2019

Massage-like perturbations

Do I have to stand up straight

More than a massage

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association of massage therapists
in good hands

Association of Massage Therapists YEARBOOK

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"We need to begin building our own totem pole. Be brave. Be honest. Be leaders. Cross that chasm and do the stuff that the other professions are too slow or too nervous to do."

Leah Dwyer

Editorial

By Rebecca Barnett

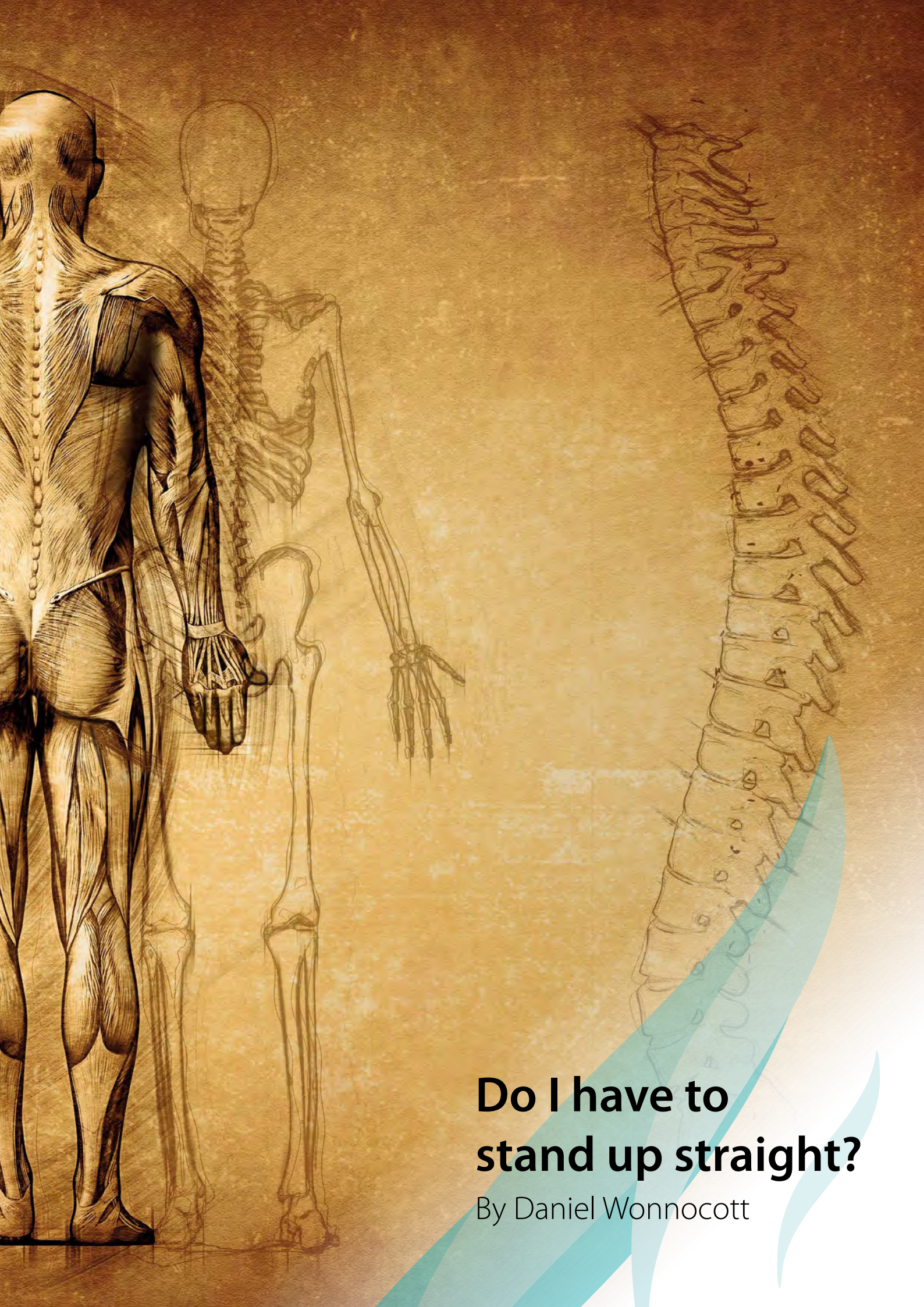
I doubt that there's anything more pretentious than quoting yourself in an editorial but the perverse and mischievous part of me relishes the idea of starting and finishing the 2019 AMT yearbook with the same words, like returning home at the end of an epic journey. After a long period of redefining ourselves through a biomedical lens, the massage therapy profession is returning to its original home. We're back to looking at the whole person, not just anatomy and biomechanics.

Our profession is currently undergoing a pretty intense and exciting transition. The phrase "Massage-like perturbations" comes from an animal model experimental study published this year but it also strikes me as the perfect way to encapsulate both the content of this yearbook and the change that is occurring within the massage therapy industry, both in Australia and globally.

Much of what we have been taught and practise is being re-examined and rethought. The articles published here document this evolution and help to provide a kind of trail guide for how to manage the cognitive dissonance that inevitably accompanies change and transition.

My heartfelt thanks and gratitude go to the authors featured in the yearbook and to all those who have contributed to the AMT blog over the past two years. You light the trail for us. The AMT blog allows us to publish more regular content to our members than at any other time in AMT's long history and the yearbook allows us to keep faith with our long and proud tradition of print journals. It's a perfect combination of the old and new.

I heartily commend the massage-like perturbations published in these pages to you.



Do I have to stand up straight?

By Daniel Wonnocott

Here's a handy posture infographic you can download.

During the initial intake, many massage therapists undertake a postural assessment. The therapist runs an eye over every element of the client's posture, looking for anything that doesn't fit some ill-defined "good" posture. But what does it actually tell us about the cause of our clients' presentation? And is focusing on correcting posture the best we can offer clients?

What if:

- the client has always had this posture but only had their presenting complaint for a few days?
- there is a structural change that is outside of their control?
- the client is comfortable in this posture?
- the posture is protective and not a true representation of their "normal" posture?

What are we looking at anyway?

When someone is in pain, it seems logical for them to avoid positions that aggravate their symptoms and to adopt positions that relieve symptoms. A tilt here and a twist there may not be visually symmetrical and may require asymmetrical muscle use to hold, but it might be useful in the interim for the client to feel safe until things settle down.

Think about a strained muscle or sprained ligament. Would it affect the way you move and how you hold your body? Or imagine fracturing your foot and trying to maintain even weight through both feet?

In this instance, the "poor" posture our client presents with is not the cause of the mechanical provocation. Rather, it provides them with relief. Focusing on changing posture towards an "ideal posture" in this situation may lead to more sensitivity. The focus needs to be on calming the nervous system and restoring normal function to the affected area.

In other instances, nerves may become sensitive to tension and might be offered some protection by the muscles changing the joint positions to unload it. Think of an elevated and protracted shoulder with a slightly bent elbow: could this client be protecting the median nerve from excess tension?

Or the client who always has really tight hamstrings and calves: are they trying to protect an unhappy sciatic nerve from being overstretched? Suddenly working out that tight muscle and stretching (tensioning) it regularly until "proper" alignment is achieved seems pretty redundant. Shifting focus towards reducing the sensitivity and improving the tolerance to stretch on the nerve is key to helping your client with this presentation.

What about the client who comes in stressed, anxious or depressed? Is picking apart their posture and highlighting any supposed faults going to help them unwind and feel better? Simply looking at someone's posture cannot give us this insight. A good subjective and objective assessment will likely help you come to a working diagnosis but the postural assessment offers no real value in this scenario.

Given that posture is but a snapshot in time, striving to be proficient in standing still doesn't take into consideration the plethora of potential positions and functions a client may need to undertake in their daily lives. And the only person who can help us define a suitable treatment goal is our client.

I would argue that we could skip the postural assessment and still gather all the relevant information by listening to our clients, asking good questions, using our clinical reasoning skills and orthopaedic testing. A good assessment will usually help explain the postures we see, but the posture itself doesn't tell us why it has been adopted.

Should postural correction be a treatment goal?

If a client presents with less than ideal posture and no underlying issues, is it still worth working towards improving their posture?

This is a fair question. However, I argue that simply looking to improve postural symmetry and alignment falls short of helping a client get the best out of their body.

Given that posture is but a snapshot in time, striving to be proficient in standing still doesn't take into consideration the plethora of potential positions and functions a client may need to undertake in their daily lives. And the only person who can help us define a suitable treatment goal is our client.

- What movements do they need to perform regularly?
- Can they access the required ranges of motion?
- Are they proficient in these movement patterns?
- What types of loads are involved?
- Do they possess the strength to control loads effectively?
- What is their level of conditioning in relation to the things they would like to be doing?
- Is there an adequate reprieve from the ongoing demands faced for healthy adaptation to occur?

