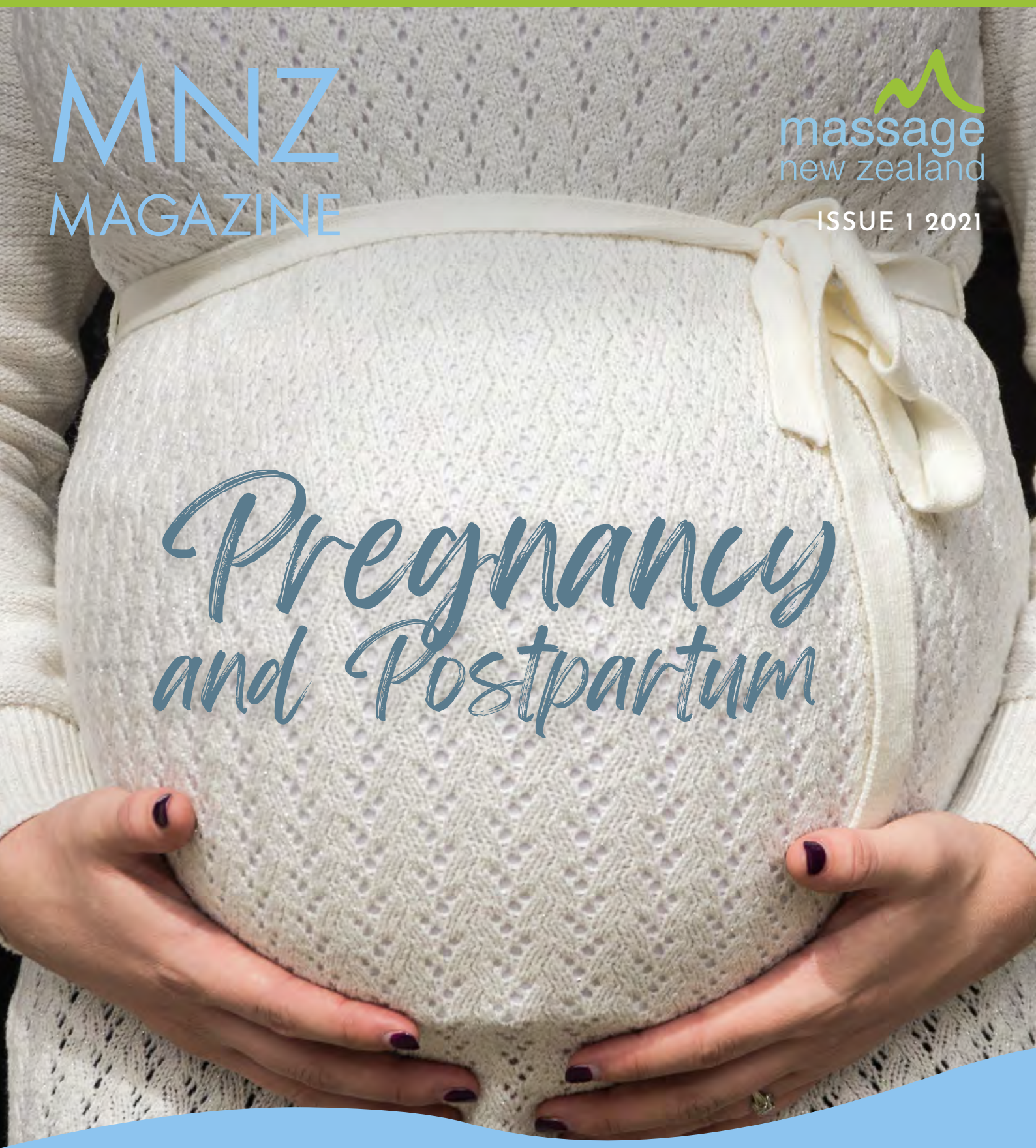
PROVIDING NEWS AND INFORMATION TO MASSAGE THERAPY PROFESSIONALS IN NEW ZEALAND

MNZ MAGAZINE

massage new zealand

ISSUE 1 2021



Pregnancy and Postpartum

SIMPLY TREATING WOMEN DURING PREGNANCY • PELVIC ORGAN PROLAPSE: HOW CAN MASSAGE THERAPY ASSIST THOSE IMPACTED BY PROLAPSE? • PREGNANCY MASSAGE: SOME MYTHS AND FACTS • DIASTASIS RECTI: WHAT IT IS AND WHAT WE CAN DO ABOUT IT • WHY IS POSTPARTUM SO HARD?

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MNZ MAGAZINE
ISSUE 1 2021

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REGULAR

FEATURE ARTICLES

EDITORIAL

Kia ora members,

Welcome to issue 1 for 2021. We kick off the year with a revamped editorial team – Odette and Rachel. Together we hope to bring you the best articles and contributors we can source. We are excited to be working together and hope to continue the previous work of the MNZ Magazine team, sharing our passion for research and evidence-informed massage therapy.

In this issue we draw your attention to the topic of Pregnancy and Postpartum. We have curated a diverse range of articles which we hope will update some of your knowledge in this area. Treating clients during pregnancy and in the months after birth is work many of us already do, so it is important that we are providing evidence-informed treatment to help them through this often challenging and stressful time.

Dr Sarah Haag, physiotherapist and pelvic health specialist from Chicago, offers insight into pregnancy and pain; why low back pain and pelvic girdle pain are so common; and how we might help our pregnant clients. Wellington degree-qualified RMT Becky Littlewood provides some excellent feature articles. One on Pelvic Organ Prolapse (POP) – discussing how massage therapists can assist women with this condition. The second on Diastasis Recti, helping us understand one of the most common physical adaptions to happen during pregnancy. Becky is an excellent writer and is really developing her critical thinking skills. She is a wonderful example of a MNZ member who is recognising the importance of evidence - informed practice. We are pleased to have her contributing again.

Alice Sanvito, self-confessed skeptical massage therapist shares her thoughts about myths related to massage during pregnancy, and why it is important to offer pregnant clients evidence-informed advice and treatment. Canadian RMT and massage therapy educator Paula Jaspar discusses the postpartum stage and how massage therapists can assist their clients.

In our Pathology column, Becky Littlewood discusses a condition known as succenturiate lobe and what to be aware of when working with women with this diagnosis. Becky also provides an excellent A&P update on the pelvis and pelvic floor. In Business Matters, Steve Hockley writes on building a niche market, why it can benefit your business and what to consider when going down that path. We put the spotlight on another new graduate, Chris Coleman, who shares some goals for his new career. And finally, in Research Update, our regular columnist (and honorary kiwi in our books!), Ruth Werner, discusses three articles addressing massage therapy with pregnant clients. As always, her insights are thought-provoking and help us to consider the research more critically.

Enjoy!

Odette & Rachel

ARTICLE SUBMISSION AND ADVERTISING SPECIFICATIONS

SUBMISSION DEADLINES

The MNZ Magazine will be published:

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

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:

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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 (not including references): Standard article 250-1000 words, feature article 1000-2000 words.**
- **Format: MS Word**
- **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 – Rachel Ah Kit, Odette Wood

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PRESIDENT'S REPORT

Dear Members,

It has been a turbulent time for all. Hopefully, most of us are back to 'normal' in our practices by now. A big thank you to Clint, our past President, for all his work as the COVID-19 pandemic was unfolding, leading the team through, and liaising with AHANZ to provide clear guidelines to follow with health protocols.

I would like to thank the Executive Committee for welcoming me back into the fold. I am hugely admiring of the expertise and commitment to the massage profession that they have.

From stepping into the role, it has been a busy time. We had a strategic planning meeting in November and from that, several initiatives arose.

Three things were identified as needing urgent attention.

1. The review of qualifications by NZQA
2. The redefining of the Scope of Practice
3. The need to create working groups to help our small Executive Committee with specific projects.

Allied Health Aotearoa New Zealand (AHANZ) also brought to our attention the New Zealand Institute of Economic Research (NZIER) opportunity to be involved in putting forward policy to the Government to redefine the Allied Health profession to include community-led initiatives. We would not have been able to move forward without the help of our membership. A BIG THANK YOU to all those members who answered the call to contribute to this amazing opportunity. Iselde de Boam, MNZ AHANZ Representative, and a small working group put forward a document in a very tight timeframe.

Iselde and I held a meeting with Steve Osborne from the Ministry of Health to find out more details on possible regulation in the pipeline for the massage profession. This is an initiative to include professions that are not currently covered under the HPCAA.

MNZ has also held three Strategic Plan Zoom meetings to encourage the transparency and communication between MNZ Executive Committee, members, non-members, and stakeholders. Thank you to Christy Munro, MNZ Vice-President for organising and leading these meetings, and facilitating key working groups to drive forward with strategic plan projects.

I have enjoyed being able to communicate directly with everyone once more through the President's monthly email. All information and updates can be viewed on the MNZ Newsfeed - https://www.massagenewzealand.org.nz/Site/members/news/. I believe transparency is fundamental in bringing us together as an organisation.

Helen Smith

ADMIN REPORT

Dear MNZ Members,

We do hope you all enjoyed the warmer summer months and managed to get out and about to visit some spectacular locations and support local businesses around New Zealand. We are rather lucky to have had some freedom of movement and feel safe during our travels, unlike many locations around the world in the past few months. We hope that 2021 will be a much more pleasant and settled year for the world.

MNZ staff and Executive Committee will continue to work hard together this year to improve policies and systems involved in the running of MNZ organisation. We aim to gain traction on several priority projects involved in the MNZ strategic plan. Please keep an eye on your membership emails and on the MNZ Newsfeed for updates - https://www.massagenewzealand.org.nz/Site/members/news/.

If you are interested in helping with any MNZ working groups or being more involved with the executive, then please get in touch – admin@massagenewzealand.org.nz. MNZ position vacancies are available to view here - https://www.massagenewzealand.org.nz/Site/members/jobs/mnz-jobs.aspx.

Thank you to all members who have renewed their membership subscription on time. It is a hectic time of year for Esther, so we really appreciate members keeping everything up to date. Be sure to log your CPD hours. It is a lot easier now to log your CPD as you go, rather than having to remember once renewal rolls around. Visit the CPD webpage in the members section of the MNZ website and click on LOG CPD - https://www.massagenewzealand.org.nz/Site/members/cpd/my-cpd.aspx.

If you have any questions regarding membership, please do contact Esther at membership@massagenewzealand.org.nz

A couple of reminders from the MNZ admin team:

Southern Cross Health Insurance - If you are a RMT Level 6 or higher registered with MNZ, you may be eligible to become a Southern Cross Health Society Easy-Claim provider. Southern Cross Health Insurance clients who have the "Wellbeing" policy with the "Body Care" module are eligible to claim for massage therapy with a MNZ RMT. Easy-Claim is a convenient way for Southern Cross members to claim for treatment at the time of purchase, without completing a claim form. RMTs can send an electronic claim via the online system and get paid directly by Southern Cross. Southern Cross will check RMTs details using the Find A Therapist Tool. Please include your clinic details so that you appear on the Find A Therapist tool on the website. You can add/update your details here: www.massagenewzealand.org.nz/Site/members/my-membership/. Contact Southern Cross Easy-claim provider on 0800 700 053 or email easy-claim@southerncross.co.nz

Preferred Suppliers - Please remember to make use of your MNZ Membership benefits by visiting Preferred Suppliers page to see some great discounts on products and services - https://www.massagenewzealand.org.nz/Site/members/resources/preferred-suppliers.aspx. As part of your membership, it is essential to keep your First Aid certificate updated. St John offer 5% discount to MNZ Members. Login to the MNZ members website, go to St John under Preferred Suppliers to find details on how to book your discounted course online.

We are looking forward to another great membership year and aim to have even more members than last year. The more members we have on board the bigger and stronger our massage presence and massage community gets. If you know of a massage student or a massage therapist who is not currently a member, please talk to them about MNZ or encourage them to get in touch with us to find out about membership.

Enjoy reading this newest issue of the MNZ magazine!

