration.

3. **ACCELERATE EXISTING GOALS:** There is a need to consider how decisions today can help us reach our existing goals and

commitments faster. Our investments need to be optimised for their ability to solve both existing priority problems such rates of family violence, lack of social housing and also their contribution to climate. All of these challenges fall under the Sustainable Development Goals, the Living Standards Framework and are measured through Aotearoa Indicators.

4. **INVEST IN TOMORROW:** Our decisions must consider how they will prepare people and business leaders for the jobs, companies and technologies of tomorrow, ultimately growing holistic wealth. Investment (short term financial support, investment for growth, or investment to retrain and educate) should be focussed on those industries and sectors which, given our current knowledge of future trends and risks, are likely to be both essential and beneficial for New Zealand.

5. **BUILD COLLECTIVE IMPACT:** Moving from recovery to resilience will require the whole of society to take a systems approach to leadership and collective impact[1]. This means government, business, Māori, the community and philanthropic sectors working together in partnership to help solve system-level challenges, on a collaborative basis.

6. **MEASURE IMPACT, BEYOND FINANCIALS ALONE:** Today there is a shift from measuring success in terms of purely financial outcomes alone, to include non-financial measures of impact. When making investment choices we should assess both measured positive and potential negative impacts (unintended consequences) of our decision making.

7. **ACT WITH ETHIC OF CARE, AS KAITIAKI:** The crisis has shown an upsurge of community support for the ethic of care/ kaitiaki. This is positive and we need to incorporate these values into our decisions more strongly. Care is also at the heart of the Māori values system, which calls for humans to be kaitiaki, caretakers of the mauri, the life-force, in each other and in nature. This means any recovery plan is developed in partnership and consistent with the principles of Te Tiriti o Waitangi.

[1] https://ssir.org/articles/entry/collective_impact

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REGULAR

PATHOLOGY

COVID - 19 ASSOCIATED COAGULOPATHY (CAC)

By Carol Wilson RMT

Lumen Learning.com

AETIOLOGY & DEFINITION

COVID-19–associated coagulopathy (CAC) is used to describe the coagulation changes in patients infected with the COVID-19 virus. Coagulation (clotting) is the process of the blood changing from a liquid state to a gel state with the aim to prevent blood loss. However, when this goes wrong, the person develops many clots in many areas. Let's look at coagulation. (Fig 1.)

PATHOPHYSIOLOGY

In the normal coagulation cascade, chemicals called clotting factors (or coagulation factors) prompt reactions that activate still more clotting factors. The process is complex, but is initiated along two basic pathways:

- The extrinsic (from outside the body) pathway, which is normally triggered by trauma.
- The intrinsic (from within the body) pathway, which begins in the bloodstream and is triggered by internal damage to the wall of the vessel.

(OpenStax College, 2017)

Werner (2020) describes COVID-19 coagulation issues as a chemistry-heavy sequence, which transitions from viral invasion to cytokine overreaction, inflammation, platelet activation, and the

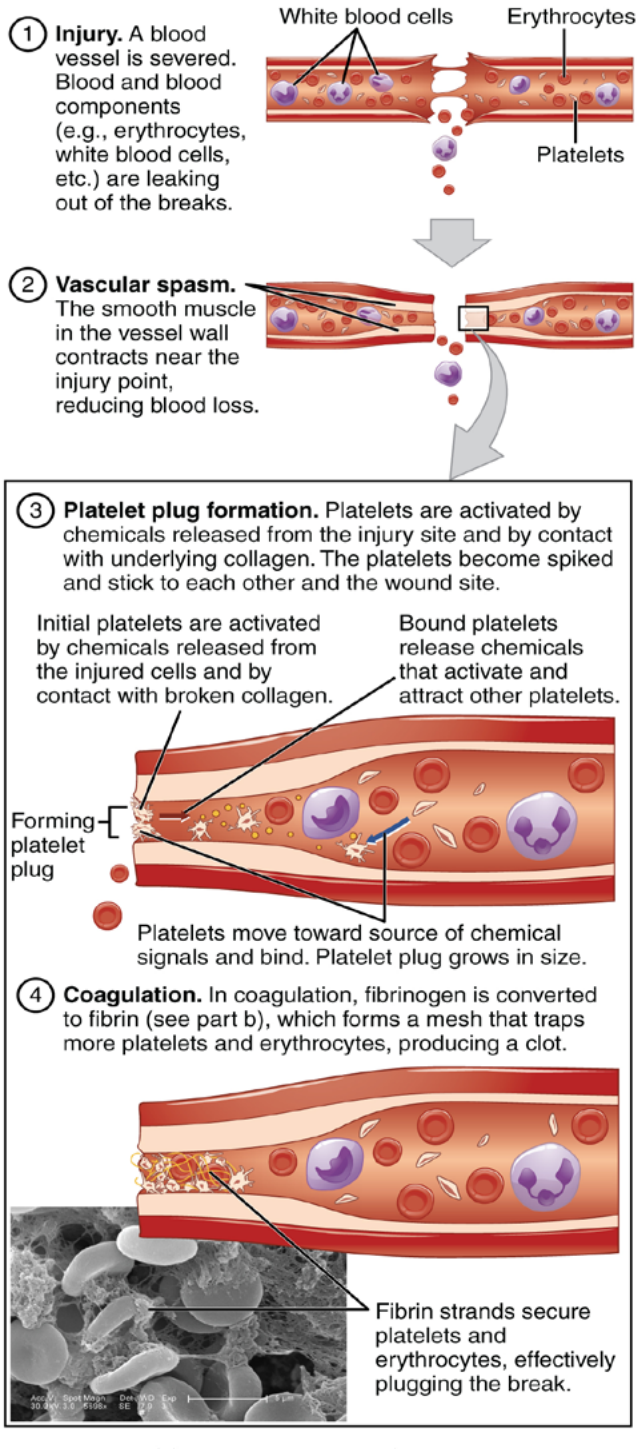

Fig 1. General Steps of Clotting (OpenStax College, 2017)

setting off of the clotting factor cascade. Hence the infected person develops lots of clots. These clots interfere with oxygen/carbon dioxide exchange, when they form in the alveolar capillaries. They may develop in the liver, the kidneys, the brain or other tissues and lead to multiorgan failure, which in time may lead to death. (Werner, 2020).