The challenge isn't in identifying postural faults but rather is helping our clients understand where they are in the present and how to prepare for the future. Those requirements will likely change as often as their posture does.

Focusing on building up qualities that help make someone more robust and resilient will better serve them to fluidly transition between all the postural possibilities they encounter in their day-to-day lives. Focusing on someone's ability to tick off a static postural checklist we learnt in college might make treatment planning easier but it doesn't take into consideration the complexities of an individual's situation and what qualities, if any, require attention.

Is postural assessment still a thing?

How often has a client walked into your clinic and told you that they already know they need to "work on their posture"? How many clients walk out of an appointment with essentially the same sentiment –"posture is the cause of their problems"?

What do you do when a client has "good" posture but still has pain?

What are the implications of how we discuss and integrate posture into our treatment?

If postural assessment doesn't provide us with insight into the cause of a client's presentation and it doesn't help us determine what type of intervention is required to help them reach their goals, one might question the need for assessing and correcting posture at all.

As therapists, we hold a position of power and influence. Our words and explanations hold weight. The information and advice we give needs to be relevant, up to date and based on sound reasoning and common sense.

There is still no sound and agreed upon definition of what "good" or "bad" posture is, yet it is often touted as being a main factor for a client's pain without any question or review of current evidence.

Pain is a very complex and multi-factorial experience. Our interactions have the potential to shape a person beyond the table. Instilling unvalidated explanations into our clients can have a lasting effect. How a client views their body and the beliefs they hold around it can play a role in their behaviours, actions and emotions. Telling a client they have "bad" posture fails to provide any real insight or path forward and offers no benefit. It might also leave the client feeling ashamed or fearful and untrusting of their body, or result in them investing time and money on treatments aimed at correcting posture under the false premise that it is the cause of their pain. Adding to a client's stress, fear, concern and financial burden is more likely to have a negative impact on their experience of pain.

If postural assessment doesn't provide us with insight into the cause of a client's presentation and it doesn't help us determine what type of intervention is required to help them reach their goals, one might question the need for assessing and correcting posture at all.

Where to from here?

It is the responsibility of all therapists who use posture as an explanation for pain to change the narrative. The good/bad posture explanation is out. Listening to our clients and designing treatment plans that will make a positive impact upon them is in.

I wish I had a nice simple method or system to gift you (or charge $$$ for a weekend course to teach you the one technique that you need to know if you're serious about helping your clients). However, people are complex and so is the human body. The good news is that both are incredibly robust, adaptable and respond well when given the chance in the right environment.

Maybe, just maybe, if we offered some support and encouragement, and helped our clients thrive in their environment, good things will happen.

About the author

Dan is a straight shooting down to earth therapist who is fed up with the bullshit and fairy-tales that currently populate the professional massage space. He put aside his aversion to reading research and topics that scared him and learnt to check his own biases in order to become a better therapist for the clients who put their trust in him for help. Having worked extensively in clinical practice and elite sport he has seen lots of shiny tricks but also knows how basic things can actually be and still prove effective. With a sense of pride in the value we bring to our clients, Dan has set about simplifying the complex and stripping back all the jargon and grandiose theories in an effort to help therapists of all levels provide practical yet effective care to their clients.

Further reading

Does posture correction matter?
http://pains.news/infographic6

What do physiotherapists and manual handling advisors consider the safest lifting posture, and do back beliefs influence their choice?
http://pages.today/lifting3

Drop the plumb line…static posture assessments were so last decade
http://assessments.training/posture7

Upright and uptight
http://b.link/upright84

More than a massage

By Tara Goulding

SCAN ME

Watch this clip which focuses on considerations when walking with the elderly.

I met Barbara* in March 2015. I still remember her first appointment – she booked me for in-home massage for general aches and pains, not uncommon for an 83 year old. I arrived at her retirement village apartment and found her in the kitchen, which was the only area with enough space to set up my massage table. Her intake was the longest I have ever done: Barbara's health history was extensive, her list of complaints long, and her desire to have someone listen to her also very strong.

Barbara was not the sort of woman who ever went to the doctor, firstly because she had trouble getting there but, more significantly, she didn't trust the medical system and was afraid that she'd end up in hospital and never come out. While Barbara presented with several signs and symptoms, nothing had actually ever been diagnosed and my suggestions to get particular problems checked out were always pooh-poohed. However, there was nothing to her or my knowledge that would prevent her from receiving massage, so we were all systems go.

I set up my massage table in her kitchen at the lowest height, assisted her up and helped her get comfortable. Within five minutes of starting the treatment, Barbara was already making "Oh! Ahh!" massage noises and inquiring about my schedule to book her next session. She confided that she spends most of her time alone as her husband died many years ago, most of her friends had died, and her son Nick* lived in the city and only visited every couple of weeks. It was then that I realised, even if she didn't, that I was there to provide her with much more than massage therapy and that she wasn't going to be the only one benefiting from our sessions together.

I saw Barbara eight times in five months, always working gently on her while she told me stories of her life. She was one of those people who had really lived, doing exciting things like driving cross-country in foreign lands, rubbing shoulders with the rich and famous, building her own house (I mean, actually building it with her own two hands), and travelling to exotic far-away places. I have no doubt that she enjoyed telling me these stories as much as I enjoyed listening to them – therapy for us both, really!

Then I didn't see her for nine months. When she did call me again she told me she wasn't sure if she could still get massages – she couldn't get undressed/dressed and couldn't get up onto the massage table anymore and was basically living in her lounge room and sleeping in her recliner. No problem, I said, let's set a time for your next session and when I arrive we can reassess what you can and can't do, and work around that.

From then on, I was massaging Barbara fully clothed – her hips while she was standing with support from her walker, and then her legs, feet, arms, hands, shoulders and head while she was seated in her recliner. Not the easiest way for me to work I admit, and I discovered that I'm probably too old to be sitting cross-legged on the floor but it got the job done and Barbara was happy.

Barbara filled me in on everything that had happened since I saw her last – from trouble with her carers, her last friends in the retirement village dying, issues with her son Nick, and the doctor increasing her pain medication.

Some of these made her tired so she would often doze off during our sessions. Other times she would say as I arrived "I haven't taken my tablets yet because I really want to talk to you today." Barbara wanted to increase the frequency of her massages to every two weeks, and I suspected it was only partly due to her physical issues.

However, Nick wasn't so convinced of the benefits of my visits and made her life a bit difficult in regard to our sessions, telling Barbara she was "wasting her money". When he moved in with her, our sessions became less open and honest on her part, and more fearful that he would ruin the relaxation experience for her. He and I almost had words about this once – I say 'almost' because I diffused the situation as quickly as he started it but I could tell that it still really upset Barbara.

Her mood hadn't been great the last few times I saw her and she wasn't eating much at all. She said she just didn't feel hungry, and didn't want to eat all the things she used to love. The next time I visited, I brought her two hot cross buns. She was so incredibly thankful that she cried with delight that someone cared enough to do that for her. It's amazing how happy two 50c buns can make someone.

Another seemingly little thing that made Barbara happy was that I often wore flowers in my hair. She would always ask me to turn around so she could see which flower I was wearing that day. The really pretty ones had their photo taken (I assume the back of my head is not internet-famous from these photos but you never know). Her favourite one was a really colourful flower-comb from American Samoa. I once forgot to flower-up and was about to leave the house, then went back and restyled my hair so I could add a flower and create a little more happiness for her. It's the little things that matter.

As the months went by and her health deteriorated (and she still refused to seek medical attention), Barbara's son realised how much his mother loved my visits and how much the massage therapy benefited her both physically and mentally. They both agreed that they wanted to increase my visits to weekly.

Barbara's demeanour had started to change though – our client-led conversation was becoming more serious and introspective, and she was talking about getting her affairs in order, making sure her will and finances were OK, and wanted Nick to promise not to take her to a hospital. This, along with some new clinical signs, was pointing to the fact that Barbara was very close to the end of her life. She was not in good health physically or emotionally, and she knew it. There were some visits where all I could do was massage her hands gently while she drifted in and out of fairyland. At one point she even asked me, "Why is it taking so long for me to die?" I mean, what can you say to that, except to be silently thankful that your massage studies included a big component of counselling skills.

Everyone tells us to keep a professional distance from our clients, to not form friendships. But I say, how can we not, especially at times like this? I was Barbara's only friend and even then it was only for an hour a week. She needed me for more than just my hands.

I was finding that although I felt privileged to be assisting Barbara so personally during this time, I was also dreading the inevitable – every time I arrived at her home and let myself in, I'd feel that little bit of relief when I heard her call out "I'm still here!"