Nici Stirrup
Executive Administrator

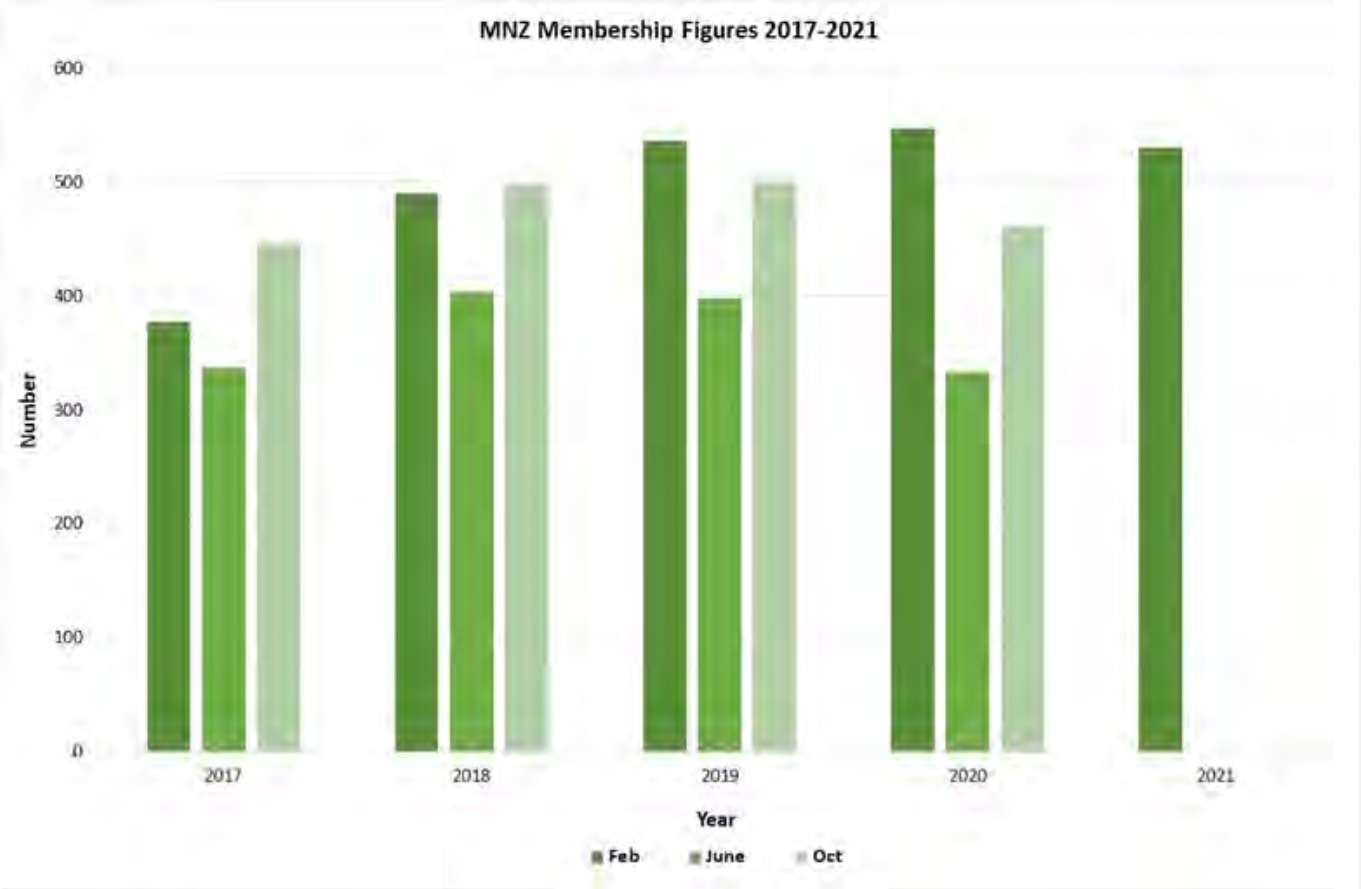
Esther Shimmin
General Administrator

MEMBERSHIP UPDATE

As of the 1st of February 2021, we had a grand total of 530 members. In comparison to this time last year, we are tracking well as we recover from a year that no-one expected.

Feb 2020	Feb 2021
RMT: 419	RMT: 422
SMT: 106	SMT: 94
AFF: 22	AFF: 14
Total: 547	Total: 530

The graph below shows membership growth since 2017.



In January of this year, we saw a lot of our student members upgrading to RMT membership. Congratulations to all the students who graduated in 2020. You and your tutors got through an incredibly challenging year. If you are intending to continue your studies, please send Esther your confirmation of studies and she will renew your student membership.

We are pleased to see that our RMT figures have recovered following the impact of COVID-19 and lockdown. RMT and AFF member renewals have now been processed for 2021 effective from 1 April. Thank you to all who have renewed on time. RMTs should have received the renewals pack by now including your new Annual Practicing Certificate to display in clinic. It might still be en route so please look out for that in the post.

As always, if you have any questions about membership or CPD, please contact Esther at membership@massagenewzealand.org.nz

SIMPLY TREATING WOMEN DURING PREGNANCY

By Dr Sarah Haag, PT, DPT, MS

As healthcare practitioners, treating a woman during pregnancy or postpartum may seem intimidating. While there are hundreds of hours of continuing education for learning how to care for pregnant women, there are often misunderstandings surrounding pregnancy and the postpartum period.

Pregnancy is a fantastic event that dramatically changes a woman's body over 40 weeks. During this time, many women will experience new sensations, and some of those sensations can be quite alarming!

Many women will strive to be as healthy as possible for both themselves and their future child. This quest for improving or maintaining health can be challenging for women. What is normal? Gaining 11-16kg with a singleton pregnancy is expected if the woman has a BMI within normal limits before pregnancy (Rasmussen et al., 2009). If babies are only 3.5kg on average, where does the other weight come from? The remainder of the weight gain comes from mammary and uterus mass, maternal blood volume, extracellular fluid, fat stores and extraembryonic tissue and fluids (National Research Council. Subcommittee on Nutritional Status Weight Gain During Pregnancy et al., 1998)

Taking into consideration the hormonal changes, the weight gain, and physical changes that occur during a healthy pregnancy, it is understandable that some discomfort or pain or urinary incontinence might happen. In spite of how common these complaints may be, they are not normal. ***Not normal*** is not meant to imply pathological, but rather to encourage women and other practitioners to seek guidance and pursue a course of action to feel better.

Some of the most common complaints during pregnancy are low back pain, pelvic girdle pain, and diastasis rectus abdominis. Why are these issues so common in pregnancy?

Low back pain and pelvic girdle pain are both widespread and can sometimes be hard to distinguish one from the other. Low back pain is often defined as pain occurring between the 12th rib and the lower gluteal folds (Hoy et al., 2014). Pelvic girdle pain is defined as pain between the iliac crests and the lower gluteal folds, including the SI joint area and possibly the pubic symphysis (Vleeming et al., 2008). While low back pain and pelvic girdle pain may seem to overlap, pelvic girdle pain is differentiated by difficulty with transitional movements and walking.

Fifty-six to seventy-two percent of women will experience low back or pelvic girdle pain during their pregnancy (Clinton, 2017). The likelihood of having low back pain is higher during pregnancy if a woman has had back pain in the past. Oftentimes it is assumed that the extra weight, increased lumbar lordosis or the shift in the center of gravity is to blame for the onset of low back pain. Pelvic girdle pain is sometimes attributed to the increase in the levels of the hormone relaxin. None of these potential culprits have been found to be responsible for the development of pain during pregnancy (Clinton, 2017).

It's true that low back and pelvic girdle pain is very common during pregnancy, but if the pain isn't due to pregnancy why is it happening? Low back pain is highly prevalent in non-pregnant people. Up to 80% of people will experience low back pain at some point in their lives, and most of those people will experience low back pain again. Women are also more likely to have low back pain (Bohlega, 2004). This may indicate that women experiencing pregnancy related low back pain are actually just pregnant women who happen to have low back pain. The good news is that much like non-pregnant people, low back pain during pregnancy does typically get better.

Round ligament pain is sometimes reported during pregnancy, but what is round ligament pain? Round ligament pain is often the diagnosis given when a pregnant woman reports a sharp, shooting pain, often in the lower abdomen or groin region. This is a pain that can be quite random, or associated with transitional movements, such as sit to stand. Scholarly articles do not address round ligament pain as it has been described in the clinic. As long as

there are no other medical concerns, reassurance can be very helpful. Helping a woman feel better and keep moving is a reasonable plan of care, as there are no other recommendations available.

Diastasis rectus abdominis (DRA) is another common occurrence during pregnancy and postpartum. DRA is the separation of the 2 muscle bellies of the rectus abdominis. While most women will experience some degree of DRA during pregnancy or postpartum, DRA is not associated with an increase in low back pain or pelvic issues when compared to women without DRA (Sperstad et al., 2016). Understanding that DRA is very common, and may be considered a normal adaptation during pregnancy, may help practitioners reassure women with DRA that they are safe and able to continue to participate in their desired activities.

What can be done for women who are experiencing discomfort or difficulties during pregnancy? There doesn't seem to be any evidence that would suggest a pregnant woman in pain is so different than any other person in pain, with the exception of course that she is pregnant. Or are pregnant women different?

The biopsychosocial model of care takes into account the biological, the social, and the psychological domains that may contribute to a person's experience of pain. When considering the person in front of you, it is important to remember that the relative contributions of each domain are "neither predetermined, nor static and their relevance and contribution vary between patients" (Jull, 2017, figure 1). Considering the potential biological contributions of pain during pregnancy, it is important to acknowledge the potentially significant impact of the psychological and social domains. Pregnancy, motherhood, career decisions, relationship issues: all of these are thoughts, decisions and judgements that impact the way a woman presents to a healthcare practitioner.

Even with the variability of each patient, exercise, education and manual therapy are three common interventions offered to people in pain. All three of these interventions can be effective in helping women during pregnancy stay healthy and improve pain and function.

Exercise is not just safe for pregnant women, but very important for the health of both mom and baby! Exercise guidelines for pregnancy are available in many countries (Evenson et al., 2013; Exercise and physical activity in pregnancy: Guidelines, reviews, statements, recommendations, standards, 2021), but women tend to be less active during pregnancy (Gaston & Cramp, 2011). In spite of the guidelines, women are reporting that their healthcare providers are not providing encouragement information on the benefits of exercise while pregnant (Hayman et al., 2019). In addition to the overall benefits of exercise during pregnancy, exercise one time per week was found to substantially reduce the risk of pelvic girdle pain (Andersen et al., 2015).

During pregnancy, women may respond differently to exercise. The Talk Test is recommended (American College of Obstetrics and Gynecology, 2020), which instructs women to work at a level where they are out of breath but can still carry on a conversation. It is also important to review absolute and relative contraindications for exercise during pregnancy. Women will be aware of medical issues going on, so it is important to include questions about any complications that may be occurring, so that treatment can be modified or put-on hold as appropriate.

Exercise for DRA can be helpful! There is no evidence that any one particular exercise or exercise program is better than any other, but there is some evidence that exercise is better than not doing any exercise (Michalska et al., 2018;). Understanding the issue, a patient has with her DRA, if the issue is pain, function, or aesthetics will assist in determining if their concerns can be addressed with conservative measures of if a referral to another provider is necessary (Fuentes Aparicio et al., 2021).

Manual therapy is not generally contraindicated during pregnancy, but understanding the goals of the woman is important, and the words that are used to explain any interventions is important. Performing treatments to "loosen things up" may confuse a person who has been told they are "unstable". Providing a hands-on intervention that improves confidence and reduces pain, while increasing self-efficacy could be more helpful than a completely passive treatment. Confidence and self-efficacy can also be considered when choosing a treatment position. Many pregnant women have been told they must never lie on their backs; however, supine positioning may be comfortable for the woman. The reason that women are advised to avoid the supine position is to avoid compression of the inferior vena cava. In advanced pregnancy, the weight of the fetus can compress the inferior vena cava and reduce the blood supply to the woman. The good news is, when compression of the vena cava is happening, there is no doubt that it is happening. The woman will be very uncomfortable and have trouble breathing. A simple change in position will alleviate this situation and perhaps inform position choice for that person in the future.

Education is a key component to any healthcare intervention. The explanations that healthcare practitioners give to their patients are important and powerful. Healthcare providers will hopefully acknowledge the amazing strength in women who are undergoing amazing changes to bring a new human into the world. These women are strong and resilient, but at times receive messages that imply they are not. Evidence-based treatments, tailored to the needs of the individual in front of them, can help make a common complaint in pregnancy nothing more than a temporary inconvenience.

AUTHOR BIO

Dr. Sarah Haag graduated from Marquette University in 2002 with a Master of Physical Therapy. She went on to complete Doctor of Physical Therapy and Master of Science in Women's Health from Rosalind Franklin University in 2008. Sarah has pursued an interest in treating the spine, pelvis with a specialization in women's and men's health, becoming a Board-Certified Women's Health Clinical Specialist in 2009 and Certification in Mechanical Diagnosis Therapy from the McKenzie Institute in 2010. Sarah is also a Registered Yoga Instructor.