Belen-Apak & Sarıalioğlu (2020) found indications that lungs damaged by the COVID-19 virus have alveolar damage and a large amount of fibrin clots in the enlarged vessels and capillaries.

RISK FACTORS

Clots forming where they are not supposed to can result in blocked blood vessels. This may cause disseminated intravascular coagulation (DIC), where disseminated means throughout the body and intravascular means inside the blood vessels. The clots caused by DIC use up the body's clotting substances and platelets. Once clotting substances and platelets are used up, then the body is at risk of serious bleeding. DIC may happen suddenly from an infection or major injury (trauma), or it may happen slowly, usually from cancer or infection (Moake, 2020). Once the problem starts it is hard to stop.

SIGNS AND SYMPTOMS OF COAGULATION

Sudden DIC may be noticeable as bleeding from needles and IVs, bruises on the skin, vomiting or passing blood in stools. DIC that starts slowly, may show as clots in legs, causing swelling, pain, or redness. Whereas clots in the lungs may cause difficulty breathing.

To read more, Werner (2020) has written on this topic of COVID-19 coagulopathy, check out the article:

https://www.abmp.com/updates/blog-posts/covid-19-related-coagulopathy?fbclid=IwAR289TfxUE-bEFNHqXFBmKSgT6bl1EflD47s0DD7BDglf2BHLogwam7V15s

LUNGS DAMAGED BY THE COVID-19 VIRUS HAVE ALVEOLAR DAMAGE AND A LARGE AMOUNT OF FIBRIN CLOTS IN THE ENLARGED VESSELS AND CAPILLARIES.

Connors & Levy (2020) have described the development of coagulation abnormalities, as seen in SARS-CoV-2–infected patients, as most likely a result of the extreme inflammatory response. They are called Pulmonary Intravascular Coagulopathy (PIC), which is more likely to be an immune thrombosis (clot) that is distinct from classical DIC.

TREATMENT

In DIC the immediate correction of the cause is the priority. If able to treat the cause, replacement therapy using frozen blood plasma products may be used. Sometimes heparin (an anticoagulant, blood thinner) is used. If treatment is effective, disseminated intravascular coagulation (DIC) should subside quickly.

Massage therapy questions to ask regarding COVID-19 Associated Coagulopathy (clotting)

Check out Werner's (2020) excellent update on questions to ask clients who may have had COVID-19:

https://www.abmp.com/updates/blog-posts/questions-clients-who-have-had-covid-19?fbclid=IwAR2bacXkZPVaNdl_qeuCz8vGwnjyoIZy7x_XSK6vqfYZwc4qADU7TNV2G6g

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ANATOMY & PHYSIOLOGY

IMMUNE SYSTEM

By Carol Wilson RMT

It is easy to be aware of your breathing and your heart beating, but we are generally much less aware of the immune system and its many functions required in order to ensure we stay well. COVID-19 has driven us all to think more about the immune system and practices that may assist in keeping it in balance, such as certain meditative practices, lifestyle, exercising and nutrition.

Let us take a look at the many layers of the immune system and how bacteria and viruses may invade the body. Our immune system consists of three main lines of defence, all with the key function to protect us.

1ST LINE DEFENCE - Surface Barriers (Moat and Castle Wall): such as your skin and mucous membranes.

Like a moat and castle wall (Fig. 1) these physically form an actual barrier to prevent the entry of pathogens into the body, or are in the form of a chemical barrier, such as moist membranes being slightly acidic to inhibit the growth of bacteria or fungi (such as in the bladder or vagina). They include enzymes such as in gastric juices, that aim to destroy pathogens, ingested into the stomach.

2ND LINE DEFENCE – Non Specific Chemicals and Cells (Patrols): watching just the castle wall.

If the bacteria, fungi or virus attach themselves to the skin or mucous membranes and are not prevented from entering the body, we have cells and chemicals that recognise these. An inflammatory response is part of the second line of defence. The inflammatory process includes the use of specialised white blood cells such as macrophages (Fig. 2), fever, and the release of chemicals aimed at killing pathogens and helping repair tissues.

Fig 1.

(a) A macrophage (purple) uses its cytoplasmic extensions to pull spherical bacteria (green) toward it. Scanning electron micrograph (1760x).

Fig 2. (Marieb & Hoehn, 2019)

Cytokines are chemicals involved in the inflammatory response. They are signallers to our second line defence white blood cells (WBCs) such as neutrophils, and to monocytes, to attack invaders. Cytokines (such as histamine) make vessel walls leaky, so WBCs can move to where they need to be more easily.

The key signs of inflammation are redness, heat, swelling, pain and loss of function. These responses increase blood flow (redness), enable WBCs and plasma proteins to reach sites of injury (swelling), increase local temperatures (heat) and generate pain. All warnings of the local inflammatory response.