I've had clients die before – an elderly man with brain cancer who couldn't speak a word of English but loved being touched; an elderly lady who lay so still she had me checking her breathing just in case; a lovely middle-aged father of two who thought he'd survived stomach cancer whose obituary I stumbled upon not long after he stopped calling me for appointments. But Barbara was different. Barbara was my friend.

Of course, the day I'd been dreading came too soon – two years and 39 massages after I met her. I updated my Facebook that day:

" My client died last week. The day after I last saw her. I arrived at her home today for her usual weekly appointment, and her son apologised for not calling to save me the trip. We sat and talked for a bit, I helped him arrange some flowers into a vase, and he gave me her Tibetan Singing Bowl that she had told him she wanted me to have. Feeling rather strange at the moment."

After I left her home for the last time that day, I realised how much this experience had affected me over the last few months. As massage therapists, we often see people at their most vulnerable. Helping a client through their time of death (and for Barbara, it was not an easy death) is taking this vulnerability to the next level. It's a rare gift when someone allows you to be part of their most intimate thoughts, feeling and fears, and I consider it an absolute privilege that Barbara wanted me around at her end of days. Almost two years later, and the Tibetan singing bowl is still in the same spot. I don't really know how to use it properly, but it's special, so it stays.

*Names changed to protect privacy.

About the author

Tara Goulding has been a Massage Therapist since 2006, in both Parramatta and now Central Coast (NSW). Most of her massage career has been spent as a mobile therapist – she loves being able to offer this convenience to her clients while also offering herself a convenient excuse not to exercise. She lives on a farm with her husband, Star Trek-loving rooster, three ducks, and a revolving door of foster bunnies and guinea pigs.

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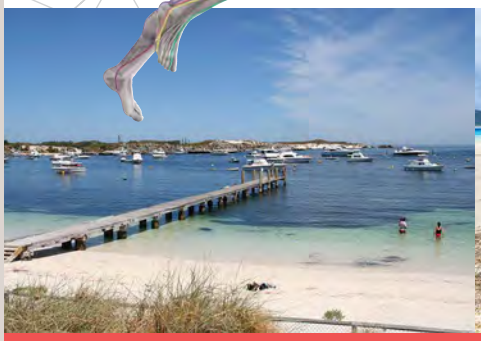

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Massage and movement for musculoskeletal pain

By Geoff Miller

Click here to access the Cochrane Library, a collection of databases that contain different types of high-quality, independent evidence to inform healthcare decision-making.

The focus of the Traditional Chinese Medicine (TCM) approach to health is to facilitate the flow of Qi (pronounced "chee"). Massage and movement are seen as complementary ways of achieving this. Individually, massage and movement can help with pain relief but I would like to posit that the combination is more than simply the sum of the parts.

My initial interest in health studies came from my study and practice of taijiquan ("tai chi") and qigong. This led me into the study and practise of TCM, in particular TCM Remedial Massage. A lot of Chinese wisdom is preserved and transmitted in pithy little sayings and one of these is very appropriate to the central theme of this article:

Tong zhi bu tong
Bu tong zhi tong

This means, roughly:

Where there is free flow (of Qi) there is no pain
Where there is obstruction of flow, there is pain.

Massage Therapy

Although there is good evidence that massage works in the short term – not least that clients keep coming back for more – we still don't know for certain how it works. We do know that some of the older ideas, for example that massage somehow releases "toxins" from cells, are definitely wrong. (The "massage releases toxins" myth may have come from seeing lactic acid as a waste product rather than a component of the energy production cycle.)

Other ideas, such as trigger points as a cause of referred pain, have become harder to support. Although the existence of "deep" trigger points has been used as a justification for deep tissue massage, there is no evidence for any specific or particular effectiveness of this approach and the theoretical basis for its claimed effectiveness has largely been disproven.
Massage does not break down "scar tissue" in muscles, and while there has been a lot of work on the body's connective tissue (fascia)[1], the existence of the fascial adhesions that massage is supposed to affect remains unproven.

Another interesting but still unproven theory is that massage works primarily on the nervous system rather than directly on the physical muscles (Jacobs 2016).[2] By working on the nociceptors (danger sensors) and proprioceptors (position sensors) in the skin and muscles, the brain is given new information and can then let muscles relax and move more freely. In this model, the massage does not directly affect the muscles being worked on, rather the effect is mediated through the brain.

Positional release techniques, such as those used in Ortho-bionomy[3], and some stretching methods are also claimed to achieve their results through re-educating the nervous system rather than directly forcing a response from the soft tissues.

It is also clear that while massage on its own can provide short-term pain relief it does not affect a long-term cure. In a Cochrane review of massage for low back pain the authors concluded that:

"We have very little confidence that massage is an effective treatment for LBP [low back pain]. Acute, sub-acute and chronic LBP had improvements in pain outcomes with massage only in the *short-term* follow-up. Functional improvement was observed in participants with sub-acute and chronic LBP when compared with inactive controls, but only for the *short-term* follow-up. There were only minor adverse effects with massage."[4]

It is also possible that the local effects which massage therapists and clients observe are actually a result of broader, systemic effects. As the massage client settles into the process and relaxes, this relaxation loosens up the whole body (although the therapist is only working on one area at a time and hence may interpret what she is achieving as a local effect). The importance of relaxation is not, obviously, a new idea: Herbert Benson studied this in the late 1960s and early 1970s, documenting his work in the *The Relaxation Response*[5] but the meditation techniques he was studying are much older. (Wouldn't it be ironic if it turns out that the most effective form of massage is actually the basic relaxation massage taught in the Certificate IV level rather than the fancy, localised techniques taught as part of the Diploma of Remedial Massage or Advanced Diploma/Degree in Myotherapy?!)

A more recent study found that massage provided short-term pain relief for knee osteoarthritis. In light of the above comments about relaxation it is interesting to note that the massage treatment employed in this study was a standardised whole-body, 60 minute massage, not simply a localised knee rub.[6]

What has become clear through research, though, is that effective massage involves an interaction between therapist and client. It cannot be a one-size-fits-all approach. An interesting pair of studies came out in 2009-10, both looking at the effect of massage on pain in post-operative patients. In one study the massages were given by nurses, working to a strict protocol.[7] In the other study, professional massage therapists were recruited to work with the patients so each patient received an individualised therapy based on what he/she wanted.[8] In the first study, there was no significant effect on the patients' pain, as measured by their demand for pain relief, although they apparently enjoyed the massages they received and recommended that this service should continue. In the second study, with individualised therapy, there was a significant reduction in the patients' demand for pain relief and a significant reduction in their time in post-operative care.

I personally don't have a problem with thinking that massage can have a direct, local effect on the tissues being worked on as well as an indirect effect mediated through the nervous system and the positive effect of a sympathetic therapist. The nature of that local effect is still to be clarified: until we can find a way to view what is happening at the molecular level to living tissue as a person is being massaged we won't know … and that day is a long way off. At the moment all we have are conclusions based on indirect evidence, so we might as well lie down and enjoy it!

Movement

A review of Cochrane Reviews relating to the effects of physical activity and exercise as an intervention for chronic pain in adults was undertaken in 2017.[9] Geenan et al identified 21 Cochrane Reviews which covered 10 different diagnoses: osteoarthritis, rheumatoid arthritis, fibromyalgia, low back pain, intermittent claudication (cramping pain in the legs), dysmenorrhoea, mechanical neck disorders, spinal cord injury, post-polio syndrome and patellofemoral pain.

The conclusions of the review were qualified because most of the included studies were small (fewer than 50 participants) and the types of physical activity investigated varied in frequency, intensity and type. There was evidence that physical activity reduced the severity of pain, improved physical function, had a variable effect on both psychological function and quality of life and had no adverse effects other than temporary muscle soreness. However, these results were not all found or, indeed, looked for in all studies.

Additionally, participants had predominantly mild-to-moderate pain, not moderate-to-severe pain. However, on the basis of this comprehensive study, the authors concluded that:

"physical activity in general is acceptable and unlikely to cause harm in people with chronic pain, many of whom may have previously feared it would increase their pain further."[10]

My particular interest, as a taijiquan practitioner and teacher, is the effects of taijiquan. Taijiquan ("tai chi") is a Chinese form of martial art and health exercise that is widely practised inside and outside China, although purists often argue that much of what is claimed to be taijiquan has moved so far from its roots as to have lost much of the point (and the benefits) of the genuine art.