Sarah joined the faculty of Rosalind Franklin in 2019. In her roles at Rosalind Franklin, she will be acting as the physical therapy faculty liaison for the Interprofessional Community Clinic and teaching in the College of Health Professions.

Sarah cofounded Entropy Physiotherapy and Wellness with Dr. Sandy Hilton, in Chicago, Illinois in 2013. Entropy was designed to be a clinic where people would come for help, but not feel like 'patients' when addressing persistent health issues.

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PELVIC ORGAN PROLAPSE: HOW CAN MASSAGE THERAPY ASSIST THOSE IMPACTED BY PROLAPSE?

By Becky Littlewood, MNZ RMT

AETIOLOGY & DEFINITION

Pelvic organ prolapse (POP) affects women and is a condition whereby the pelvic organs descend from their normal position in the pelvis (NHS, n.d.). The bladder, rectum, uterus, or top of the vagina fall downwards into the vaginal canal, creating a bulge in the tissues of the vaginal wall or descending out of the vagina (NHS, n.d.). Prolapse can be asymptomatic for some women, whereas others report symptoms of vaginal pressure, a bulge in the vagina that can be felt or seen, difficulty inserting tampons or menstrual cups, an aching in the pelvis that may worsen with standing or coughing and may feel worse at different times of the day, and urinary and/or faecal incontinence. In asymptomatic cases, women are often only told they have POP when having a vaginal or rectal examination for another reason.

Causes of POP are multifactorial. Over half of women with prolapse have sustained an injury to the pubococcygeal pelvic floor muscle (Iglesia & Smithling, 2017). This muscle is part of the levator ani muscle (in Latin the 'anal lifter') (DeLancey, 2016), and in some cases, complete avulsion of the levator ani muscle is experienced. The levator ani is capable of stretching up to three times its normal resting length, in order to allow passage of the baby during the second stage of labour (descent of the baby through the birth canal) (Krugar et al., 2017). Childbirth causes most pelvic floor injuries, particularly instrumental deliveries involving forceps and/or ventouse (Memon & Handa 2013).

According to the British Medical Journal (Barber, 2016) 30-76% of women will experience prolapse. Anterior vaginal wall prolapse, where the bladder descends into the vagina, is twice as likely to occur as posterior vaginal wall prolapse, where the bowel descends into the vagina (Barber, 2016).

Increased ligament length and failure of connective tissue attachments of the uterus and vagina can also exist in women with POP (DeLancey, 2016). This is supported by a 2020 narrative review of prolapse, which places collagen weakness at the centre when regarding causative factors of prolapse (Glinter & Marcus-Braun, 2020). However, disordered collagen is still considered controversial due to small sample sizes in research and differences in methodology (Gong & Xia, 2019).

Menopause, pregnancy and childbirth, genetic factors, aging, obesity and previous hysterectomies can all contribute to the likelihood of POP occurring (Glinter & Marcus-Braun, 2020). Risk factors also include neurologic dysfunction, joint hypermobility, smoking and increased intra-abdominal pressure caused by heavy lifting, chronic constipation and/or coughing (Saunders, 2017).

During menopause, there is a greater predisposition towards POP due to lower estrogen levels. Estrogen impacts the amount of collagen in connective tissue, especially collagen I, which plays a major component of tissue tensile strength (Alperin, 2019). In particular, the cardinal and uterosacral ligaments can be affected

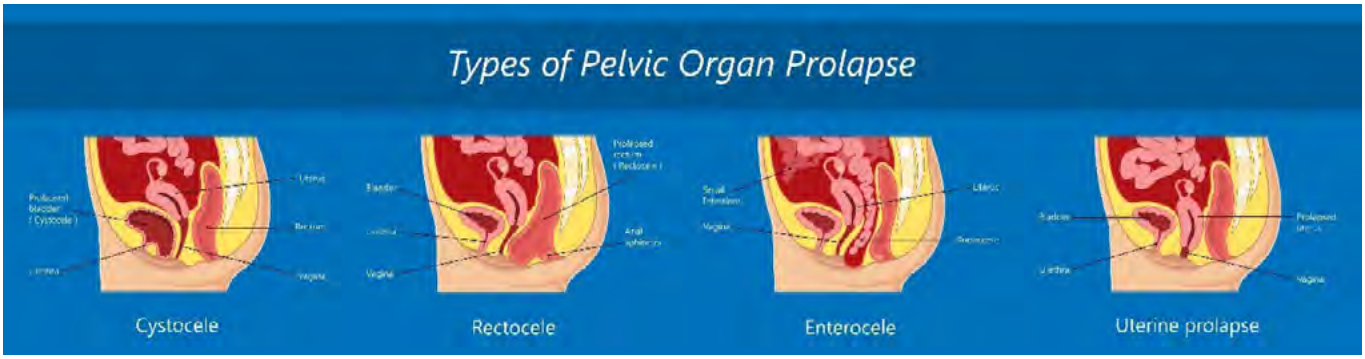


Figure 1. Types of prolapse

as they are part of the endopelvic fascia that attach the bladder and uterus to the sacrum and ischial spine.

EPIDEMIOLOGY

POP is a common condition in women who have had children.

Prolapse types:

- Anterior vaginal wall prolapse, also known as bladder prolapse and cystocele.
- Posterior vaginal wall prolapse, also known as rectal prolapse and rectocele.
- Uterine prolapse: descent of the uterus into the vagina.
- Vaginal vault prolapse: descent of the top of the vagina into the vaginal canal (more common post-hysterectomy).

There are differing levels of severity of pelvic organ prolapse. The pelvic organ prolapse quantification system (POP-Q) is a useful method that clinicians use to objectively assess and record pelvic organ prolapse (Persu, 2011):

- First-degree prolapse: The organs have only slipped down a little.
- Second-degree prolapse: The organs have slipped down to the level of the vaginal opening.
- Third-degree prolapse: The vagina or womb has dropped down so much that up to 1 cm of it is bulging out of the vaginal opening.
- Fourth-degree prolapse: More than 1 cm of the vagina or womb is bulging out of the vaginal opening.

(Institute for Quality and Efficiency in Health Care (IQWiG), 2006)

SIGNS AND SYMPTOMS

When symptoms do arise in POP, it can be felt as a heavy dragging downwards of the tissues of the vagina, and there may be urinary or faecal leaking, which may change in frequency and severity at different times of the day. Spending a long time standing or experiencing stress and fatigue can impact symptoms.

POP is affected by weakened pelvic floor muscles as well as overly tensioned (hypertonic) pelvic floor muscles. It is important that pelvic floor muscles are able to move through their full range of motion, enabling them to work functionally. If the pelvic floor is hypertonic, relaxing this muscle group is important, to help prevent leaking. Weakness of these muscles means strengthening is required, especially if there is ligament weakness as having strong pelvic floor muscles is integral to providing support for the pelvic organs.

POP can impact a woman's mental health (Zeleke, 2013). Women with pelvic floor dysfunction (urinary and faecal incontinence and POP) have a threefold higher risk of depression (Mazi et al., 2019), and having anxiety and depression can exacerbate these symptoms (Taple et al., 2020).

MASSAGE THERAPY IMPLICATIONS

The changing weight of the body in pregnancy causes the brain to perceive the body differently. This can lead to pregnancy adaptations whereby new movement strategies are created, impacting movement and alignment in postpartum (Forczek, et. al., 2018; Mei, et. al., 2018). Massage can address hypotonic and hypertonic muscles that result from these new strategies. A full assessment of movement and muscles that attach to, and affect, the pelvis is important in postpartum. In the older population (e.g., peri- or post-menopausal years), pregnancy adaptations and post-pregnancy movement strategies have often not been addressed and thus this population also benefits from a full strength and movement assessment.

The pelvic floor is stretched during childbirth and these muscles can become inhibited and hypotonic. During movements that create intra-abdominal pressure (lifting, coughing, sneezing, laughing, shouting etc), there can be a 'bearing down' on the pelvic floor muscles (much like the Valsalva Manoeuvre) and if the strength to resist this pressure is absent there is risk of prolapse resulting. Helping clients to strengthen the pelvic floor can activate these muscles and remind the nervous system that they are on board. Strengthening the pelvic floor with the diaphragm helps to regain functional strength in this area (Wallden, 2017).

Massage can help women to relax and recover after childbirth and pregnancy, helping to calm the nervous system and improving state of mind. This can reduce stress and if there is POP, can also help reduce the symptoms of prolapse. Being educated

around the prevalence of prolapse after pregnancy will help you to inform your clients that strengthening the pelvic floor (and/or relaxing if hypertonic) and re-learning good movement strategies is crucial before returning to high-impact exercise.

POP, specifically if experiencing incontinence, can lead women to feel embarrassment and shame, making it difficult for women to discuss their symptoms. However, being able to discuss this openly can provide much needed support, leading to a more positive outlook, which can contribute to a reduction in symptoms as stress levels reduce.

Viewing POP through a biopsychosocial lens, massage therapists are well placed to contribute to social support, by providing a safe space to discuss symptoms, thereby normalising the conversation around prolapse. Massage therapists can refer women to pelvic health physiotherapists, who are able to perform pelvic exams to check for prolapse and pelvic floor strength and can teach women pelvic floor muscle training to assist in prevention of incontinence during pregnancy and postpartum (Franz et al., 2012).

Referring women to their GP to seek psychological support if needed, is important. As stated, pelvic floor dysfunction and POP can contribute to depression and anxiety. Mental, physical, and emotional exhaustion in postpartum, acute and chronic stress, anxiety, as well as depression prior to pregnancy, are also implicated (Schmied et al., 2013). Asking about a woman's emotional and mental health, can flag the need for psychological support.

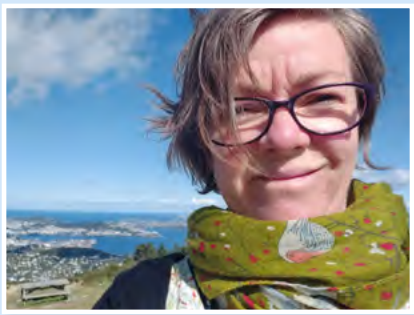
It is important to help women with prolapse to view the condition in a positive light. In the biopsychosocial view of prolapse, changing the outlook can help to reduce symptoms. Figures 2 and 3 show how our belief system can impact our symptoms, for better or worse.

Figure 2. The downward spiral of thoughts around prolapse

Figure 3. A better outcome through more positive thoughts

Having a list of community support is also helpful; postpartum groups, local mothers groups, online groups for support, postpartum exercise groups. These resources can provide women with social support that assists them to have a positive outlook. For older clients with POP, providing resources for exercise groups run by people educated in prolapse will be beneficial; yoga, Pilates, Feldenkrais etc.

There is much a massage therapist can do to assist women who have been impacted by prolapse. As many of our clients are women, and many of them have had children, educating ourselves on this prevalent and important condition will help us to provide a truly holistic service to our clients.



AUTHOR BIO

Becky is a Level 7 RMT based in Wellington. Completing Level 7 through Southern Institute of Technology meant that she was able to conduct original research into postpartum massage and rehabilitation, winning her an award for joint-Top Research Project

Becky owns Rejuvenate Therapy: Massage & Bodywork, and runs an evidence-based practice, serving those with a myriad of needs. Becky loves her work and loves continuing to improve her knowledge and practice.

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PREGNANCY MASSAGE: SOME MYTHS AND FACTS

This article was collated by Rachel Ah Kit, MNZ Magazine Co-editor, in conjunction with Alice Sanvito. It contains excerpts taken, with permission, from Massage and Fitness Magazine, a free online magazine for massage therapists and fitness professionals. You can read the original article in full at https://massagefitnessmag.com/massage/massage-pregnancy-myths/

Don't massage in the first trimester. Never massage a pregnant woman's ankles. These are two of the common beliefs surrounding pregnancy massage that are still circulating in society. Do we have evidence to support these beliefs? Or are they just myths? We checked in with Alice Sanvito, LMT, from St. Louis, Missouri, USA to find out what research says and what we, as massage therapists, can do when working with pregnant women.

Alice, where did the belief that massage in the first trimester is contraindicated originate?

"The reason given is fear of causing miscarriage. This is probably based on fear of litigation rather than any actual potential that massage could cause harm. Most miscarriages occur during the first trimester of pregnancy and the most common cause is genetic abnormalities. Many spontaneous abortions occur before the woman knows she is pregnant. Among women who know they are pregnant, the rate of miscarriage is 15 to 20 percent. [1]

Since most miscarriages occur during the first trimester, massage therapists may fear that if a woman miscarries after receiving massage, she may attribute it to the massage. Most women do not know they are pregnant until they are well into their first trimester. The only way to completely avoid massage during the first trimester is to refuse massage to all women of childbearing age, which is something most massage therapists would agree is excessive."