A Cytokine storm is when the inflammation is dramatic and ongoing (Fig .3). Inflammation associated with a cytokine storm begins at a local site and spreads throughout the body via the systemic circulation. With severe inflammation, and a large influx of cytokines, the responses often occur at the expense of local organ function. This may cause damage to local tissue structures, fibrosis and result in persistent organ dysfunction (Tisoncik, Korth, Simmons et al, 2012).

To read more on the cytokine storm and the relationship with COVID-19, check out Luchau's article in the May-June 2020 issue of Massage and Bodywork Magazine.

http://www.massageandbodyworkdigital.com/i/1234356-may-june-2020/82?

3RD LINE DEFENCE – Adaptive immune system (Trained Unit): patrolling throughout the whole of the body systems, uses specific lymphocytes which are, thymus-derived cells (T Cells) and bone marrow-derived cells (B Cells).

The third line is specific. It recognises and is directed against particular pathogens or foreign substances (antigens) that initiate the immune response, using T cells and B cells. This defence line is systemic. Immunity is not restricted to the initial infection site, but is now throughout the body. It also has "memory." After an initial exposure, B cells are able to recognise and mount stronger attacks on the previously encountered pathogens, using antibodies developed from memory cells.

Once B cells have come in contact with an antigen, they are activated to produce plasma cells (which produce the antibodies) and memory cells. Memory cells are primed to recognise the next time we come in contact with the same antigen and so the secondary (next) response is much faster and makes many more antibodies. This could even be many years later when the second response occurs (Marieb & Hoehn, 2019) (Fig. 4).

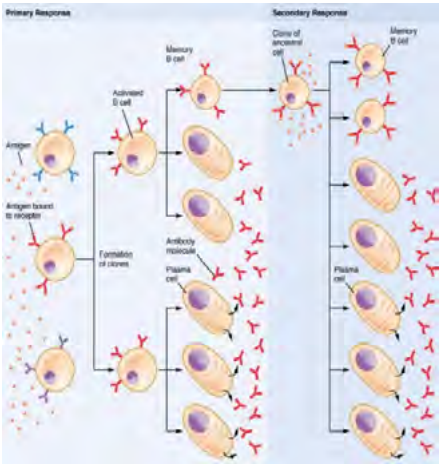

Fig 4. Primary and Secondary B Cell responses. (OpenStax College, 2014)

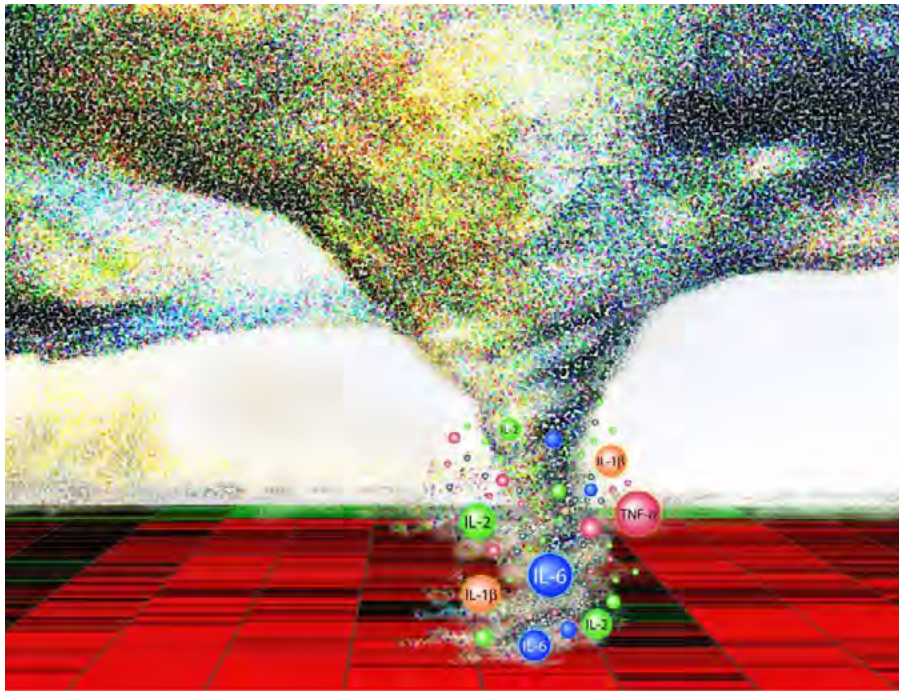

Fig 3. Cytokine Storm imagery from Tisoncik, Korth, Simmons et al, 2012

In a secondary response, within hours of coming across the antigen again, these memory B cells create a new army of antibody making plasma cells. Within 2-3 days the antibody concentration in the blood rises quickly to reach much higher levels than in the primary response.

T cells which mature in the thymus gland and then move to other lymphoid tissue, cannot deal with antigens that are in their natural state. T cells are best suited for cell-to-cell interactions. Their direct attacks, target body cells infected by viruses or bacteria, abnormal or cancerous body cells or maybe cells of transplanted foreign tissues (Marieb & Hoehn, 2019).

The diversity in our lymphocytes (B cells and T cells) is determined by our genes, which in turn are also influenced by the microbes that are in our environment, therefore genes may determine the foreign substances the immune system recognises and attacks.

At the most basic level, the race between antibody production versus pathogen multiplication, determines whether or not you become sick.

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BUSINESS MATTERS

SUSTAINING YOUR PRACTICE AND DRIVE IN DIFFICULT TIMES

By Steve Hockley, Executive Director, BNI Wellington & Wairarapa

Navigating your business through difficult periods can be challenging. There are some key factors to consider when facing these situations. Usually when addressing this topic, you would start with preparation – planning in advance. Currently though, in this time of COVID-19, the hard times have already happened and the consequences are before your business now. Therefore, you will find ideas for preparation (for future events) at the end of this article, worth reading but not your current focus at this point. We cannot change what has already happened so where to from here?