Pain relief has not been a major factor in academic research on taijiquan, with the main focus being on muscular strength, balance and motor control; taijiquan has also been shown to improve physical function and quality of life as well as psychological wellbeing. Lan et al. (2013) reviewed previous work on taijiquan and concluded that:

"...patients with rheumatological diseases can benefit from Tai Chi exercise. Although Tai Chi is performed in a semisquat posture, joint pain can be prevented because most motions of Tai Chi are performed in a closed kinematic chain and in very slow speed. However, patients with arthropathy should perform Tai Chi in high-squat posture to prevent excessive stress on lower extremities….
Tai Chi can be recommended to patients with rheumatoid arthritis, osteoarthritis, and fibromyalgia, as an alternative approach to improve patient's well-being."[11]

Movement in a closed kinematic chain refers to movements performed with the foot (for leg exercises) remaining in contact with the floor or ground, which is the case for much of the movement within a taijiquan sequence. Closed chain exercises tend to involve compressive rather than shearing or twisting forces and generally involve multiple muscle groups. For example, in taijiquan shifting weight forward into a front bow stance and then back into a rear-foot stance while concentrating on maintaining hip-knee-foot alignment throughout the movement.

This kind of conclusion, which also described research pointing to the benefits of taijiquan for patients with osteoarthritis, osteoporosis, low back pain and other musculoskeletal disorders, runs the risk of presenting taijiquan as some kind of magical cure-all. Many of the papers reviewed by Lan et al. (2013) and discussed in similar reviews can be criticised on some or all of the following: small sample size, inadequate controls, risk of bias and, perhaps most significantly, lack of clarity in what might be producing the claimed effects in the participants. However, even allowing for this, there is a convincing volume of evidence showing the benefits of taijiquan programs when conducted with proper training and attention to the underlying principles of the art, and the lack of significant associated risks.

In a recent analysis of data from an earlier study, Lauche et al. (2017) focussed on relief of neck pain, comparing the effects of a short taijiquan program with a more Western-style program of neck exercises. The reduction in perceived pain from both interventions was associated with improved postural awareness:

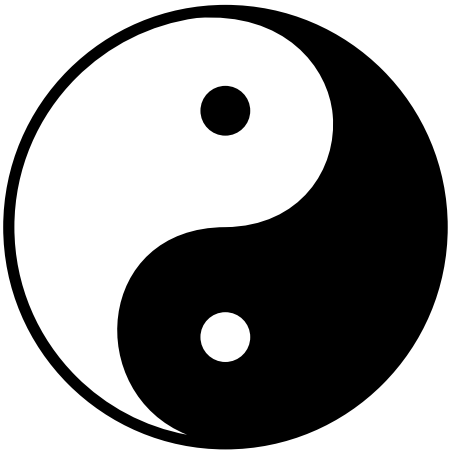
"In addition to psychological well-being, neck pain improvement was significantly associated with postural awareness in subject[s] with chronic nonspecific neck pain independent of treatment characteristics. *Training of postural awareness seems to be an important mechanism of action of different exercise-based interventions for chronic nonspecific neck pain.*"[12]

It would be incorrect to attribute the benefits of this approach solely to taijiquan. Postural awareness is also emphasised in other forms of physical training such as those developed by Moshe Feldenkrais, F.M. Alexander and Ida Rolf and her successors, as well as in many different styles of yoga. However, taijiquan can be a more accessible form of training, particularly as lends itself to group training as well as individual instruction.

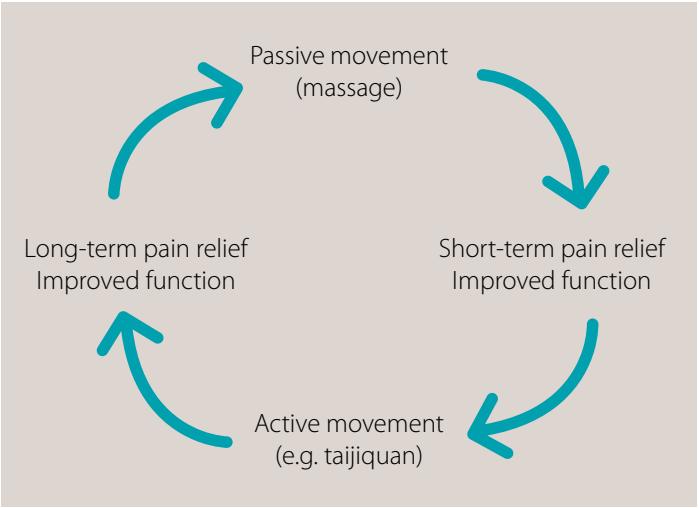
Conclusion

Having begun with a Chinese view of health, let me return to that approach. Western philosophy tends strongly towards a reductionist approach – there can be only one right answer – whereas the Eastern approach is generally much more inclusive, accepting that there is often value in multiple approaches to a problem. As part of this more inclusive approach, different types of therapy should be seen as complementary rather than antagonistic.

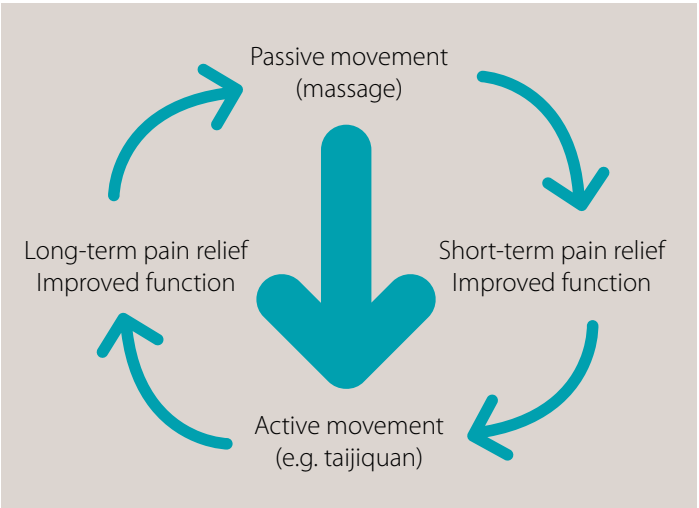
Many of you will be familiar with the taiji diagram, sometimes described as two fish circling, that illustrates the complementary inter-relationship of Yin and Yang:



I would like to suggest is that the relationship between massage and movement can be represented similarly as a cyclic relationship:



The difference is that there is a time factor involved. In the initial stages massage may be more important, providing short-term relief to facilitate movement, allowing participation in exercise programs such as qigong or taijiquan. With continued participation in these programs, supported as needed by massage, it is the movement that provides the benefit and massage may drop to a maintenance mode. Adding time to the previous diagram (the down-pointing arrow) the emphasis should shift from passive to active therapy:



Lifestyle change may require building this kind of regular movement into a daily routine. It is also important to develop awareness of movement, not just when doing taijiquan or other forms of exercise, but throughout all daily activities. I have often said to taijiquan groups that coming to a weekly class is fine but what is really important is how you put what you do in class into practice for the next 6 days and 23 hours!

Perhaps it may be obvious but to learn to move without pain, it is first necessary to move. Initially, the emphasis may be on passive therapy (massage) to explore the limits and the available range of movement but at some point this has to shift into active movement. Taijiquan is not the only way of doing this but I know from personal experience and experience as a teacher that the slow movements give you time to develop awareness of how your body is moving as you shift and balance your weight, and allow you to experiment with body positions and alignment to seek a pain free way of moving. There is no magic bullet, so sitting still and waiting for one is certainly not going to help.

Note

Two of the references (Furlan et al. 2015; Geneen et al. 2017) were produced by the Cochrane Collaboration. This organisation grew out of the need to support evidence-based healthcare by providing impartial and up-to-date reviews of published research. These are made freely available through the Cochrane Library. More information about its work can be found at https://www.cochrane.org/

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About the author

Geoffrey Miller has practised and studied tai chi and related Chinese martial and health arts since 1996. At the end of 2009, he qualified as a remedial massage therapist and has since worked professionally as both a massage therapist and tai chi teacher while pursuing further academic studies in health sciences. As a card-carrying old-age pensioner, he has an interest in working with older people, and with people with disabilities; the latter interest was sparked through a work placement while studying at Canberra Institute of Technology. He is also a published author and enthusiastic (but incompetent) musician.

Are massage therapists a bunch of losers?

By Tim Clark

Watch Tim present his Masters research at the 2018 AMT Annual Conference.

We need to have a talk.

At the 2018 AMT Annual Conference, I had the pleasure of working with a room full of wonderful massage therapists in a session on the topic of self-awareness. In one exercise, I asked everyone to indicate how much they agreed or disagreed with a series of statements, such as *'I always feel like something bad is about to happen'* or *'It's important to always please other people'*, which I hoped would draw out some insights about beliefs we hold that aren't necessarily helpful.

Of the eighteen statements, the one that garnered the most 'agree' or 'strongly agree' responses was:

'I often compare my accomplishments with others and feel that they are much more successful.'

Obviously anyone, regardless of their occupation, could agree with this statement but the fact that it was the most popular view in a room full of massage therapists – and one of my own personal bugbears – made me think about what it is that predisposes us in particular to see things this way.

Why do so many of us feel like we don't measure up?

Why do we think we're losers?

How do we measure success?

Let's have a look at how we measure our success.