A quick search on Google Scholar reveals no research linking massage therapy with miscarriage, and yet there are plenty of websites continuing to tell women to avoid massage in the first trimester.

Alice maintains, "there is no reason to think that massage will cause miscarriage. Women engage in sports, exercise, household chores, sexual activities, and other tasks of daily living while pregnant. Massage is no more vigorous or dangerous than any of these activities. If a woman is not restricted from normal activities due to other complications, it is not necessary to deny her massage during her first or any trimester."

A recent study into women's perceptions of the safety of massage during pregnancy "did not receive a seamless narrative about the safety of massage and, as a result, they felt uncomfortable and started doubting the safety of massage when they received inconsistent messages from massage professionals." [2]

So, as massage therapists it seems we should be providing a consistent message?

"How many pregnant women are turned away unnecessarily because this massage myth persists? It's time we lay it to rest. There is no reason to believe that massage is hazardous to a woman or her child at any stage of pregnancy, provided that the mother is otherwise healthy and has no complications."

And can ankle massage cause a miscarriage?

"Perhaps one of the worst prenatal massage myths is that massaging the ankles could cause a woman to miscarry or go into labor prematurely, and they should be avoided. There is no evidence or plausible mechanism to support this claim and perpetuation of this misinformation could potentially cause harm. The reason given is a belief in "reflex points" or acupuncture points near the lateral malleolus that allegedly correspond to the uterus, and massaging these points will stimulate the uterus, leading to miscarriage or premature labor. It is also claimed that massaging these points can induce labor.

What does the evidence tell us? There is no physiological reason to believe that acupuncture meridians or reflexology points exist. Consider this: if inducing miscarriage or labor were as easy as rubbing the ankles, unplanned pregnancies would not present a problem for women, and there would be no need to medically induce labor."

A study to "investigate whether acupuncture is effective for the induction of labour in post-term pregnancies" concluded that there was no significant difference between women who received acupuncture to the common "reflex points" and those who received a sham treatment. It did however show that "spending a day in hospital was a welcome distraction during the difficult period of waiting for labour to begin." [3]

To add weight to this argument, a Cochrane Systematic Review from 2017, looking at 22 trials and over 3,000 participants, concluded that

"there was no clear benefit from acupuncture or acupressure in reducing caesarean section rate" [4], which meant acupressure massage around the ankles does nothing to induce labour and therefore will not result in miscarriage.

If massaging ankles is safe for pregnant women, then massage therapists should be including that in treatment, right?

"Some massage therapists, on hearing this news, will respond that they will continue to avoid the ankles just in case. However, there is a potentially serious problem with this irrational response.

Many pregnant women experience swelling and discomfort in their feet, ankles, and lower legs and specifically request massage to alleviate it. Denying them not only withholds relief but may even cause harm. If a woman were told that ankle massage is contraindicated and she later has a miscarriage, she might later remember a time when she had rubbed her ankles and come to the erroneous conclusion that she caused the miscarriage herself and live with terrible guilt. Massage misinformation does have the potential to cause harm."

So, what can we massage therapists be confident doing while treating a pregnant client?

"Massage therapy has generally been found to be safe. A study into the safety of massage therapy found few reports of adverse effects and when they have occurred, most often it has been at the hands of an untrained person or the result of "exotic" techniques. [5] Still, massage therapists should inquire about the mother's health history at intake and verify that the pregnancy is progressing normally, and there are no complicating factors. If there are any symptoms out of the ordinary, the mother should be advised to consult her physician before proceeding. However, there is no reason to deny massage to a healthy woman experiencing a normal pregnancy.

Massage therapists have treated pregnant women for many years without adverse effects. Prenatal massage has been reported to relieve pain, reduce anxiety and depression, and generally leave the mother feeling relaxed and nurtured. Increasing evidence on the effect of maternal stress on child development suggests that massage therapy could play a role in maternal and neonatal health.

However, for massage to be fully utilized in the care and well-being of pregnant women, more research is needed to support the potential role of prenatal massage and therapists need to be well-informed.

Since little is yet known about the specific effects of massage therapy or exactly by what mechanism it works, massage therapists should exercise caution in how they communicate with pregnant clients and refrain from dispensing inaccurate information. Massage therapy is generally safe when administered by a properly trained professional. There is no reason for a massage therapist to fear giving massage to a healthy woman experiencing a normal pregnancy."

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AUTHOR BIO

Alice Sanvito is a licensed massage therapist in St. Louis, MO, U.S.A. Grateful to be in practice since 1991, she can't imagine a better job. In her own words, Alice has been getting into trouble by bringing up actual science since the first hour of her first day of massage school when she corrected her teacher who claimed that water reverted to separate hydrogen and oxygen molecules when it evaporated.

Notorious for her collection of quotations, 'Shit Massage Therapists Say,' in real life she's actually much nicer than people expect. You can read more by Alice where she blogs about massage therapy, pain science, and related topics at http://www.massage-stlouis.com/ask-the-massage-therapist.

DIASTASIS RECTI: WHAT IT IS AND WHAT WE CAN DO ABOUT IT...

By Becky Littlewood, MNZ RMT

AETIOLOGY & DEFINITION

Diastasis recti abdominis (DRA) is a thinning of the linea alba, which is the connective tissue that runs from the symphysis pubis to the xiphoid process and separates the rectus abdominis muscles (Thabet & Alshehri, 2019) – Figure 1. DRA is a normal physiological response during pregnancy to make space for the enlarging uterus. As pregnancy progresses, the connective tissue stretches and thins, leading to increased space between the medial borders of these muscles (Gustavsson & Eriksson-Crommert, 2020). Known as inter-recti distance (IRD), the increased space can cause a bulge in the midline during intra-abdominal pressure (Mommers et al., 2017).

EPIDEMIOLOGY

DRA affects 100% of pregnant women (Gustavsson & Eriksson-Crommert, 2020), 45-60% at 6-weeks postpartum (Gustavsson & Eriksson-Crommert, 2020), 39% at 6 months postpartum (Gustavsson & Eriksson-Crommert, 2020), 33% at 12 months postpartum (Mommers et al., 2017), 39% of older women who have been pregnant (Gustavsson & Eriksson-Crommert, 2020) and finally, 52% of menopausal women (Gustavsson & Eriksson-Crommert, 2020). DRA "regresses spontaneously after childbirth in most women" (Mommers et al., 2017).

Research shows that contributing factors to DRA are weight gain during pregnancy, a higher body mass index, a large baby, multiple pregnancies, lumbopelvic pain and a history of caesarean sections (Werner & Dayan's, 2019; da Mota et al., 2015; Iqbal, 2020; Alma et al., 2019).

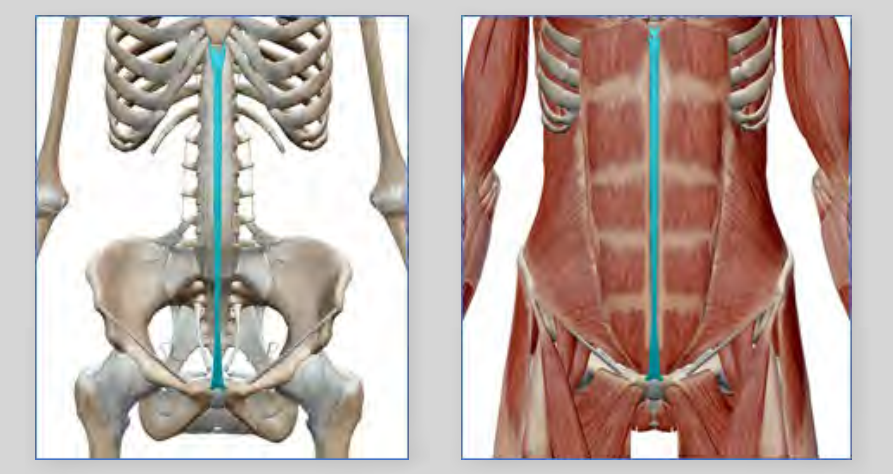

Figure 1. Images created by Becky Littlewood using anatomy app

Alamer et al. state that participants who had not engaged in abdominal exercise were more likely to experience DRA (2019). In some cases a deficiency in collagen type I and III is a contributing factor (Blotta et al., 2018). However, there is no consensus among researchers that these factors are causative (Bø et al., 2017).

SIGNS & SYMPTOMS

A diagnosis of DRA can be made when there is a gap of more than two fingers width in the linea alba, (Gluppe et al., 2018). Gluppe et al., outline that finger widths can be categorised into "normal (<2), mild DRA (2–3), moderate DRA (3–4), and severe DRA (≥4)" (2018).

DRA can be categorised into three different areas, below the naval, above the navel and completely open (Figure 2) and is tested at 4.5 cm above, at and 4.5 cm below the umbilicus (Gluppe et al., 2018).

MASSAGE CONSIDERATIONS

There is a marked lack of literature on which to base intervention choices for DRA, and a lack of consensus regarding management of DRA in physical therapy settings (Gluppe et al., 2018; Gustavsson & Eriksson-Crommert, 2020; Michalska, 2018; Thabet & Alshehri, 2019). A quick Google search will show up thousands of suggested exercise plans and programmes to 'fix' DRA, most of which are not supported by research.

A 2020 research study, exploring the knowledge base of midwives and physiotherapists regarding DRA and IRD, highlighted that the participants (n=16) from both professions had differing views on the relevance of DRA to the postpartum (post-birth) woman (Gustavsson & Eriksson-Crommert, 2020). The midwife participants considered it to be a psychosocial issue, that women struggled to embrace their postpartum body, whereas the physiotherapists considered that there was a correlation with function, and that it was causative of lower back, and pelvic pain.

Hills et al. (2018) report that functional anti-gravity exercises may be better to challenge lumbopelvic stability and rotation ability with regards to DRA. In addition,

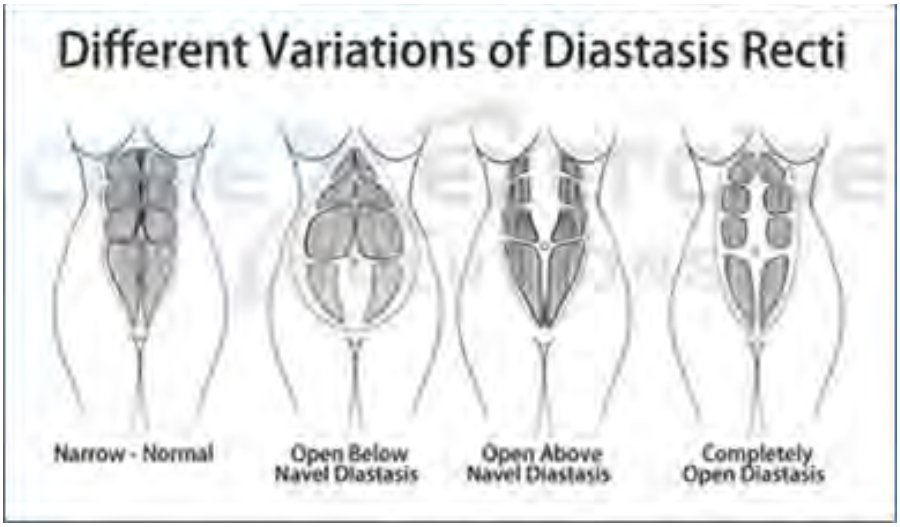

Figure 2. Different variations of Diastasis Recti obtained with permission to use.

measuring the ability of the linea alba to transmit force from the lateral abdominals instead of measuring the distance of the inter-recti muscles, may be a better method of assessing DRA.

It has been suggested that activating the transversus abdominis before performing a curl-up abdominal exercise provides good tension of the linea alba, which contributes to better force transfer between one side of the abdomen to the other and that this may be a better way to view functional improvement of DRA (Lee & Hodges 2016; Werner & Dayan 2019).

As there is differing opinion and results coming out of research studies and still much to be learnt about this condition, it is important to work with a physiotherapist who is up-to-date with current recommendations, especially when it is severe, as surgery may be needed and referral for this may be warranted.

We can ascertain that manual therapy itself cannot reduce DRA, however there is a place for it with regards to improving quality of life (QoL). Reducing stress levels and promoting calm will help a woman with DRA to feel better equipped to cope with her situation. Viewing the condition through a biopsychosocial lens will help massage therapists to support women experiencing this condition. Highlighting the lack of information and consensus on treatment will set realistic expectations. Ultimately, we draw on the ability of manual therapy to converse with the nervous system in order to reduce stress, and the ability of the therapist, through active listening and evidence-based information, to provide comfort, nurture and support.