SWITCHING ON YOUR MINDSET

Sitting at home for eight weeks without the ability to see patients has been stressful to say the least. Currently you are probably reasonably busy as people rush back to the services that they have missed, but for how long? For most, the money situation is playing on the mind. For all this, it is important to face the new world with a positive, solution-seeking attitude. This is particularly the case for practice leaders and owners. Your team are looking for guidance and hope.

It is also true that people do not buy fear, this means that when you are suggesting a course of care you want to do it with confidence. How do we do this when things are tough? Here are a few hints:

- Yes, keep up with current events but do not obsess on them, most of it is environmental and nothing you can do will change it. Focus on where you can make change and improve your world. Update yourself on the news at set times, rather than letting the news overtake your day.
- For every negative thought, offset it with five positive ones. This is a bit of a natural magic number as it reflects how our mind naturally acts to positive and negative information. Our minds are set up to reflect more on negative information to avoid making the same mistakes again, yet it is the positive information that inspires us to step out and do more and better.
- Use tools like gratitude statements – reflect on all the things that you are grateful in your life, the big ones, and the small ones. Write these down somewhere that you can see them and use them again.
- Start thinking again of what you want to create with your business and the change you want to make in your world, write these goals down. Your goals may well have changed since last time you did this.
- Imagine the business and health person you want to be and actively choose to be that person.
- Listen and support others with problems while remembering that they are not yours, you can support others while avoiding taking on their feelings – this can be especially true of patients who rely on you for support.
- If you need help reach out to your support group, or a professional if needed.

OPPORTUNITIES

Times of recession or great change in the market are hard, they also represent great opportunity. Just some of these are:

1. Your customers and potential customers' mindsets have been challenged and are therefore looking for something different. With COVID-19 the whole country has been thinking about their health and their health practices. These changes allow you to launch new product offerings or ways of dealing with your patients.
2. Like you, your competitors are under pressure, some may close. This gives your practice the chance to grow its market share and gather new customers.
3. New premises opportunities will become available and are likely to be at a much more reasonable rental, or simply a better space or location than your current practice.
4. In almost all industries great staff have been extremely hard to find over the past few years, over the next few months there will be more staff on the market. Also, existing staff are likely to be more understanding and grateful for the opportunity that your business is giving them due to the environment.
5. Other businesses are looking for new

ways of doing things to increase turnover, a tough environment can be a great time to network or create business alliances that may have been unlikely before.

MANAGING A BUSINESS IN TOUGH TIMES

There are three key areas to concentrate on when managing your business through a recession or other major shock. Measuring your business, marketing and promoting your business and communication to all your stakeholders whether they are staff, owners, customers, or landlords.

MEASURING YOUR BUSINESS

This is mostly about the money both recent and projected into the next two months.

Firstly, let's talk about frequency. If you were looking at your businesses figures monthly before, you ideally would be doing it weekly now. If you were weekly you might even go to daily. This means owners and key staff like practice managers collecting the figures and discussing what they mean.

The first report to look at is your profit and loss. This enables discussion about both the income and costs. These figures should be compared against a comparable figure. Then look at your projected income and costs over the next two to three months on a cash basis or predicted cashflow report. Be honest here and do create a worst-case scenario along with an expected one. If you need help here discuss with your accountant.

Looking at the key performance indicators, these will often be:

- PVA – Patient Visit Average – usually, simply your number of individual patient visits divided by the number of actual patients over maybe a year. This gives you an idea of how often people come back and if they follow recommended care plans.
- Total number of patient visits – compare against similar periods in other years, or at the moment, compare week by week to see if the number is going up.
- Number of visits by practitioner – is this going up, who is doing well?
- Number of new patients – this is a key number to predict future income and a real challenge after eight weeks when you could not see new patients.

MARKETING YOUR BUSINESS

Counterintuitively and challengingly, businesses usually need to up their marketing activity during a recession. There is also a theme to marketing in a recession. This theme is one of confidence and assurance. People are more scared than usual and will chose known brands and names. This often may mean that they are more likely to choose a business they have been referred to.

These days this may mean joining a networking group, talking to the businesses and people who refer you, encouraging customers to refer their friends. It also will mean more activity in social media, checking that your signage is confident, straight forward, and attractive.

COMMUNICATION

Everyone in a tough environment is a little scared. When humans are scared, we lose some of our ability to listen and think. This means that you want to communicate more clearly and with more confidence than usual.

This will mean that when talking to patients you may want to be clearer and more direct about your care suggestions, you might want to reflect more about what you thought they have said and understood. Also be patient, they may seem to not be listening but are simply distracted.

This fear position is also true of your staff and others who you deal with, like landlords etc. Being open and confident is especially important.

PREPARATION

As we said at the start usually talking about resilience in business we start with preparation. What do we do IF something adverse happens? With COVID-19 one bad thing has happened which few of us expected. When you think about it, human populations have been hit with pandemics on a reasonably frequent basis time and time again.

Events that we cannot control happen to businesses on a frequent basis, major economic downturns every 10 years or so, here in New Zealand earthquakes can occur, as well as pandemics and all sorts of other things that impact our businesses.

The first thing to prepare is to build up a cash reserve. Ideally this would equate to what it takes for your business to survive for 3 months on 50% of its normal income, even better if you base it on 6 months. Like saving for retirement, putting some money aside into a separate account is the easiest way. Yes, it is simpler to describe than do.

The next step is to have an emergency response plan. Emergencies can be worldwide, city wide or just business wide. For a massage business it can just be a big corporate office moving away. Plan for each of these, what are the steps you will take to manage each, ask questions such as what you will do if you lose:

- Key staff
- Access to your premises
- Suppliers
- Technology

Formulate an emergency response plan for each risk.