First, perhaps most commonly in Western mainstream culture, we use numbers. Numbers allow us to be specific about measurable things like revenue, client retention, market share, staff numbers and booking rates. They offer us a clear point of reference for comparison to others, which can make us feel either superior or inferior. Knowing that my friend is booked out three weeks in advance might make me feel like a bit of a loser if I'm struggling to fill my schedule. Put your hand up if you've ever felt that way.

Second, we make subjective appraisals of other people. We look at how they present themselves, what their website says, what qualifications they have, how experienced they are, and we judge – consciously or not – where we sit in relation to them.

We think: *Oh, that person has been a therapist for thirty years. I've only been one for five years, so they must be better than me.* Or: *That person works with elite athletes. I couldn't do that, so they must be better than me.*

And we don't just compare ourselves to other massage therapists. It seems to be a defining characteristic of healthcare professionals that we're keenly aware of our place in an occupational hierarchy, based on some unspoken social agreement about value and prestige.

To paraphrase something a friend recently said to me: massage therapists like to distance themselves from sex workers because we all need a dog to kick.

Whether you think that's true or not, it certainly captures the essence of the hierarchy, in which every group except "Group Number One" is the subject of another's derision.

Not exactly helpful.

Yes, numbers and subjective appraisals can be helpful but not in the examples I've given here. Looking at others as better or worse has little to do with how we work as therapists. Superiority might feel nice for a moment but it can lead us to over-estimate our abilities and reduce our capacity for empathy. Conversely, seeing ourselves as inferior can leave us feeling depleted or depressed and, therefore, unable to give our clients the positive energy they really need.

It seems to be a defining characteristic of healthcare professionals that we're keenly aware of our place in an occupational hierarchy, based on some unspoken social agreement about value and prestige.

Are we losers?

For some of you, this is obvious stuff but coming to this conclusion myself has been a long, slow process. If, like me, you were raised to give precedence to an external locus of control i.e. you allow forces outside you to govern what you do, it can be really hard to figure out what it is that drives you from the inside and to build your internal locus of control. The messages around us in Western society and its institutions, especially the media, foster a culture of competition and comparison, which can make it hard to see what we've chosen for ourselves and what others have coerced us into believing. These messages are drilled into us from childhood so by the time we're adults, they're basically hardwired.

Numbers and subjective appraisals are more helpful if we are able to balance them against our own goals and values. Personally, the idea of being booked out three weeks in advance sounds like prison to me. Of course I want a steady stream of clients so that I am financially secure and feel fulfilled but to me it's equally important to live at a steady pace, to have freedom and flexibility, and to enjoy what I do.

I can handle earning less if it means I'm happy and healthy. Others may treasure the idea of a non-stop work cycle because they value the financial security it brings above all else. They are able to manage the stress that comes with that because they're driven by what they see as a greater purpose. Neither perspective is correct or incorrect. Both are based on the ability to prioritise certain aspects of life over others.

Don't worry, be happy

The way around this would be to really sit down and look at, and into, ourselves rather than out at others; to be very clear about what it is that we want out of life and what we consider to be 'accomplishments' and to stop relying solely on comparison to teach us what we do and don't want to be. (Incidentally, this is typically a goal of life coaching, counselling and psychotherapy. If you've never considered using a professional to help you figure these things out, maybe now is the time?)

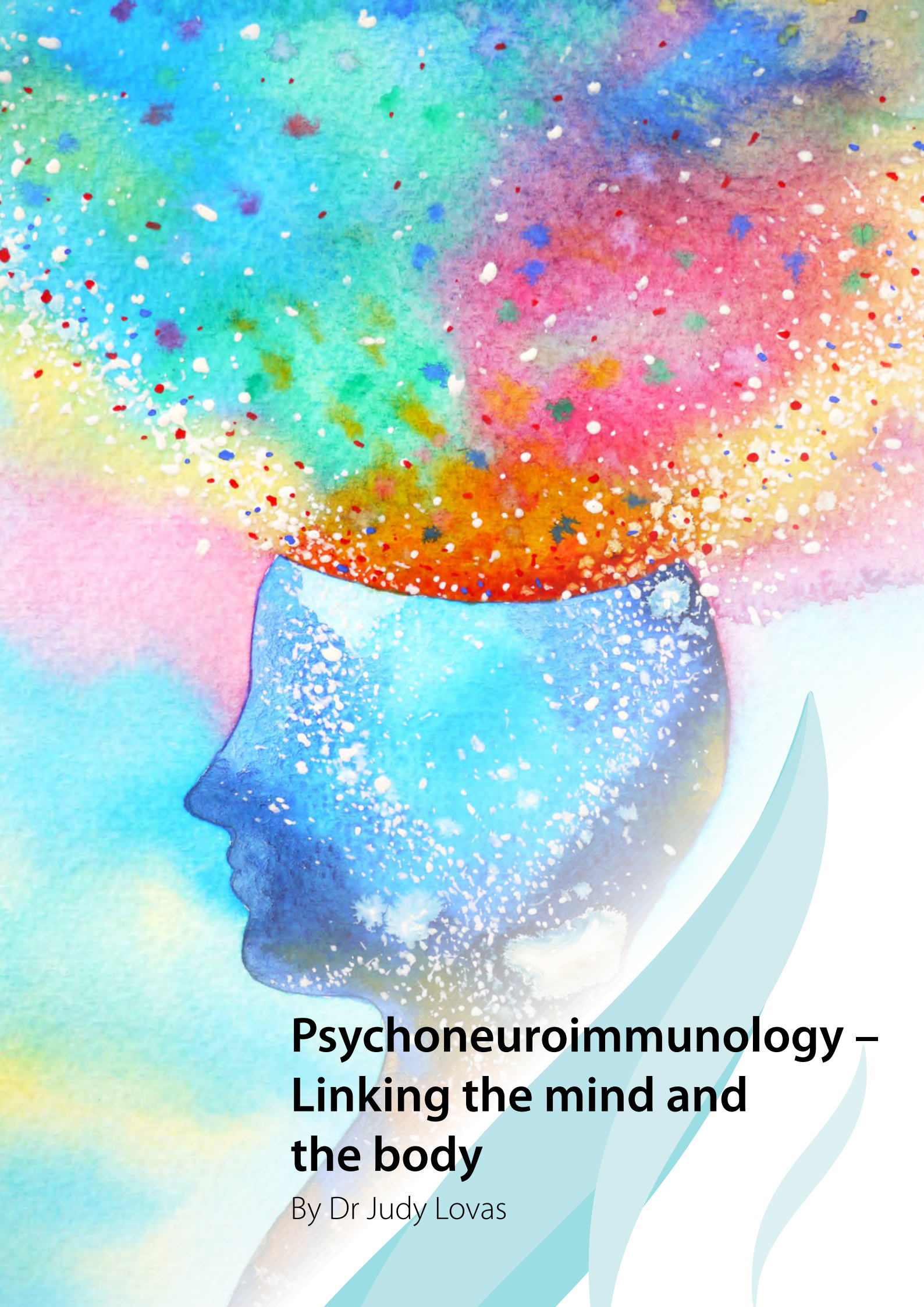
Importantly, we need to recognise that no journey towards this kind of self-understanding is smooth or easy, that there is no success without failure, and that we can fail *and* be successful at the same time. Sometimes I forget or get confused about my values and I act in ways that invariably lead me to guilt or shame, which leads me, after a while, to want to turn it around. It's a constant effort to keep those prime values in sight and to return to them when things feel hopeless.

In some ways, and at some times, this gives me the quality another friend of mine once called 'un-f*ck-with-ability'. What this somewhat inelegant term means is that, as long as I am living according to my values and achieving what is important to me, the external comparisons become redundant. I can't be messed with. Whether I'm a winner or a loser is irrelevant because I'm not even playing the game. I'm over here doing what is important to me as a massage therapist: helping someone feel better, improving someone's quality of life, nurturing someone's soul.

And that's plenty for me.

About the author

Tim Clark has a diverse background, including education and the arts, which informs his holistic work as a massage therapist at Time and Space Therapies in Melbourne. He completed his Masters thesis in 2018. His Masters thesis uses psychotherapeutic theory to examine the relationship between a massage therapist and her client.



Psychoneuroimmunology – Linking the mind and the body

By Dr Judy Lovas

Watch the author of "The telomere effect", Elissa Epel, talk about telomeres.

Once the study was published in 1975, psychologist Robert Ader coined the term Psychoneuroimmunology (PNI), to describe interactions between these systems.

Today, PNI is a multidisciplinary and clinically important discipline that examines pathways and mechanisms by which our thoughts, emotions and health are intimately linked on cellular and molecular levels.

In fact, the research now goes beyond the molecular level and includes studies in the effects of stress and relaxation at levels of chromosomal activity and genetic expression, particularly in immune cells and inflammatory pathways.