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WHY IS POSTPARTUM SO HARD?

By Paula Jaspar, RMT

This is a question I have been asked over and over again in my practice. Often followed up by the next line, "I asked my friends why no one told me the truth, and they all said that no one would ever have babies if they knew."

Rumi said "Look for the answer inside your question." Let's explore what answers reside in the question itself, and how we can help.

"Why is postpartum so hard?"

The postpartum period is challenging with inevitable changes in anatomy, physiology, social and emotional well-being. The mother has experienced pregnancy, labour, birth and now carries a monumental task of protecting and raising a child into adulthood.

In my practice, patients often confide that they do not like their 'new' postpartum body, that they would like their pre-pregnancy body back. The symptoms they experience may include digestive upset, pain, incontinence, vulvar pain, engorged breasts, and fatigue. They are consistently grateful, and in awe, that their body was able to 'grow a baby' and 'can feed a baby', yet there is so much subsequent change for the woman who gives birth.

From the top of their head with the drop in estrogen, she will experience telogen effluvium (Mirallas & Grimalt, 2016; Piérard-Franchimont & Piérard, 2013), or postpartum hair loss. While this can be alarming, it is completely common, and hair loss will be minimal by 3 months postpartum. She will feel discomfort in her shoulders and arms. There is a physical demand to carry a growing babe which can cause wrist, elbow, shoulder and back discomfort. In the first 6 months, babies will gain between 140-200 grams a week and double their birth weight by 5 months (Child Growth Standards, n.d.). Moving to the torso, her ribs have expanded and now must return to pre-pregnancy position. The lungs, diaphragm, and heart have all been displaced superiorly and the skin of the abdomen has been stretched and hangs differently (Datta, Kodali & Segal, 2010). Women may have more edema in the lower extremities or adipose tissue on the thighs.

Fatigue is a common complaint in the postpartum period. Changes in sleep patterns happen immediately and continually with newborn feeding schedules, anxiety, responsibility, and expectations. Babies feed frequently and have unpredictable sleep schedules. Women may return to work early on while still needing to balance childcare, feeding, and self-care. Adding the complexity of the mental and emotional load of the pandemic makes for the perfect storm of no sleep. Decreased sleep can affect milk production, mental health, and relationships. Sleep and rest should be a prime goal in the postpartum period.

The notion of postpartum being "so hard" also stems from the psychological impact of parenthood. A change in role, identity, and responsibilities can have a big impact on mental health. This is best explored with mental health professionals.

As a massage therapist, how can I help?

We can be helpful in the following ways:

1. Dialogue with the patient about pain. Many parents won't know what is 'normal vs. abnormal' pain. They will assume, "I just had a baby. Isn't everything supposed to hurt?" Pain could be muscle and joint. Pain could be emotional. Pain could be in regards to sexual intercourse. Pain may not have an obvious reason. Pain is communication, and we serve our patients well when we actively explore what our patients are willing to share with us.
2. Provide a clinical space for deep rest. Allowing for the body to reflect and reorientate during a restful treatment is helpful.
3. Conduct excellent patient-focused interview and assessment. How is she feeling? What is her birth story? What are her goals and outcomes for massage therapy care? Doing a thorough needs assessment allows for a more efficient treatment and management plan.

4. Consider treating the anatomical accommodations. Manual lymph drainage for swollen legs and feet. Swedish massage for relaxation. Myofascial release for novel input to increase pliability and suppleness of tissues with tension. Joint mobilizations for joints that may have restricted movement. Encourage ribs into a more neutral position. Address abdomen and breast tissue. Provide treatment to the upper extremity in regards to carrying the baby.
5. Provide patient education for home care. These are patient-centered stretches and strengthening exercises, as well as modifications of activities of daily living. Some simple stretches of neck and shoulders, low back and forearms can reduce discomforts in those affected areas. Remember to consider the challenges of time, space, and energy. Keeping things simple will encourage success.
6. Learn about what social supports she has. Many parents are struggling with loneliness and feelings as if they should 'know what to do'. Parents are constantly learning and adapting to the experiences and learning of their baby. Many parents will comment in my treatment room, "I hope I don't mess the kid up" or "I'm saving up for when they need to go to counselling because of my bad parenting". My standard words of support are, "Do the best you can, for the situation you are in, with the skills that you have. No one can ever fault you for that."
7. Reassure her that motherhood is a journey, that she is in the evolution, that she - and the journey - will keep unfolding. Affirm that it's good she's coming for massage, and that it's OK (and important) to access other supports as well. Which leads to...
8. Accept that your knowledge is limited. Refer onward if you find that you are facing a gap in knowledge. Always remember, "no referral is a bad referral". Patients deserve to have a wider circle of care.

The simple truth is that the postpartum period IS hard. Everyone's lived experience is unique to them and their baby. Parenting has a steep learning curve while she is also having to recover from the physicality of birthing that tiny human. We can do our best work by trusting our patient to guide us with their interpretations of their own body and experiences. Massage therapy can work wonders in helping a new mother feel more whole, calm, and empowered.

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AUTHOR BIO

Paula Jaspar is a Registered Massage Therapist. She is a member of the College of Massage Therapists of BC and the Massage Therapy Association of BC and graduated from the West Coast College of Massage Therapy in 1997. She completed her doula training in 1998. She completed her Masters of Education from Simon Fraser University in 2015. Paula has worked at a variety of places such as medical clinics, care facilities, spas and schools. She currently teaches at Langara College in the Registered Massage Therapy Program and continues to teach multiple postgraduate courses. She has taught at The West Coast College of Massage Therapy, Vancouver School of Bodywork and Massage, Douglas College and by invitation.

Paula also does guest speaking for local Health Units, community centers and special interest groups. She has been invited to speak at conferences in Canada (Vancouver, British Columbia; Toronto, Ontario) and the US (Millbrae, California; New Orleans, Louisiana; San Diego, California). Her work has been published through International Journal of Massage and Bodywork, the DONA International Journal, the BC Massage Practitioner Journal, Today's Parent and have been featured in the Vancouver Sun and National Post. She is focused in education about massage therapy, perinatal health, pediatric massage, post-surgical treatment (post cesarean, breast reconstruction, mastectomy, orthopedic) and pain management. Paula has had a variety of experiences in the health care field and is constantly improving her skills and knowledge base. Paula's philosophy to treatment is that massage

therapy is a commitment from her patient and herself. She had provided care to women in the APHC (Antepartum Home Care Program) and to women diagnosed with high-risk pregnancies at BC Women's and St Paul's Hospitals. She also provides postpartum care for post cesarean section complaints, breast care and general fatigue, swelling and pain. She has a special interest in the perinatal care, pediatric care, post-surgical, pain, transitions and self-discovery. You can find out more about Paula at **https://vanfct.com**

PATHOLOGY

SUCCENTURIATE LOBE

By Becky Littlewood, MNZ RMTT

A succenturiate lobe is a second or third placental lobe located at a different point in the uterus and much smaller than the main placenta (figure 1). It is generally benign unless the blood vessels connecting the lobe to the placenta are located over the internal os (the opening to the uterus, above the cervix) (Stelzl et al., 2017; Rathbun & Hildebrand, 2020). This is known as 'vasa previa'. This pathology is more prevalent in women over 35 years and/or women who have undergone IVF. Occurrence is 2/1000 pregnancies (Ministry of Health n.d.).

With 'vasa previa' there is a risk of rupture during labour, causing blood loss to the foetus and risking its life. It also contributes to retained placenta and uterine infection as well as postpartum haemorrhage.

A client will normally be told if she has succenturiate lobe and if there is 'vasa previa'. If so there will need to be medical clearance for massage. There is no literature that covers 'vasa previa' and massage. However, we can cautiously proceed, with medical clearance, using guidance regarding 'placenta previa'. This condition is where the placenta covers the internal os, causing risk of placental tearing towards the end of the third trimester, as the cervix begins to dilate. This can lead to maternal haemorrhage or oxygen deprivation to the foetus. If medical clearance has been given for either 'placenta previa' or 'vasa previa', massage work will need to be very light using very gentle, myofascial techniques, petrissage, and effleurage only. No joint mobilisations can be performed, or any work to the round or broad ligaments (Yates, 2010).

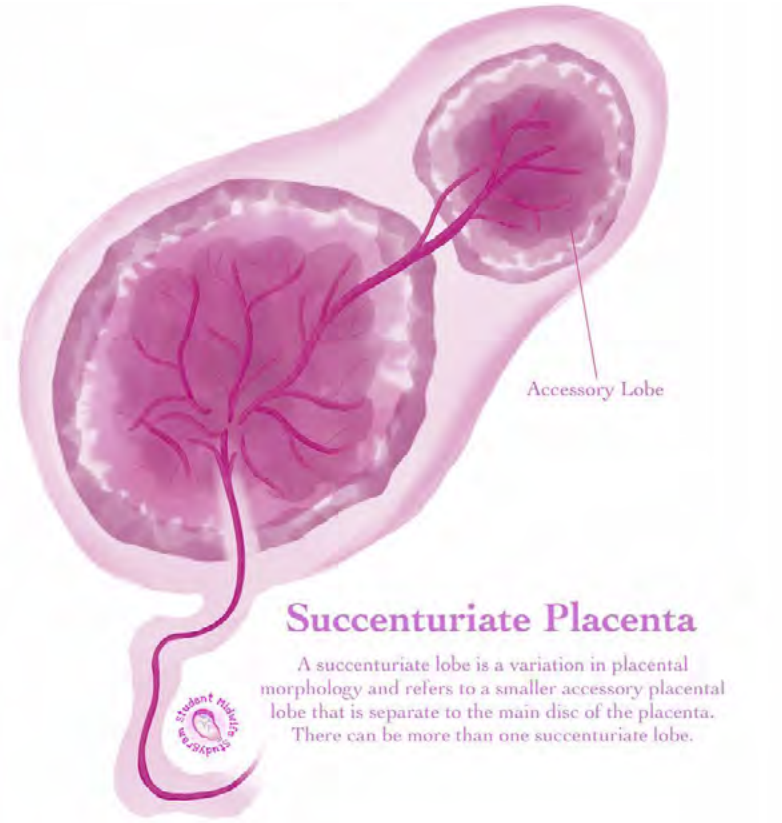

Figure 1. Succenturiate lobe. (Source: Student Midwife Studygram)

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ANATOMY & PHYSIOLOGY

ANATOMY & PHYSIOLOGY OF THE PELVIC FLOOR

Becky Littlewood RMT

The pelvic floor is a group of muscles, ligaments and fascia that support the bladder, bowel and uterus and provide resistance against incontinence. Figure 1 shows the bony landmarks of the pelvis that the pelvic floor and pelvic wall muscles attach to.

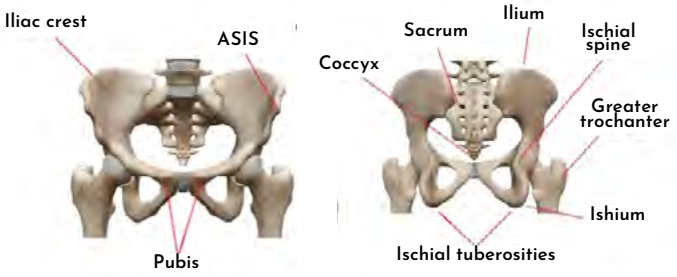


Figure 1. Bony landmarks of the pelvis

The image on the right in figure 2 shows the sacrospinus ligament to which some of the coccygeus fibres attach. This ligament assists the sacrotuberous ligament in preventing excessive posterior and upward movement of the sacrum, assisting in stabilising this area.

Upward movement of the sacrum is also limited by the action of some of the pelvic floor muscles, pulling anteriorly on the sacrum.

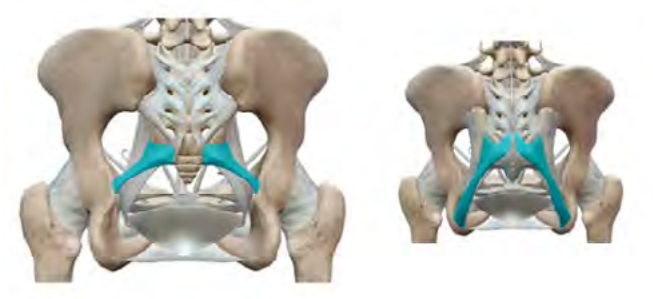


Figure 2. Ligaments of the pelvis

PELVIC FLOOR MUSCLES

The levator ani is made up of the puborectalis, pubococcygeus and iliococcygeus. The coccygeus and levator ani collectively create the pelvic diaphragm (the pelvic floor, as shown in figure 3).