On a final note, it is not the disasters in our lives that define us, it is how we respond to them.

AUTHOR BIO

Steve Hockley is a BNI Executive Director and Business Coach. He has been a BNI Director for 11 years and looks after the 15 BNI chapters that meet in Wellington and the Wairarapa. BNI (Business Network International) is New Zealand's largest structured business networking organisation for small to medium businesses.

You can find out more about BNI at www.bni.co.nz

USEFUL SITES - SUSTAINABILITY IN YOUR CLINIC

We have come across these suggestions regarding eco-friendliness and sustainability in your massage practice on the following sites – check them out for yourselves.

As Massage Therapists and keen believers in holistic healthcare, it is important we also practice eco friendly methods in our clinics. Are we sourcing sustainable products and materials, are we fully eco-conscious. Hayley Ward, Jo Smith and Donna Smith have researched this question at SIT. Check out their poster:

https://www.sit.ac.nz/Portals/0/upload/Hayley%20Ward_MT7340_Research%20Poster_v296_gracias%20a%20Dios.pdf

Useful suggestions such as a waste audit to see the general waste products generated in your clinic:

https://www.massagetherapycanada.com/every-bit-helps-4329/

Simple and inexpensive ways to consider practicing massage in a more sustainable manner:

https://www.massagestudybuddy.com/going-green-make-your-massage-practice-earth-friendly

Eco-friendly initiatives can be a great selling point. Make decisions based on your budget. "Look at your personal priorities, weigh against those priorities and your big picture vision." Check out Michelle Vallet's approach:

https://www.amtamassage.org/publications/massage-therapy-journal/green-massage-practices/

Tui Balms has a "sister" business in the UK, using cardboard containers and has an environmental policy and a vegan wax (no bee products):

https://www.songbirdnaturals.co.uk/environmental-policy#packaging

So we are interested in knowing if Tui Balms here is planning on doing the same – you can read about Tui Balms ingredients here https://www.tuibalmes.co.nz/all_natural

Massage Mastery Summit: Moving Past COVID-19 - recorded and free. Ruth Werner continues to link us to wonderful new information. The new kids on the block at Massage Mastery have put together a summit of top-level thinkers about our profession and what's next:

https://www.facebook.com/groups/2675369542720708/

The Face Cradle Hammock: a blog video on managing respiratory droplets:

https://www.abmp.com/updates/blog-posts/face-cradle-hammock

From Lockdown to recovery – listen to one of our very own Rachel Ah Kit talk to RNZ The Detail's Sharon Brettkelly who has been checking in with Rachel over the last three months during the covid-19 crisis here. Rachel tells her story of her business through lockdown and recovery. Excellent interview and captures what many of us have been experiencing.

So good to have our profession in the spotlight in public media.

https://www.rnz.co.nz/programmes/the-detail/story/2018752891/from-lockdown-to-recovery-tracking-a-small-business-during-covid

BOOK REVIEW

PLAYING WITH MOVEMENT: HOW TO EXPLORE THE MANY DIMENSIONS OF PHYSICAL HEALTH AND PERFORMANCE

Reviewed by Allison Wainscott RMT Wellington

By Todd Hargrove

Available on Kindle or as a paperback – $19.95 USD

Hargrove was blessed with high level skills in a several sports, and a mind curious to analyse movement to improve his performance. With these traits, when challenged with chronic pain from computer work, he left a career as an attorney and become a researcher about pain and movement. He is a qualified Rolfer and Feldenkrais practitioner, and has created a website, bettermovement.org, to communicate research to a wider audience. He has also published two books, Playing with Movement (2019) and an earlier book A Guide to Better Movement (2014).

In the preface to A Guide to Better Movement Hargrove makes a point that has direct relevance to the way that massage therapists work with and communicate with clients. (His comments refer to the wider group of touch and movement therapists.) "Many therapists over emphasise some alleged defect in the body as responsible for pain … At the same time the role of the nervous system and the brain is neglected or misunderstood … it is quite often the nervous system, and not some assumed pathology in the body that actually changes during a successful treatment … In order to maximise the benefit of any practice … we need to understand the mechanisms at play." I believe it is important to have this point firmly in mind when reading Playing with Movement so as not to think Hargrove is dismissing the effectiveness of touch therapies. Rather, he questions our explanations of cause and effect. That seems like a valid challenge. We can all strive to be more astute in our perceptions of observable and subjective information from clients and in being informed and accurate in explanations to clients.

That said, Playing with Movement takes a systems approach to physical health and movement and contends that the body is a complex system that is self-organising. He contrasts this to complicated systems such as a machine where the relationship between parts can be controlled with precision given the necessary expertise. "When qualified experts have major disagreements over the basics of how to solve a problem, it is most likely complex." (Kindle Loc 917), and "Because we cannot acquire full knowledge over complex systems, we need to act more like a gardener cultivating growth, and less like a craftsman shaping an object." (Kindle Loc 939).

Young animals learn fundamental skills for survival from their play. They explore, take risks, come up with new tactics, and play fight with each other. What they do is intrinsically motivating. Hargrove explores how to keep human movement playful and motivating. Ensuring that any movement programme includes variation and a little bit of chaos will challenge perceptions and the organisation of the nervous system. Similarly, our social and physical environment has a big influence on the nervous system and therefore on our movement health.

The chapter on mobility makes a distinction between flexibility (range of motion) and mobility (how well one moves at end range of motion). For athletes, having good control at end range is protective against injury. Developing strength and agility helps to achieve this control. Hargrove notes that a large body of research has failed to show the benefit of stretching in reducing sport injury.