PNI demonstrates that all chronic diseases involve inflammatory processes. Furthermore, PNI offers overwhelming evidence that inflammation and depression are linked.[1] It is understood that poor immune function is a key component in major depression. This link occurs via cytokines, chemical molecules that regulate inflammation. Pro inflammatory cytokines stimulate the inflammatory response and anti-inflammatory cytokines inhibit it. Cytokines are responsible for what is known as 'sickness behaviour'.

The fatigue, lethargy and cognitive difficulties experienced during a hefty dose of the flu are directly caused by cytokine activity to encourage rest and recovery.

In times of acute stress, we know that pro-inflammatory cytokines decrease depression to help survival. However, pro-inflammatory cytokines increase depression during long-term, chronic stress.

When there is dysregulation of pro and anti-inflammatory cytokines, chronic inflammation can lead to depressive symptoms. In his book, *The Inflamed Mind*, Cambridge University psychiatrist Edward Bullmore outlines the growing evidence that inflammation and depression are not just linked but appear to have a causal relationship. This exciting development continues to be researched.

Other immune cells such as T cells and natural killer cells are impaired during depression. In depression, these cells demonstrate a significant loss in their activity, distribution, proliferation and ability to kill pathogens.

Bullmore acknowledged that clinical and medical practice often lags many years behind scientific advances. However, to encourage evidence-based, improved clinical practice, researchers at Cousins Institute of Psychoneuroimmunology at UCLA translate current scientific evidence to better clinical practice.

For example, research in mind-body therapies such as Tai Chi, yoga and meditation[2] has examined the impact of these therapies on inflammation. A review of 26 randomised controlled trials described the effects of mind-body therapies (MBTs) on circulating, cellular and genomic markers of inflammation.[3] This qualitative evaluation showed mixed effects of MBTs on circulating inflammatory markers. Interestingly, there were more consistent findings showing decreased expression of inflammation-related genes and reduced signalling in pro-inflammatory markers. Results from research like this support the inclusion of MBTs in healthcare.

Other fascinating research in PNI include studies into the effects of therapeutic interventions such as relaxation therapies on telomeres and telomerase.

Telomeres are to chromosomes what plastic tips are to shoelaces. They protect the chromosomes from fraying, deteriorating and risking damage to the DNA.

Telomerase is the enzyme that protects and nourishes telomeres. Reduced telomerase activity reduces telomere health. Everyone's telomeres shorten with age, while psychological stress, inflammation and chronic disease increase the rate of telomere shortening and decrease telomerase activity, thereby reducing telomere viability. Therefore, telomere length is a marker of cellular aging and health. Recent studies suggest that some forms of meditation, improved diet, exercise, social support and relaxation may reduce the rate of telomere shortening and increase telomerase activity.

One study trained caregivers of a family member with dementia to practice a simple form of meditation for a minimum of 12 minutes per day for 8 weeks.[4] Two subjective outcomes – cognitive functioning and depressive symptoms – and one objective outcome – telomerase activity in immune cells – were measured before and after the 12 weeks. Significant improvements were found in all 3 outcomes. However, the extent of improvement in telomerase activity is worth noting. The carers who meditated a minimum 12 minutes per day for 8 weeks had a 43% increase in telomerase activity compared to the control group. In research terms, this is a particularly large improvement.

Forty years ago, PNI studied links between the nervous and immune systems. Today, sophisticated research supports age-old wisdom that the mind and the body are not separate entities. Neuroscientists, doctors, psychiatrists and researchers increasingly recognise evidence that psychological stress can affect inflammatory processes, chronic disease and specific biological markers of health and ageing. Massage therapists can feel confident that by reducing stress, pain and fatigue, hands-on techniques can in turn decrease inflammation and psychological conditions such as depression.

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About the author

Judy Lovas PhD has been studying Psychoneuroimmunology since the mid 1990s. Judy studied the effects of massage therapy on immune function and demonstrated increased T and B cell function. Her PhD examined psychological and immunological outcomes of massage therapy and guided imagery on secondary conditions in people with spinal cord injury. Judy presents seminars in Evidence based Relaxation Therapy and Introduction to PNI. You can visit http://artandscienceofrelaxation.com for more information.

Why placebo is lit

By Aran Bright

Watch Aran presenting at the 2017 AMT mini conference in Canberra.

Holy guacamole, the topic of placebo is intense and complicated. And it is awesome!

One of the reasons massage therapy is so effective is down to placebo or contextual effects so we owe it to our clients to understand this topic. Placebo effects play a big role in any health care encounter.

Hopefully, by the end of this article you will gain an understanding of why it is probably more important to focus on the client's experience of a massage than it is to focus on what techniques you used, at least when it comes to pain reduction.

What is placebo?

In many cases the word *placebo* is associated with "doesn't work", "a sham" or plain old "useless". But actually, placebo is from the Latin *placere*, "to please", and literally means "I shall be acceptable or pleasing".

Medically, a placebo is an inert substance that is used to trigger a real, measurable effect; a positive effect. The good news is it may well be one of the most powerful tools open to a massage therapist in the treatment of pain. If massage therapists consider what is required for a client to have a placebo experience, we give ourselves the best chance of positive outcomes for pain reduction.

Placebo, non-specific effects and touch-based analgesia

Before we begin to get into how placebo works, it is important to note that massage can never really be a true placebo in one sense of the word. The medical definition implies that the placebo should have no direct effect on the subject. Touch does have measurable effects so the more correct terms for placebo effects from massage are 'non-specific' or 'contextual' effects.

As mentioned earlier, placebo means "to please", therefore it does keep things simple to consider any non-specific therapeutic approach that has a positive outcome as a placebo.

Touch-based analgesia (touch as a method to reduce pain) is one well-researched topic associated with massage. The interesting thing about touch-based analgesia is that is does appear to be context specific. In other words, if we interpret touch as caring or therapeutic, this enhances the effectiveness of it.

Also, if we focus on the sensation of touch (mindfulness), such as the warmth of someone's hands, this also enhances the effect of touch. So here we have two different mechanisms at play: positive interpretation of touch and awareness of touch. Both mechanisms matter and they are not the same thing.[1, 2]

What Is The Placebo Effect?

With regard to the analgesic effects that massage has, there are at least three mechanisms that look to be a factor. The first mechanism you are probably familiar with: the pain gate model.[3] This theory has been around for a while and is based on touch triggering larger diameter receptors in the skin which are given priority over nociceptive (noxious) receptor signals at the spinal cord level. So by touching someone repeatedly in a pleasant way, this should reduce the amount of nociception experienced. This is the theory behind TENS and many other skin-based therapies.

One metaphor that may be useful to understand the pain gate theory is that the spinal nerve synapses to the spinal cord can act like a bouncer at a nightclub. The body has a number of nightclubs (lamina) that nerve signals can pass as they travel along the spinal cord and then to the brain. The body has a capacity to up and down regulate the signals at the spinal cord level to prioritise some pathways over others. This is a little like a bouncer at your local nightclub choosing who can and can't come in based on who they think are more important.

In other words, the body can prioritise certain pathways (pleasant touch or nociception) depending on what it determines to be the most important.

The other mechanisms at play here are far more complex but we will group them under the heading of "emotional appraisal neurocircuitry". These areas of the brain include the pre-frontal cortex, the accumbens, the amygdala, the mid-brain and the somato-sensory cortex. These are the touch and emotional areas of the brain and they can control the "volume knob" on pain and sensation depending on what the brain thinks is important.[4]

Placebo at work

One of the best demonstrations of the placebo (or non-specific) effects in massage was a clinical trial of over 300 people with low back pain. The trial was split into three groups: relaxation massage, therapeutic (remedial) massage and usual care (GP care). What was discovered at the end of the study is that both forms of massage are better than usual care to a clinically relevant level. What was surprising is that the functional outcomes of relaxation massage outlasted remedial massage.[5]

There is no logical way to explain the effects of the relaxation massage outperforming therapeutic/remedial massage from a direct effect. Relaxation massage by its very definition is general, whole body and gentle. What is most likely occurring is self-healing, a down regulation of pain and increase in function through the non-specific (placebo) effects of massage.

Touch, placebo and mindfulness

It's possible that these three factors could well be the most important when it comes to pain reduction and massage. Touch-based analgesia has an effect on the spinal level as discussed previously but the placebo effect and mindfulness work through higher processing levels. What is interesting is that both the placebo effect and mindfulness don't actually reduce the amount of nociceptive signalling to the brain. Instead, they work in higher centres of the brain. [6, 7, 8]

So what does this mean in terms of practical application for the massage therapist?