Their role is to:

- prevent urinary and faecal incontinence.
- provide resistance to intra-abdominal pressure when e.g., sneezing, coughing, jumping, lifting heavy objects.

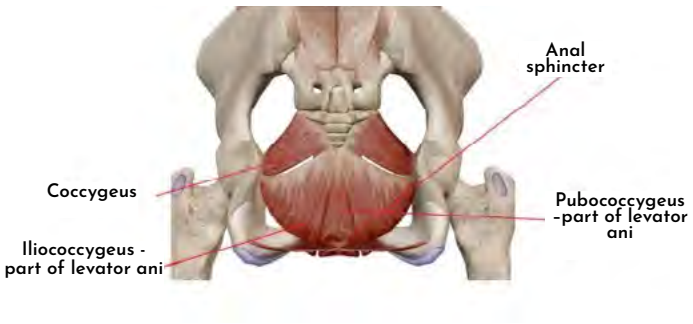


Figure 3. Pelvic floor muscles

Coccygeus: Attaches from the ischial spine and sacrospinus ligament into the lateral border of the coccyx and sacrum. Innervated by pudendal nerve S04-S05.

Illiococcygeus (figure 4): Attaches from the ischial spine and tendinous arch and into the coccyx (the tendinous arch runs from ischial spine to the pubis and is made of thickened fascia, imbedded in the pelvic fascia that layers over the obturator internus muscle). Innervated by sacral spinal nerves S02-S04.

The iliococcygeus is the aspect of the pelvic floor that lifts (the levator part of levator ani) in Latin this is translated as the "anal lifter".

Pubococcygeus: Shown in figure 5, this attaches from the pubis and obturator fascia to the coccyx. Innervated by branch of sacral spinal nerve S04.

Puborectalis (figure 6): A u-shaped muscle that attaches to the pubis, extends towards the coccyx, circles around the rectum and doubles back on itself to reattach to the pubis. It places an anterior bend in the rectum, preventing faecal

contents from falling out and preventing faecal incontinence. This muscle relaxes to allow for defecation. Innervated by branch of sacral spinal nerve S04.

Pre-rectal fibres of the puborectalis (figure 7): Form a u-shape around the urethra in male and female, and vaginal opening in the female and are important in preventing urinary incontinence. Good muscle tone is required for this function. Innervated by branch of sacral spinal nerve S04.

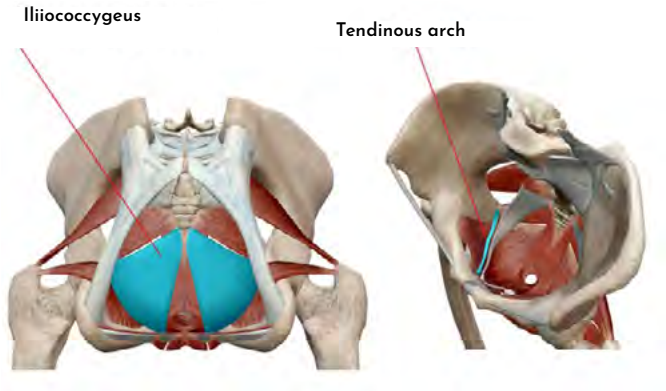


Figure 4. Posterior view Illiococcygeus and view of tendinous arch

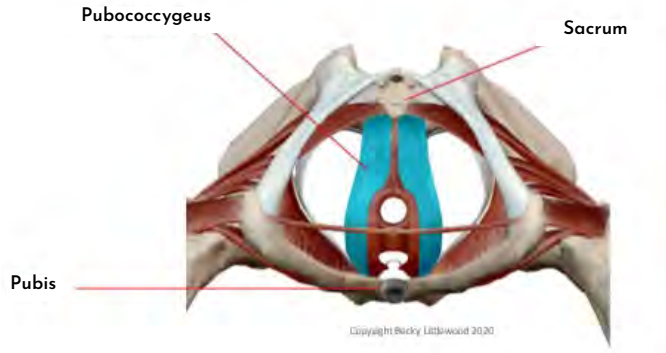


Figure 5. Superior, transverse view of pubococcygeus.

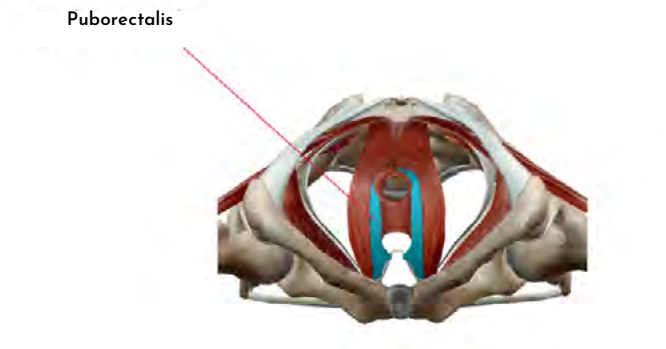


Figure 6. Puborectalis muscle - view from the top of the body (superior, transverse view)

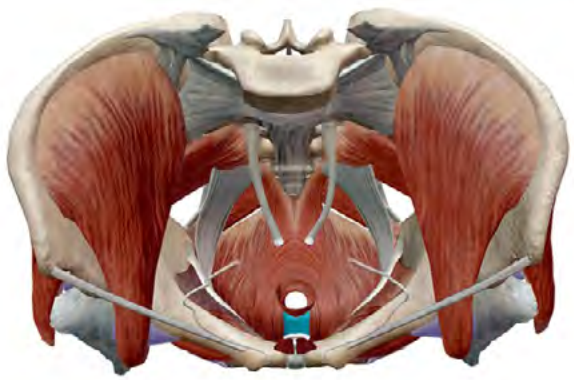


Figure 7. Pre-rectal fibres of the puborectalis

Perineum: The perineum is diamond shaped and is bordered by the symphysis pubis, the ischiopubic rami and sacrotuberous ligament, and the tip of the coccyx. It can be viewed as two halves; the anterior portion is known as the anterior urogenital triangle and the posterior portion is known as the posterior anal triangle. These two triangles are 'split' by a theoretical line between the ischial tuberosities. The anterior urogenital triangle is further supported and strengthened by extra layers of deep fascia. Located underneath the pelvic floor, it is a complex structure. Innervated by the pudendal nerve, S02 to S04.

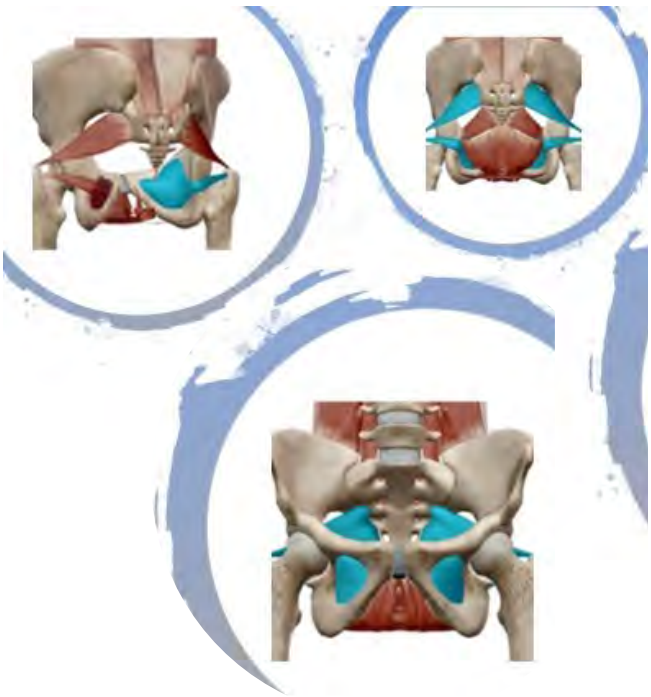


Figure 8. Piriformis and obturator internus – the pelvic wall

Pelvic wall: piriformis and obturator internus (shown in figure 8)

Piriformis: Attaches from the sacrum to the greater trochanter. Innervated by spinal nerves L05-S02.

Obturator internus: Attaches from the obturator foramen to the greater trochanter. This muscle shares fascial connections with the iliococcygeus via the tendinous arch (thickened fascial line from ischial spine to pubic symphysis) and the pubococcygeus, thus making this muscle an access point to the pelvic floor for massage therapists. If there is tension in either of these muscles, it shows there is possibly tension in the pelvic floor muscles. Innervated by spinal nerves S01-S0.

Remainder of deep six; quadratus femoris, inferior gemellus, obturator externus, superior gemellus

- quadratus femoris attaches from the lateral border of the ischial tuberosity to the intertrocanteric crest of the femur: innervated by spinal nerves L05, S01.
- inferior gemellus attaches from the ischial tuberosity to the greater trochanter: innervated by spinal nerves L05, S01.
- obturator externus attaches from the anterior/medial side of the obturator foramen to the trochanteric fossa of the femur – innervated by obturator nerve L03, L04.

CPD HOURS – REMEMBER TO LOG YOURS ONLINE

massage new zealand

Log them anytime, you don't need to wait till the end of the membership year.

massagenewzealand.org.nz

Any questions? Email Esther:
membership@massagenewzealand.org.nz

BUSINESS MATTERS

IS YOUR BUSINESS NICHE ENOUGH?

By Steve Hockley, Executive Director, BNI Wellington & Wairarapa

A common business question is: should a business specialise or should it be a generalist?

When any business specialises, we call this growing or operating in a niche – a distinct segment of the market. Niches can be quite wide like remedial massage or really narrow like say pregnancy massage. They will usually reflect the training or interest area of the owners and massage therapists in a clinic.

From a marketing perspective niches work really well because it is a normal human desire to use someone who has the answer to our specific problem or concern. So, if you have a pregnancy massage related issue and you google and find a therapist who specialises in pregnancy massage, you are quite likely to contact that person for help – they know about your area of concern.

This is especially true with areas that clients may have some concerns or anxiety about, for example massage for children. Many parents would not want to take their child to a therapist they did not know had specific training or experience in treating children.

From a business point of view, having a niche means that you can align your name, online presence, signage and other marketing material to highlight your niche. Making it obvious to your prospective clients that you can help them. You can even have more than one niche. Some businesses go as far as to have two business names and marketing strategies that each promote two different offerings to two different markets.

There are many benefits of having a niche:

1. You get the business that you want and are interested in by being more specific
2. Because you have stated a specialist area you will attract more business with that need
3. You practitioners can specialise and train around your niche areas – making them experts.
4. Because you are an 'expert' you may attract requests for comment and other public relations (PR) benefits

The main objection that I get around becoming more niche is a fear that by being more specialist the business will not attract general business. While this is true to an extent you will find that you will get general business through referral and other reputational marketing. This is because your clients will still see you as an amazing massage therapist regardless of your specialty. Also, wouldn't you rather be the one business in your area who promotes a specialty than just one of many who are fighting over the same general work?

So, how do you niche?

The first step is to decide which niche or niches you want to target. As a general rule of thumb the bigger the population in your area, the narrower your niche can be i.e. you can have a foot specialist in Auckland but that might not work so well in a small town. Apart from market size, the key driving factors in which niche or niches should exist include:

1. What interests you professionally and where you and your team want to make a difference?
2. Your training, what areas have you already specialised in

3. Is it a definable market? This can be a technique or speciality that meets a market need like deep tissue massage.

Work with your team on why you are concentrating on a niche and what this will mean for the business and the way they will talk to clients and people who call up. Next, ask whether there are special packages or offerings you can make for your niche and the problem you work with. This might mean longer or shorter sessions, particular techniques, full specific assessment, use of supporting equipment like a special treatment table, heat pack machine etc.

Now you have everything in order, you will want to tell everyone. Often

this may mean a name change to highlight your niche more readily. Make sure that your website specifically talks about your niche and what you do that is special, just saying that you specialise in some areas such as children or pregnancy can make a difference. That said, the more evidence you can provide will help convince people that you are a great at helping people in your niche area. Things to highlight include:

1. Special and/or specific techniques
2. Special equipment and tools like treatment tables
3. Specific related training that you and your team may have had
4. Articles or blogs you might have written
5. General information about the sector/need
6. Other health professionals that you may work closely with or get referrals from e.g. midwives, physiotherapists, GPs, Specialists

A niche business can be more fulfilling, busier and support your passion within the industry. Maybe it is worth a try?

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

GRADUATE PROFILE

CHRIS COLEMAN

Diploma in Clinical Massage Therapy, NZCM, Wellington

ABOUT CHRIS

Since graduating, I have been working full-time as a massage therapist at Absolute Therapy in Wellington. I'm a keen walker, outdoor swimmer (Welly weather permitting!) and squash/badminton player. Signed up for an upcoming McLoughlin Scar Tissue Release® course.