Simple ideas for exploring and maintaining functional joint mobility are offered. Posture is also discussed, and good posture is described as complex, individual, dynamic and contextual. Co-ordination, balance, strength and endurance, pain and psychosocial factors are all factors that can affect how an individual organises posture.

Our neural system is also at work in learning new movement tasks. Initially it limits the potential range of movements at our

disposal and as a result we often appear wooden and awkward when learning a new activity. Fluidity of movement comes later. But, interestingly, in an event, skilled athletes will often perform like beginners if they focus on technique rather than the end goal.

The final chapter on pain describes the physiology of pain and the psychosocial factors that affect pain sensation. It is an important chapter in being able to understand persistent pain and through doing so, be better prepared to encourage and inform clients, and provide treatment that encourages the nervous system to relax and reset. Hargrove comments that "the best evidence for treating persistent pain points towards improving general health … expose yourself to a healthy level of physical stress, reduce mental and emotional stress, maximize recovery time … do everything you can to let your body know it is strong, safe, resilient, and capable." (Kindle Loc 3070).

I recommend this book for its encouragement to consider the body as a complex system with a tendency to self-organise. Using an evidence-based approach, Hargrove explores how the body adapts to many different factors and acknowledges the variables that may differ from person to person. Throughout the book, there are many fascinating facts that will be of interest to specific clients - these facts alone are bound to be conversation starters.

"SUSTAINABILITY"—OF MASSAGE THERAPY BENEFITS

Greetings, MNZ readers!

The theme of sustainability presents some challenges for a research column. It is possible to pull together research on massage therapy sustainability practices with regards for the environment, including our carbon footprint and waste production, but that really isn't the focus on this column. Likewise, data is available about the sustainability of a massage therapy career—how long people tend to stay in this position, and what factors might lengthen or shorten that timespan, but again, that's not my wheelhouse. So to apply the concept of sustainability to research, this is where I landed:

Information on the sustainability of benefit (also called duration of effect) of massage therapy is sparse. Many studies look just for short term changes—pre/post measures that are taken right before and after sessions. Occasionally we might see a run-out measure taken a few days after the treatment series concludes, but nothing further. This makes it hard to know how long the benefits of massage therapy treatments may last.

This review will look at three studies that investigated the duration of effect of massage therapy in open-ended situations: chronic headaches, perinatal care, and pre-hypertension diagnosed in women. Each of these studies provides some indication of what to expect for how long massage therapy may make positive changes in experience, function, and habits. While the scale of sustainability varies, I am happy to find instances where this factor is being considered in massage therapy research.

RESPONSIVENESS OF MYOFASCIAL TRIGGER POINTS TO SINGLE AND MULTIPLE TRIGGER POINT RELEASE MASSAGES- A RANDOMIZED, PLACEBO CONTROLLED TRIAL

Moraska, et al., Am J Phys Med Rehabil. 2017 September; 96(9): 639-645.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5561477/

Abstract (edited for space and formatting)

Introduction: This study aimed to assess the effects of single and multiple massage treatments on pressure-pain threshold (PPT) at myofascial trigger points (MTrPs) in people with myofascial pain syndrome expressed as tension-type headache.

Methods: Individuals (n=62) with episodic or chronic tension-type headache were randomized to receive twelve twice-weekly 45 minute massage or sham ultrasound sessions, or wait-list control. Massage focused on trigger point release (ischemic compression) of MTrPs in the bilateral upper trapezius and suboccipital muscles. PPT was measured at MTrPs with a pressure algometer pre and post the first and final (12th) treatments.

Results: PPT increased across the study timeframe in all four muscle sites tested for massage, but not sham ultrasound or wait-list groups ($p<0.0001$ for suboccipital; $p<0.004$ for upper trapezius). Post hoc analysis within the massage group showed 1) an initial, immediate increase in PPT (all p-values<0.05), 2) a cumulative and sustained increase in PPT over baseline (all p-values<0.05), and 3) an additional immediate increase in PPT at the final (12th) massage treatment (all p-values<0.05, except upper trapezius left, $p=0.17$).

Discussion: Single and multiple massage applications increase PPT at MTrPs. The pain threshold of MTrPs have a great capacity to increase; even after multiple massage treatments additional gain in PPT was observed.

Ruth's observations:

Full disclosure: I have worked with Dr Moraska in the past, and have very much

appreciated his contributions to the world of massage therapy research.

This team conducted an important study in 2015, asking whether trigger point massage might have an impact on chronic tension-type headaches. The researchers found an unexpectedly positive response among their placebo group, concluding that "Further research is needed to establish if a difference between placebo and trigger point release massage exists."[1]

This is their follow-up study, which focuses on how (or if) massage therapy impacts pain-pressure threshold (PPT) at cervical myofascial trigger points, and how massage therapy compares to a placebo intervention, and a wait-listed group of participants.

As a point of reference (because it can be confusing), in this context if the PPT increases, this is a good sign: it means the participant has increased pain tolerance at the hyperirritable, pain-referring nodule-like areas called trigger points.

Readers of massage therapy research will be familiar with the challenges of creating an acceptable placebo intervention. In the best of all possible worlds a participant doesn't know whether they are in the intervention or placebo group. This is easy to accomplish in drug trials, but harder in research about manual therapy. The Moraska group found an innovative solution: they randomized participants into a wait-listed group as a control; the intervention group that received trigger point release (TPR) massage for cervical muscles; and a placebo group that underwent ultrasound treatment to the same muscles—except the ultrasound machine was disabled, and the ultrasound operator didn't know it was disabled—that's some excellent blinding!.