Pleasant touch, Context and Engagement

To gain the best results in terms of pain reduction, we should be focusing on three main factors:

1. **Pleasant touch.** It's quite clear the activation of pleasant touch receptors in the skin is our first line of defence against nociception.
2. **Contextual factors.** Are we creating a therapeutic experience for our clients? Do they see the process they are engaged in as a healing, therapeutic ritual? Are they engaged in the process? Are they finding the massage calming and relaxing whilst also focused on the sensation of touch? Consider for a moment some of your most admired massage gurus. What are the common things we will always tend to see? A myriad of diverse techniques that can range from fast stimulation, movement and stretching to calm, slow sustained holds. Apparently all these different methods obtain fantastic results, and I would suggest the thing they have in common is pleasant touch. Even those methods that can be painful at times are normally mixed in with something that feels amazing.
3. **Environment and setting.** Most experts will throw complex technical language around, describing the changes and improvements you can expect to see and why this is important. And finally, the therapist is engaged. And the more excited and engaged the therapist is, the more engaged the client is. We can probably take for granted that the person who gets good results from a particular treatment will be highly engaged in that process because they love that feeling.

Conclusion

It is important to consider the client's experience of a massage and how touch does not need to be complex to gain clinically worthwhile results. You do not need to bend someone like a pretzel or align anything to get better improvements in pain and function.

However, if you are working more in a functional domain, such as increasing range of motion, then biomechanical approaches and techniques are still entirely relevant.

Either way, having a better understanding of why we need to consider the placebo effect in the management of pain can lead to better treatment outcomes.

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About the author

Aran Bright started his career as a massage therapist in 2002 after graduating from the Australian College of Natural Medicine in Queensland. In 2006, Aran completed his Diploma of Remedial Massage and, in 2007, his Bachelor of Health Science in Musculoskeletal Therapy. Aran graduated from University of Queensland with a Graduate Certificate of Sports Coaching, completed a Certificate IV in Fitness and an Advanced Diploma of Myotherapy. He currently runs his own businesses, Bright Health Training and Brisbane Workplace Massage, with his wife, Sheree.

Something's gotta change

By Sharon Livingstone

Watch Sharon at her argumentative best at AMT's 50th anniversary great debate.

It's winter. You put the heater on in the massage treatment room, warm the towels, warm the treatment table and drape a cosy blanket across the client. How lovely. How thoughtful. Clients love it. Then, about 10 minutes into the treatment, your female client kicks those thoughtful towels and covers off, and the oil has gone tacky from their perspiration.

Peri-menopause and post-menopause can be unsettled times for women but open discussions on menopause are rare.

Massage therapists are in the privileged position of being trusted practitioners. People are comfortable discussing health matters with us. And we need to be able to discuss menopause with our female clients because there's a likelihood that they may experience a symptom in our treatment room.

The secret that no-one discusses

My mother died when I was in my early 20s, a time when "menopause" was, at least to me, a social construct. By the time I started to think about what menopause might mean for me, my grandmother had also died, leaving me with no direct maternal guidance on what lay ahead.

I asked my doctor for some information. Her answer was "google it". I wanted an easy to access brochure with all the information and options laid out in plain English. I was quite cross with her answer but the more I've learnt about menopause, the more I understand why my doctor sent me down the interwebs rabbit hole. I stumbled out of that rabbit hole with more questions than answers. Should I take hormone replacement therapy or will that give me breast cancer? What about an investment in lubricants and creams for vaginal dryness? Will I lose the will for intercourse? Do I need a good lawyer for my impending kleptomania? Should I put a rubber sheet on the bed for night sweats?

We discuss female puberty ad nauseam and even dudes are quite knowledgeable with menstruation and the menstrual cycle. We're also content to chat loudly about menstruation as we sip our flat whites. But while we're all experts on what happens when you have your first period, we're not so expert about your final period.

Menopause is the secret that society doesn't seem interested in.

What is menopause?

Menopause is the final menstrual period a woman experiences. 12 months later, she is deemed "post-menopausal".

Peri-menopause refers to the time leading up to menopause when a woman may start experiencing changes in her menstrual periods such as irregular periods or changes in flow. Cycles can be shorter or longer in length. Symptoms may also include hot flushes and night sweats, aches and pains, fatigue or irritability as well as premenstrual symptoms such as sore breasts. These changes may be caused by fluctuations in the production of hormones from the ovary. Some women can experience menopausal symptoms for 5-10 years before their final menstrual period. There is no way to predict the age at which a woman's menopausal symptoms will start or how long they will last.[1]

Did you see that bit about there being no way to predict when menopausal symptoms start or how long they'll hang around for? That means not knowing how long you'll need to pack your sanitary items every time you leave the house (not just when your period is "due" because of that whole "irregular periods" bit). That means not knowing when you're going to stop feeling like you're about to internally combust. That means not knowing when your moods will fluctuate from calm to freaking furious at the snap of your fingers.

Imagine how a client with menopause symptoms might be feeling.

Menopause means different things to different women. Some see it as a freedom – no more periods or (pregnancy related) contraception and a time to think more about themselves. Others see it as an ending or loss of purpose – they're no longer able to have children. Others yet see it as yet another sign of getting old. Women report feeling invisible in a sexual and literal way. One menopausal client told me how she sat in a cafe for ten minutes watching everyone else being served while she wasn't. When she went to the counter to place her order, the staff apologised profusely, saying "I didn't see you over there."

There is a popular, although questionable, "Grandmother Theory" of why menopause happens. This theory further pushes women into a role where their identity and purpose is defined by their usefulness to others.

Symptoms

Some of the common symptoms of peri- and post-menopause are:[2]

- Hot flushes
- Light-headedness
- Night sweats
- Headaches
- Irritability

- Depression
- Unloved feelings
- Anxiety
- Mood changes
- Sleeplessness
- Unusual tiredness
- Backache
- Joint pains
- Muscle pains
- New facial hair
- Dry skin
- Crawling sensation under the skin
- Decreased sexual feelings
- Dry vagina
- Uncomfortable intercourse
- Urinary frequency

What's this got to do with how I massage women?

When I was in my first year as a massage therapist, I'd left my 50-something client to get changed after her treatment. She took ages. Then I heard her in the bathroom. By the time she came out to reception, her face was scarlet with embarrassment.

"I hadn't had a period for months but I've bled all over your towels."

I understood nothing about menopause up to that point. I didn't know how unpredictable menstruation was in peri-menopause. Thankfully I masked my ignorance by reassuring my client that it was no big deal. It wasn't and shouldn't be.

Menopause isn't visible. And not all symptoms of peri- and post-menopause are visible. It can't be assumed that a woman has reached menopause based on her age because of that whole "we have no way of knowing when menopause will happen". And there's the small matter of early menopause or menopause as the result of surgery (some hysterectomies) or other medical issues, like cancer treatment.

Do you include menopause on your intake form?

Ask about temperature – as with all clients, it's important to know how warm or cool they like to be. Just because it's 3º below outside doesn't mean a client wants equatorial temperatures in the treatment room.

It's easy to see that some menopausal symptoms – aches, pains, depression, fatigue, headaches, crawling sensations under the skin – might be reported to a massage therapist and be unrelated to any injury or overuse or posture.

Tim Clark, massage therapist and psychotherapist, offers further guidance on discussing menopause with clients:

Consider what your relationship with the client is like. Is there a strong bond of trust? Does it feel like the client knows you hold them in unconditional positive regard? If it doesn't feel like the connection is very strong or if you've only recently started working with them, a question like "Are you menopausal?" might be perceived as too intrusive or judgemental.

If you're confident that:
a) you hold the client in unconditional positive regard,
b) you don't believe that menopause is something to be ashamed of, and
c) the client knows both of these things, then talking about menopause should be an anxiety-free experience. And talking about it, as with other socially stigmatised experiences like mental illness, can help to normalise it and take the sting out of it.

As a massage therapist I need to be very clear about what insecurities I might have around the topic of menopause. Might I hold unconscious beliefs that make me shy away from discussing it? Might this serve to reinforce a client's insecurities? It's entirely possible that the client holds no such sensitivity around the topic, and assuming that they do might send the message that you think they should.

What can I do to stop the secrecy?

Education helps. There are links to research and reviews, and relevant articles in the "Further Reading" section below.

The Australasian Menopause Society website offers lots of information and AMS members can access menopause focused webinars and online courses.

Tim Clark also suggests that "If the client thinks (or knows – it could be a useful piece of self-disclosure) that you, the therapist, have experienced menopause, it could be easier to hear that question".

How do Massage Therapists manage their menopause symptoms at work?