What motivated you do decide to train in Massage Therapy?

My fascination for bodywork began when I studied the Alexander Technique as part of an actor training course in the 1990's. In 2017 I decided to take a career break and explored the idea of studying massage therapy here in New Zealand as an international student. I was drawn to NZCM because it offered NZQA accredited courses and presented a completely fresh challenge compared to my previous role as a TV producer/director. I was also at a point in my life where I wanted to learn a skill that could potentially help people as an alternative to general or conventional healthcare.

Training

Originally from the UK, I graduated from NZCM Wellington with a Level 5 Diploma in Wellness and Relaxation Massage in December 2018 and was also honoured to receive the Award for Academic Excellence in the same year. After taking a sabbatical in 2019, I went on to graduate from NZCM in December 2020 with a Level 6 Diploma in Clinical Massage Therapy.

When did you join MNZ and what benefits do you see?

I joined MNZ as a student at the beginning of my Level 5 Diploma course in 2018 and upgraded to full membership as a Level 6 RMT after graduating in 2020.

What do you enjoy and what you are finding challenging about working as a massage therapist?

The thing I enjoy most about being a massage therapist is that it forces me to stay in the moment and be present with the client in addressing their individual needs. For the duration of a treatment session my focus and attention are on them and their needs, so I find it a great way of keeping myself grounded. The thing I find most challenging is being comfortable with not having all the answers. The end of my studies felt like the start of my learning!

Where do you see yourself going in the profession?

My goal is to make a real difference to people's lives and their experience of discomfort, pain, disease, or dysfunction, and to make a significant contribution to the awareness of massage therapy as a highly effective alternative to conventional healthcare practice.

What advice would you give to someone starting study in the field?

Don't worry about not having all the answers! In fact, it could be that if you approach a session knowing the answer already, you might run the risk of missing something that could transform the efficacy of treatment. Never stop asking questions – both verbally and with your hands…

USEFUL SITES AND ONLINE RESOURCES

In this issue we have curated a variety of resources on topics related to pregnancy and postpartum, which can be used to update your own knowledge or as part of client education.

PREGNANCY

https://www.health.govt.nz/your-health/pregnancy-and-kids/pregnancy

The Ministry of Health provides a wealth of up-to-date information about pregnancy, birth and early childcare, including resources available to New Zealand parents-to-be. There are videos from various whānau and their experiences, helpful advice and guides to what to expect during each stage.

POSTNATAL DEPRESSION

https://depression.org.nz/is-it-depression-anxiety/depression/postnatal-depression/

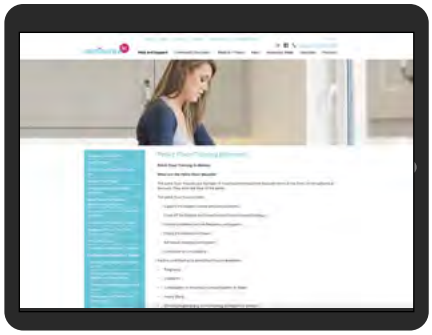
Depression.org.nz provides an excellent range of free information and self-help tools for people experiencing depression or anxiety, including information on postnatal depression. This can be a useful page to direct clients to, so would be great to bookmark it as a clinic resource.

https://bpac.org.nz/BPJ/2010/nataldep/postnatal.aspx

BPAC is the Best Practice Advocacy Centre New Zealand (bpacnz). It is an independent, not-for-profit organisation delivering educational and continuing professional development programmes to medical practitioners and other health professional groups throughout New Zealand. They have a wide range of publications and resources (check out their categories and Best Practice Journal for free). This article on postnatal depression provides information on risk factors, differential diagnosis, onset and progression, screening and assessment, psychological and pharmacological interventions, and prevention strategies. While this information is aimed at doctors and those working in primary care, it can be useful for therapists wanting a more clinical perspective, particularly useful when referring clients to appropriate providers.

PELVIC FLOOR INFORMATION

https://www.continence.org.nz/pages/Pelvic-Floor-Training-(Women)/40/



Continence NZ in a non-profit organisation that has developed a service in an area that has largely been ignored in the past by health professionals and health providers. It is a service available to people with continence problems, caregivers, health professionals and the general public, providing information and education on continence topics. This resource on pelvic floor training is another resource that can be used as part of client education. It includes information about the pelvic floor, factors affecting the pelvic floor, how to work it, along with other information.

http://www.pelvicfloorfirst.org.au/

This is an Australian site which also provides information on the pelvic floor including videos and downloadable resources, with some specifically on pregnancy and postpartum. Again, they can be useful client education resources.

POSTPARTUM HYPERTHYROIDISM

https://www.hopkinsmedicine.org/health/conditions-and-diseases/postpartum-thyroiditis

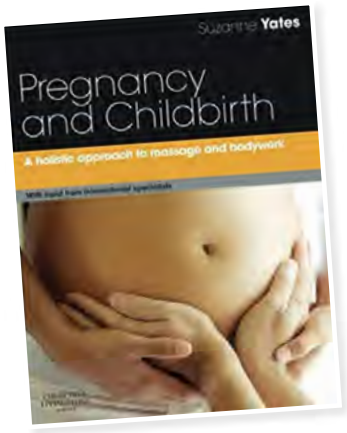
This is an easy-to-read resource which explains what the condition it, causes, at risk groups, symptoms, and includes information on how it is diagnosed and treated. A very accessible resource to have in the clinic as a ready reference and client education information, especially because it is sometimes not diagnosed as some symptoms are dismissed as common for new mothers.

PREGNANCY-RELATED EDEMA

https://www.msdmanuals.com/en-nz/home/women-s-health-issues/symptoms-during-pregnancy/swelling-during-late-pregnancy

Although labelled as a patient resource, this information is more clinical in its style. It covers causes, risk factors, symptoms and treatment and can be useful when referring a client out. The page does also link to the health professional version as well, which is much more aimed at doctors but useful if you want to geek out more on the clinical information for your own knowledge and understanding.

BOOK REVIEWS



PREGNANCY AND CHILDBIRTH: A HOLISTIC APPROACH TO MASSAGE AND BODYWORK

https://www.amazon.com/Pregnancy-Childbirth-Holistic-Approach-Bodywork-dp-0702030554/dp/0702030554/ref=mt_other?_encoding=UTF8&me=&qid=1612076440

Pregnancy and childbirth brings together, for the first time, western and eastern approaches providing a sound amalgamation of theoretical and practical information for bodywork practitioners world-wide. It describes in detail the application of massage and shiatsu from early pregnancy, including work during labour and for the first year postnatally for the mother.

This is a useful source of information for massage therapists, shiatsu practitioners, osteopaths, physical therapists, chiropractors, reflexologists, aromatherapists, acupuncturists, yoga and Pilates instructors.

For Students and practitioners to use as a learning manual and reference tool, the text provides:

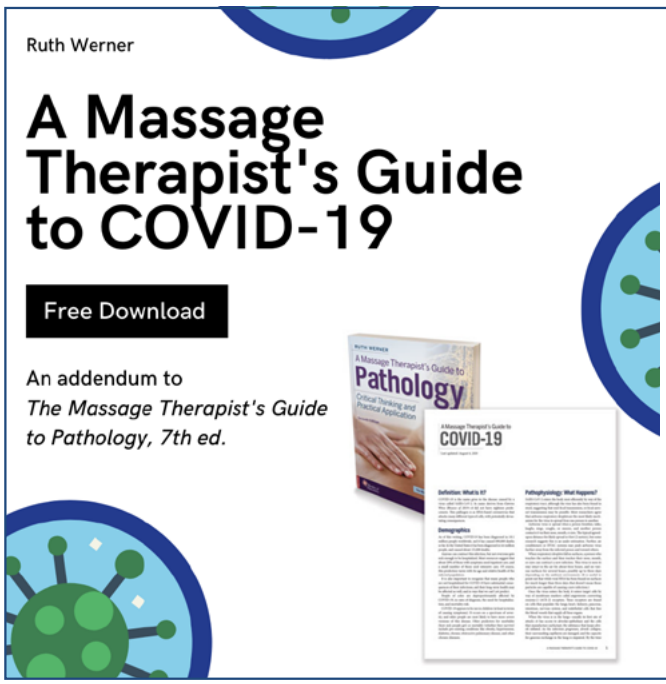
- Clarity of information
- Full text referencing
- Clear diagrams, photographs, and summary boxes
- Clinical accuracy: reviewed by, and with contributions from, international specialists including midwives, obstetricians, osteopaths, chiropractors, acupuncturists, aromatherapists and massage therapists.

THE NEW ZEALAND PREGNANCY BOOK

https://www.bwb.co.nz/books/the-new-zealand-pregnancy-book/

Each step of pregnancy, birth and the baby's first months is set out with detailed information and clear diagrams. A remarkable set of full-colour photographs brings this journey to life, expressing feelings and emotions that are so much part of having a baby.

Contemporary personal stories complement the text, offering readers insights into the joys and delights of this profound experience, and also the risks and difficulties. Women and men who have recently become parents share here some of life's most intensely private and deeply-felt times – making this a very special book for New Zealand and New Zealanders.



Ruth Werner – News Flash

Books of Discovery graciously allowed me to write a full addendum on COVID-19 to accompany the 7th edition of A Massage Therapist's Guide to Pathology.

Even better news: this addendum is available to anyone and everyone FREE of charge.

Get it and share it here:

https://booksofdiscovery.com/what-is-new/#COVID

WHAT DO WE KNOW ABOUT MASSAGE THERAPY FOR CLIENTS WHO ARE PREGNANT?

Greetings, MNZ readers, and welcome to another go-round of research interpretation (and a certain amount of opinionating) from yours truly. I have chosen three studies that address massage therapy for clients who are pregnant for this edition. I chose not to address massage for labour and delivery, because most of the studies I found about that context referenced perineal massage to limit the need for episiotomies; an important and helpful intervention, but not within the scope of practice for most massage therapists who are not also midwives or other appropriate healthcare providers.

I chose these studies because they are interesting, recent, and not locked behind paywalls, so interested readers can get the whole articles without a subscription fee. As it turned out, two of the articles were from the same research team and published by the International Journal of Therapeutic Massage and Bodywork (a publication with which I hope you are familiar), and my third choice was edited by the lead author of the other two studies—a fact I didn't realise until I sat down to write this. It must be a small world of researchers looking into massage and other manual therapies for pregnant clients.

As usual I will provide the abstracts, followed by my thoughts on the studies' strengths and weaknesses, and ways to apply the findings to practice.

Our first study is a qualitative exploration of what factors seem to influence pregnant clients' perception of safety in a massage setting.

SAFETY AND PREGNANCY MASSAGE: A QUALITATIVE THEMATIC ANALYSIS.

Fogarty, S., Barnett, R., & Hay, P. (2020). International Journal of Therapeutic Massage & Bodywork, 13(1), 4–12.

Abstract (edited for format and length)

Background: Traditionally, safety and improving safety in the treatment of pregnant women has involved identifying risks that lead to errors or adverse events, and implementing strategies to mitigate potential harm. There is research that suggests that other factors such as a lack of service, lack of care or a lack of quality also contribute to participants feeling unsafe. Currently there is no evidence-based research on the psychological aspects of the safety of massage during pregnancy.

Purpose: The present study aim was to investigate women's perceptions and experiences of the safety of massage during pregnancy. This included exploring what attributes of the clinician or practice and events that occur during the massage helped pregnant women feel safe.

Setting: Phone interview with participants from Victoria, New South Wales and Queensland.

Participants: 20 women who received massage whilst pregnant.

Research Design: Qualitative design using thematic analysis.

Results: There were five main themes related to safety and massage:

1) Autonomy—able to voice my needs and be heard;
2) Pregnancy massage is more than just a massage;
3) When my therapist is experienced and qualified, I feel safer;
4) The continuity of the massage industry's message about the safety of massage; and
5) Decision-making around massage safety.

Conclusions: Safety is made up of not only the treatment that massage therapists provide, but also the environment they provide it in and how they administer both the treatment and the consultation. The lack of cohesion in messaging about the safety of massage during pregnancy makes women doubt the safety of massage.

Ruth's Observations

This is a qualitative study, as you can derive from the title.

Qualitative research is very different to quantitative research. Its goals are to document and understand the experiences of study participants as they are described to the researchers. By contrast, quantitative research uses various measures to quantify changes that may or may not occur in the context of various interventions.

Qualitative research is probably a better fit than quantitative research to track many of the benefits we claim for massage therapy—especially around improvements in mood and emotional wellbeing. But it is also much harder to do well, since it requires being able to identify and accommodate nuances in language. A variety of tools have been developed to help with this, but it is still a daunting prospect.