All of the participants were asked to keep a headache diary for the four weeks leading up to the study, and they were screened by an anesthesiologist to confirm that they had chronic or episodic tension type headaches. The participants were aged 18-59 years, and all experienced a minimum of 2 headaches within the four weeks leading up to the study. Migraines, fibromyalgia, diabetes, depression, and the use of headache-preventing medications were ruled out.

The participants (n=55 at the finish) were randomized into the control group (who were wait-listed to receive massage later); the intervention group, and the placebo group. The massage and placebo group were treated for 45 minutes, twice a week, for 12 sessions. There was a specific, repeated protocol used for both the ultrasound and the trigger point release massage, and pressure readings were compared to a point on the tibia with no trigger points.[2]

Not surprisingly, the massage therapy group had a strong response in terms of pain-pressure threshold. No significant changes were seen in the placebo or control group.

The reason I included this study in this discussion is this: they found some duration of effect that is worth noting:

"Longer lasting effects represent a sustained change in the MTrP (myofascial trigger points) and may confer prolonged gain to clinical parameters. We observed an elevation in PPT at least 48 hours following the 11th massage. In some cases this measurement was conducted up to 7 days following the previous treatment.... Thus, not only was an immediate gain in PPT detected at the initial treatment, but intervening sessions further increased PPT above the initial amount gained. Massage therapists also subjectively reported increased difficulty locating the MTrP nodule across the study treatment time frame for subjects receiving massage."

This is complicated language, but the take-away is this: the pain-pressure threshold improved in the massage group at the beginning of the study, and it continued to improve over time—that is, the benefits were compounded with more manual therapy. Further, the trigger points became increasingly difficult to locate (suggesting resolution), and the improved measures were sustained up to 7 days after the last treatment.

Weaknesses?

I get frustrated with massage studies that use standardised treatment protocols. While I understand how this could control some variables in an experiment, it doesn't reflect massage as practiced, and consequently is unlikely to reproduce "real world" outcomes. An alternative option would have been to establish a protocol and require massage therapists to keep within the types of strokes and time allotments, but to customize each treatment to the client's needs for that day. However, this study was less about massage and the goal of relieving headaches, and more about seeing how trigger point massage compares to placebo on pain-pressure threshold, so the protocols make a little more sense in this context.

Another point of frustration is that the team asked participants to keep headache diaries before the study began, to get some baseline information and for diagnostic purposes, but they didn't do any comparison of headache experiences during or after the study. This project would have been more applicable to massage therapists if the researchers had also tracked this data, even as a secondary outcome.

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[1]Moraska, A. F., Stenerson, L., Butryn, N., Krutsch, J. P., Schmiege, S. J., & Mann, J. D. (2015). Myofascial trigger point-focused head and neck massage for recurrent tension-type headache: A randomized, placebo-controlled clinical trial. The Clinical Journal of Pain, 31(2), 159–168. https://doi.org/10.1097/AJP.0000000000000091

[2]This isn't the venue for arguing about the existence of trigger points; the authors define them using resources and explanations that are widely accepted in the medical field.

A PILOT STUDY OF PARTNER CHAIR MASSAGE ON PERINATAL MOOD, ANXIETY, AND PAIN

Robin B. Thomas, LMT, DrPH

Int J Ther Massage Bodywork. 2019 Jun; 12 (2): 3-11

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6542572/

Abstract (edited for space and formatting)

Introduction: Women worldwide experience perinatal mood, anxiety, and pain contributing to pregnancy and birth challenges, maternal and infant bonding, and childhood development. Perinatal women seek massage therapy for relaxation, pain management, and emotional support, but may encounter socioeconomic barriers.

The purpose of this study was to examine the health effects to perinatal mood, anxiety, and pain, by teaching partners of pregnant (PG) women a chair massage.

Methods: Setting: Participants' homes in Tucson, Arizona, USA.

Participants: Twelve PG women with minor mood, anxiety, and pain: 67% white, 33% Hispanic, college educated, married, aged 32 years (± 3.86 SD), 67% expecting a first child, annual incomes ≤ $50,000 (33%), > $50,000 (67%).

Research Design: A pre/postintervention pilot study in a single group for eight weeks.

Intervention: Twice weekly partner-delivered chair massage and its relation to perinatal mood, anxiety, and pain.

Main Outcome Measures: Pre/poststudy perinatal massage effects were measured with the Edinburgh Depression Scale (mood), the STAI-AD (anxiety), and the VAS (pain). Weekly text messaging tracked dose and frequency, follow-up surveys measured sustainability, and birth outcomes were acquired by texting.

Results: Study retention was 86%, protocol compliance 94%, with couples averaging 10-minute, twice weekly chair massage over the eight week study period. Paired-sample t tests indicated statistically significant improvements to perinatal mood and anxiety, Cohen's d, a large strength of effect size ($p = .012$, $d = 0.87$; $p = .004$, $d = 1.03$). A trend was observed for reduced pain, with a medium strength of effect size ($p = .071$; $d = 0.58$). Follow-up surveys indicated most couples were sustaining at least weekly massage. Birth outcomes showed healthy infants with no complications, mean birth weight of 7.26 pounds, and mean gestation of 39 weeks.

Discussion: This is the first evidence of partner chair massage as safe and effective complementary home management of perinatal mood, anxiety, and pain.

Ruth's observations:

This was a pilot study, purposely kept small (n= 12 couples) to see if there was enough of an effect to invest in a larger-scale clinical trial. The premise was simple: 30-minute side-lying massage on a massage table has been studied for pregnant people, but for convenience and cost it could be a barrier to valuable care. Would it be possible to design a shorter protocol that could be done with a partner at home, requiring no special equipment, and only brief training? And if that is provided, would couples keep it up? And lastly, how would that impact maternal scores for mood, anxiety and pain?

One thing I especially appreciated about this study how well it explained that maternal anxiety, depression, and pain can have significant impact on the health of mother, child, and the family unit. The author was able to gather important data on this issue, and to make the case that improving maternal well-being during pregnancy could have many short and long-term benefits.

It was not surprising that partner-given massage improved mood and anxiety scores, moving them into a healthy range. Pain scores were only minimally improved, which again is not surprising since the massage providers were partners with an hour of training, not professional massage therapists.

But what really moved me about this study is that the couples were surprisingly compliant: they were asked to conduct two 10-minute massages per week for eight weeks—that's a lot. And for the most part, they did it: the average massage session was 10.26 minutes, and the number of sessions averaged 15 (the target was 16). That in itself is a remarkable result.

Then the author did something I wish more authors would do: she followed up. A month after the 8-week project ended, she sent out a follow-up survey to see if couples were still doing massage. This arrived just as most of the participants were approaching their due dates. At that time 25% were still doing massage twice a week, and the rest were doing it once a week. Three months later, with a newborn in the house, 25% were still doing massage twice a week, 67% were doing it once a week, and only one couple (8%) had stopped doing any massage at all.

This, combined with the happy outcomes of uneventful labors and healthy babies, speaks well for the option of partner massage as a sustainable way to support the mental and emotional health of women in their perinatal year—especially those who may not have the time or financial resources to visit professional massage therapists on a regular basis. And of course it opens up the possibility of ways couples can care for each other with improved communication and a structured way to provide physical support to each other during a stressful time.

Weaknesses

This study is small-scale and far from conclusive, as the author is quick to observe. The Principal Investigator trained all the massaging participants, gathered all the data, and processed in using methods described in the paper. However rigorous, this still leaves the findings open to confirmation bias and other influences. Further, there were no control couples to track for mood, anxiety, and pain.

The author also points out that it would be useful to gather some data on physiological measures, including blood pressure and heart rate, to track if seated massage from a partner might also impact those health indicators.

This investigation of partner-given massage shows promising results with an inexpensive, low-tech, low risk intervention. I hope the author manages to turn this into a larger, more formal clinical trial.

LONG-TERM EFFECT OF MASSAGE THERAPY ON BLOOD PRESSURE IN PREHYPERTENSIVE WOMEN

Givi, et al.

J Educ Health Promot. 2018 Apr 3; 7:54.

https://pubmed.ncbi.nlm.nih.gov/29693035/

Abstract (edited for space and formatting)

Introduction: Prehypertension is one of the cardiovascular disease predicators. Management of prehypertension is an appropriate objective for clinicians in a wide range of medical centers. Massage therapy is primarily nonpharmacological treatment that is used to control blood pressure (BP). This study intends to investigate the long-term effect of massage therapy on BP in prehypertensive women.

Methods: This was a single-blind clinical trial study conducted on 50 prehypertensive women who referred to Sedigheh Tahereh Cardiovascular Center, during 6 months in 2009. Participants were selected by simple random sampling and were divided into control and intervention groups. The test group (25 patients) received massage for 10-15 min, three times a week for 10 sessions, and the control group (25 patients) was relaxed in the same environment but with no massage. Their BP was measured before and after each session and 72 h and 2 weeks after finishing the massage therapy.

Results: The results indicated that the mean systolic BP (SBP) and diastolic BP (DBP) in the massage group were significantly lower in comparison with the control group ($P < 0.001$). Evaluation of durability of the massage effects on BP also indicated that 72 h after finishing the study, still there was a significant difference between the test and control groups in SBP and DBP ($P < 0.001$), but after 2 weeks, there was not a significant difference in SBP and DBP ($P > 0.05$) between the two groups.

Conclusions: Although massage therapy seems to be a safe, effective, applicable, and cost-effective intervention to control BP of prehypertensive women, its effects do not persist for a long time.

Ruth's observations:

This is a relatively simple study, asking whether massage to the face, neck, shoulders, and upper chest might have an impact on the blood pressure of prehypertensive women age 18-60.

They enrolled 50 participants and randomized them into two groups: control and intervention. The intervention group of 25 participants received 10-15 minute treatments three times a week for a total of 10 sessions, and all massage was given with clients supine.

The control group (also 25) spent the same amount of time laying on a bed with closed eyes, practicing deep breathing.

As we see from the abstract, systolic and diastolic measures dropped for more for the massage group, and while those changes persisted for three days, they were not present at the 2-week mark.

Some might feel this is a disappointing result, but frankly that's not a realistic point of view. When a person uses antihypertensive drugs, the expectation is that they will have to renew their dose on a regular basis. Why should massage therapy be any different? To my mind, having a 3-day long impact on blood pressure is a significant finding, and greater than some others that have looked at massage and hypertension. This makes me wonder if there is an advantage in having short frequent sessions, as offered in this project, compared to weekly longer sessions. It would make an interesting follow up study, wouldn't it?

Weaknesses

This study is extremely simple and easy to follow, even with something of a language barrier. They point out that they only used women, and only those with pre-hypertension. Findings might have been different with a mixed group of participants, with more advanced hypertension. Still, they make a decent case that massage might help to keep patients on the healthy side of hypertension, and therefore it's worth looking at.

The authors draw conclusions that may be out of scale with their findings, but I give them credit for taking on something that is so unaddressed: how long do massage benefits for hypertension last?

I encourage readers of massage therapy research to look for sustainability, or duration of effect in research. This will help us continue to make our case for the importance of massage therapy in maintaining health and wellness.

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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Videos Available