The methods section of this study explains the researchers' process clearly, but I confess I am not well-acquainted with these skills, so I am not qualified to have an opinion on whether they were done well. This is an example of when it may be necessary to rely on the editorial expertise of the publication to reject unreliable studies, or to work with authors to make sure their methods are well represented.

As you can see in the abstract, 20 pregnant clients who had received massage in various settings consented to be interviewed about their experiences, specifically around issues of feeling physically and emotionally safe during their sessions. The interviews took place over the telephone and were recorded and transcribed. The interviewer was not a massage therapist, did not participate in the analysis of the transcriptions.

The transcripts were then put through thematic analysis: this is a process in which the researchers look for common themes, topics, ideas, and patterns of meaning that occur repeatedly.

They identified five themes, as listed in the abstract. I was particularly drawn to these:

2) Pregnancy massage is more than just a massage. Interviewees noticed the hands-on skills of the practitioners who were well educated about the needs of pregnant clients, and they also felt the practice setting and overall environment was also important to their sense of comfort and safety.
3) When my therapist is experienced and qualified, I feel safer. A massage therapist with experience in pregnancy massage, and who has appropriate credentials, confidence, and good communication skills is likely to provide an experience of safety for the client, compared to someone without these attributes.
4) The continuity of the massage industry's message about the safety of massage. Interviewees expressed confusion and frustration with conflicting information about the safety of massage for pregnant clients. They quoted advice against any massage in the first trimester for instance, or about specific areas in the shoulders or feet that had to be avoided that was inconsistent from one source to another.

Study Limitations

I thought this was a well-executed study, with a novel and important question about client perceptions of safety. This could apply for any client, but for pregnant people it is an even more charged question.

With my limited expertise in the interpretation and evaluation of qualitative data, I may be missing some weaknesses, but two issues rise to the top for me. First, it is an interesting question whether telephone interviews are preferable to face-to-face encounters to gather information about a person's experiences; one could make an argument for either setting—or even a third option with video conferencing. (A quick look in PubMed.gov reveals that this is a whole research question in itself!)

Secondly, and the authors point this out as well, an important missing piece of information here is the point of view of women who, for safety reasons, specifically chose not to receive massage while pregnant. I wonder what kinds of concerns might turn up in interviews with that population.

Application to Practice

This study provides some clear guidance for massage therapists who want to build a practice with pregnant clients: be well qualified, and make your credentials known; be a careful and compassionate communicator who is mindful of pregnant clients' special needs; and publish and promote consistent and accurate information about the safety of massage therapy for this population.

Our second article for review is also from the Fogarty research group and is published in a later edition of the International Journal of Therapeutic Massage & Bodywork. This is a quantitative study that examines the role of massage therapy for a common but poorly understood problem with pregnancy: pregnancy-related pelvic girdle pain.

PREGNANCY-RELATED PELVIC GIRDLE PAIN AND PREGNANCY MASSAGE: FINDINGS FROM A SUBGROUP ANALYSIS OF AN OBSERVATIONAL STUDY.

Fogarty, S., McInerney, C., & Hay, P. (2020). International Journal of Therapeutic Massage & Bodywork, 13(2), 1–8.

Abstract (edited for format and length)

Background: Pregnancy-related

pelvic girdle pain (PPGP) significantly impacts women's lives both physically and psychologically. Given the severity and impact of PPGP on pregnancy, the authors anticipated that pregnant women with PPGP might respond differently to massage than pregnant women without PPGP.

Setting: Two massage clinics, one in Sydney and one in Melbourne, recruited participants from December 2016 to December 2017.

Participants: Nineteen women with PPGP and 78 without PPGP.

Research Design: PPGP and non-PPGP women receiving at least one massage, with outcome measures assessed immediately prior to and after massage, and again one week postmassage.

Main Outcome Measures: Visual analog scales for pain, stress, range of movement, sleep, and self-reported side effects of massage.

Results: Both groups changed significantly and similarly over time for measures of pain, stress, range of motion, and sleep. Post hoc analysis found significant reduction in all outcome measures immediately following massage, but returned to baseline at one week postmassage for all measures except pain, which remained reduced for the PPGP group, and stress remained reduced in the non-PPGP group. The PPGP group entered the study with higher baseline levels of pain and a greater restriction in range of motion than the non-PPGP group. There was no difference in the number of side effects experienced between the two groups.

Conclusions: Although PPGP clients report greater pain and restriction in range of motion at baseline than non-PPGP clients, the response to pregnancy massage was similar. Results support a role of pregnancy massage in the management of PPGP. More research on massage for PPGP is needed to confirm a lasting effect of pain reduction from massage.

Note: the source of this subgroup analysis is this study:

Fogarty, S., McInerney, C., Stuart, C., & Hay, P. (2019). The side effects and mother or child related physical harm from massage during pregnancy and the postpartum period: An observational study. Complementary Therapies in Medicine, 42, 89–94. https://doi.org/10.1016/j.ctim.2018.11.002

Ruth's Observations

This article focuses on pregnancy-related pelvic girdle pain. This is a common and potentially serious condition that can be severe enough to lead to excessive painkiller consumption, limit daily activities, interfere with sleep, and impair the ability to walk, to work, or to care for other children. The pain is experienced between the posterior iliac crest and the gluteal fold, especially around the SI joints. It may radiate into the hips and thighs, and pubis symphysis pain may also be a feature. The authors make a very compelling case for studying PPGP, especially since it affects an estimated 55% of pregnant people in Australia.

PPGP is distinguished from low back pain by location and exacerbating activities, but it is important to point out that a pregnant person can have PPGP and low back pain simultaneously; they are not mutually exclusive.

The researchers were curious to know if clients with PPGP would have the same kinds of responses to massage therapy as pregnant clients without this condition (non-PPGP clients). I infer that because PPGP can be so severe, they thought that perhaps massage would be less effective as pain management for this group.

All the sessions were conducted in massage clinics in Sydney and Melbourne. They gathered pre/post pain measures from a total of 97 women: 19 with PPGP, and 78 without it. (The women with PPGP were identified by their descriptions of symptoms, but never formally evaluated or diagnosed by a doctor.) They also did follow-up measures a week later. They also gathered data on stress, range of motion limitations, sleep, and side effects of massage (e.g., soreness). Participant data was analyzed to recognise their age, trimester at the time of massage, and other details.

All of the women who were interviewed received at least one massage, but about 30% in each group had multiple sessions. Sessions ranged from 60-90 minutes. Some were whole-body massages, while others focused on "problem areas" as requested by the client.

The responses to massage for the PPGP group and the non-PPGP group were very similar, even though the PPGP group had substantially higher pain measures at baseline. All the participants reported improvements in pain, stress, sleep, and range of motion. Interestingly, the reduction in pain in the PPGP group persisted for longer than the non-PPGP group, while the experiences of stress were the reverse—the non-PPGP group had lower stress scores for a longer time, compared to the others.

Limitations

This is a fascinating study that opens many more questions about how massage therapy might be helpful to pregnant clients. However, because it was a subgroup analysis from another study, the authors couldn't alter any of the data collection methods, and this led to some problems.

First and foremost, as the authors state, this project has no control arm. Both the PPGP group and non-PPGP group got massage. Without a control group for comparison, it is not reasonable to declare any definitive findings.

They also point out that the clients with PPGP were not formally diagnosed, and for a more focused study on this population, that seems like a critical component.

Finally, I was surprised not to see a discussion of low back pain as a

comparator or a confounding issue for PPGP in this article. Again, that might be an artifact of the original study from which it is derived, but in any future research about PPGP and massage therapy I hope this would be addressed.

Application to Practice

This study didn't provide any details on the type of massage provided, so we don't have any technique takeaways here for women with PPGP or other symptoms related to pregnancy. However, the good responses that were observed certainly suggest that massage could be helpful for this population.

This is an unexplored field that is just waiting for someone to step in and leave their footprint. Will it be you and your next case report?

THE EFFECTIVENESS OF COMPLEMENTARY MANUAL THERAPIES FOR PREGNANCY-RELATED BACK AND PELVIC PAIN: A SYSTEMATIC REVIEW WITH META-ANALYSIS.

Hall, H., Cramer, H., Sundberg, T., Ward, L., Adams, J., Moore, C., Sibbritt, D., & Lauche, R. (2016). Medicine, 95(38), e4723. https://doi.org/10.1097/MD.0000000000004723

Abstract (edited for format and length)

Background: Low back pain and pelvic girth pain are common in pregnancy and women commonly utilise complementary manual therapies such as massage, spinal manipulation, chiropractic, and osteopathy to manage their symptoms.

Objective: The aim of this systematic review was to critically appraise and synthesize the best available evidence regarding the effectiveness of manual therapies for managing pregnancy-related low back and pelvic pain.

Methods: Seven databases were searched from their inception until April 2015 for randomized controlled trials. Studies investigating the effectiveness of massage and chiropractic and osteopathic therapies were included. The study population was pregnant women of any age and at any time during the antenatal period. Study selection, data extraction, and assessment of risk of bias were conducted by two reviewers independently, using the Cochrane tool. Separate meta-analyses were conducted to compare manual therapies to different control interventions.

Results: Out of 348 nonduplicate records, 11 articles reporting on 10 studies on a total of 1198 pregnant women were included in this meta-analysis. The therapeutic interventions predominantly involved massage and osteopathic manipulative therapy. Meta-analyses found positive effects for manual therapy on pain intensity when compared to usual care and relaxation but not when compared to sham interventions. Acceptability did not differ between manual therapy and usual care or sham interventions.

Conclusions: There is currently limited evidence to support the use of complementary manual therapies as an option for managing low back and pelvic pain during pregnancy. Considering the lack of effect compared to sham interventions, further high-quality research is needed to determine causal effects, the influence of the therapist on the perceived effectiveness of treatments, and adequate dose–response of complementary manual therapies on low back and pelvic pain outcomes during pregnancy.

Ruth's Observations

Yikes. Read that results section again: Meta-analyses found positive effects for manual therapy on pain intensity when compared to usual care and relaxation but not when compared to sham interventions.

To be honest, I have to admit that I began reading this systematic review and meta-analysis with some trepidation. No better than sham? Really? And what did they use for a sham massage? This is a notoriously difficult problem in massage therapy research, and I was intrigued to see what the authors had found.

The population they looked at were pregnant people with any combination of low back pain and pelvic girth pain. From a total of 10 studies, they were able to compile data from 1198 participants—that makes this a very robust review.

The interventions were various types of "manual therapy." Under this heading they included studies that looked at massage, osteopathic manipulation, and chiropractic adjustments.

This is where things got interesting.

This systematic review covered 10 studies. Six of them looked at types of massage therapy, including craniosacral work and partner-delivered massage. Controls in these studies were usual care, education, or progressive muscle relaxation. One study looked at spinal manipulation (that is to say, chiropractic care). And the other three looked at osteopathic manipulation—and only two of these used a sham intervention (nonfunctional ultrasound) as a control.

Overall, the findings demonstrate that these manual therapies reduce the intensity of low back and pelvic girth pain, and this provides good options for pregnant women who often want to avoid more invasive procedures if they can. The fact that the shams were as effective as the osteopathic manipulations in those two studies suggests that the elements of attention and client-therapist alignment are important as well as the nature of the specific intervention.

Limitations

I enjoyed reading this systematic review, and it was fascinating to see how the three categories of interventions impacted the important issue of low back pain and pelvic girth pain for pregnant people. But—and this is speaking wholly from the perspective of a massage therapist—

while it is technically accurate to say that positive effects were found except compared to shams, that exception does not apply to the studies focused on massage therapy, so the statement can be misleading.

This article demonstrates why reading an abstract does not provide enough information to make a judgment about a particular intervention. A casual reader could look at this synopsis and assume that massage, osteopathy, and chiropractic all have similar problems in comparison to sham interventions.

Application to Practice

This article does a great job of pointing out that the problem of low back pain and pelvic girth pain for pregnant women is substantial, and deserves attention from the medical community. It also demonstrates that our knowledge of how to be helpful to this population is still in its infancy. (Ha! A baby joke!)

I know lots of massage therapists specialise in working with clients throughout the childbearing process, during all stages of pregnancy, into labour and delivery, and as the new mother recovers from this demanding event. This review can provide some validation for the effect our work has on pain intensity for this population, and it may stimulate other researchers to delve into the topic more deeply.

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's MNZ Magazine. She serves on several national and international volunteer committees and teaches continuing education workshops in research and pathology all over the world. Ruth was honoured 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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