Because no two women have exactly the same experience, there are no hard and fast rules on how to do this. Some suggestions:

- Wear natural fibres that breathe, e.g. merino (hot flushes/ overheating/sweating)
- Avoid man-made fibres like polyester (they don't breathe and get stinky with sweat)
- Moisturise hands regularly (to stop skin splitting as a result of dry skin and frequent washing)
- Reduce working hours or increase gaps between appointments (fatigue, toilet breaks)
- Use a stool (light headedness, aches/pains, fatigue)
- Write notes up as soon as possible after treatment (brain fog/cognition)
- While this isn't strictly "at work", some research[3] suggests that regular strenuous exercise may reduce the severity and frequency of hot flushes. Regular exercise may also be helpful for managing mood and depression.
- Have a good support network of people happy to talk about the menopause experience or, at least, happy to listen to your experience.
- Consider letting colleagues know that you're peri- or post-menopausal.
- Talk therapy may also help – psychology or counselling.

Are you ready to talk?

We don't understand menopause and how it affects women by maintaining silence or stigma around it. Women are often quite eager to discuss their experience of peri-menopause and post-menopause, especially if they know someone is receptive.

When I had a client experience a hot flush as they greeted me, it was a great opening for her to share her menopause journey. I was as keen to let my clients express themselves as I was to learn from their experience.

References

1 Australasian Menopause Society, https://www.menopause.org.au/hp/information-sheets/185-what-is-menopause

2 As above

3 Bailey,TG, Cable NT, Aziz N, Dobson R, Sprung VS, Low DA, Jones H, Exercise training reduces the frequency of menopausal hot flushes by improving thermoregulatory control, *Menopause* 2016 Jul;23(7):708-18.

Further reading

The Australasian Menopause Society put together some fact sheets.
https://www.menopause.org.au/hp/information-sheets/185-what-is-menopause

Australasian Menopause Society has a list of Cochrane reviews on all matters around menopause
https://www.menopause.org.au/hp/cochrane-reviews

Science Daily collates menopause research news
https://www.sciencedaily.com/news/health_medicine/menopause/

Menopause Doesn't Make Me Invisible by Jill Gleeson, Good Housekeeping
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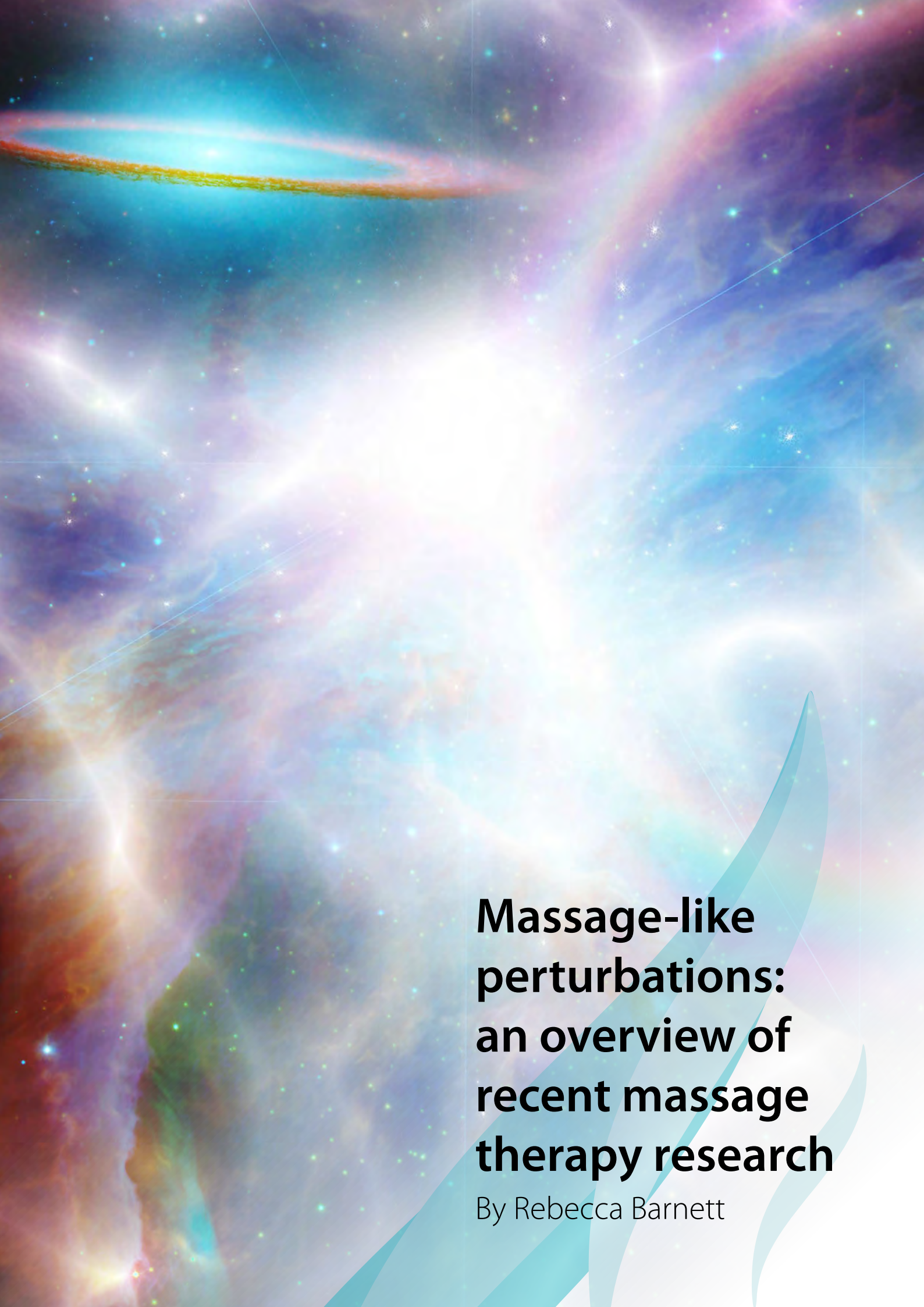
About the author

Sharon Livingstone is a massage therapist in Sydney. A love of sport drew her to the industry but discovering job satisfaction came from helping people live with less pain keeps her in it. Sharon is a writer, keen bushwalker and frustrated traveller who is also a coffee snob.



Massage-like perturbations: an overview of recent massage therapy research

By Rebecca Barnett

SCAN ME

Watch Rebecca present some research AMT conducted with the help of AMT members.

If you search PubMed for massage therapy research published in 2019, you'll be presented with 540 citations or 26 pages of references. Of course, there's lots of stuff that isn't especially relevant or useful for us massage therapists to know about - searching for articles on PubMed is the gift that keeps on giving when it comes to obscure study titles and curious research cul de sacs.

For example, there's the decidedly peripheral ('scuse the pun):

"Autokeratoplasty in perforation of the ectatic leukoma of the only functionally perspective eye"

There's the vaguely obscene-sounding animal study:

"Semen collection by trans-rectal digital stimulation and insemination campaign in goat"

(Note to self: I will not picture Barnaby Joyce, I will not picture Barnaby Joyce …)

And then there's the medical applications you never knew about that turned out not to be especially helpful after all:

"Midstream clean-catch urine culture obtained by stimulation technique versus catheter-specimen urine culture for urinary tract infections in newborns: a paired comparison of urine collection methods"

There's also the obligatory animal model study:

"Application of Consistent Massage-Like Perturbations on Mouse Calves and Monitoring the Resulting Intramuscular Pressure Changes"

And the intriguing sounding stuff from other cultures:

"Hammam-i-Bukhari (Turkish bath): A promising regimenal mode of Unani treatment"

Then there's the "seriously, what does this have to do with massage, on second thought I don't actually care" research:

"High Definition Liposculpture in Male Patients Using Reciprocating Power-Assisted Liposuction Technology: Techniques and Results in a Prospective Study"

There seemed to be a lot less randomised controlled trials of massage therapy conducted in 2019. To make up for this, though, there were some pretty large meta-analyses, health service utilisation studies and an interesting hypothesis or two …

Here's a handpicked selection of some of the most interesting research into massage therapy (and massage-like perturbations) during 2019.

Elders/aged care/dementia

If the proliferation of meta-analyses of massage therapy for dementia in 2019 is anything to go by, we should all be turning our attention to the largely unlocked potential of providing touch and massage in aged care facilities to help ameliorate the psychological and behavioural dimensions of dementia. It's a good thing so many AMT members have completed the University of Tasmania's Understanding Dementia online course!

Here is a brief overview of three separate reviews involving thousands of people with dementia.

Sensory-Based Interventions for Adults with Dementia and Alzheimer's Disease: A Scoping Review[1]

A scoping review is a kind of study that is undertaken to examine the extent, range, and nature of research activity in a topic area; determine the value and potential scope and cost of undertaking a full systematic review; summarise and disseminate research findings; and identify research gaps in the existing literature.

The purpose of this scoping review was to explore the effectiveness of sensory-based interventions for clients with dementia living in residential facilities. Forty-seven articles met the inclusion criteria, including 32 Level I (systematic reviews, meta-analysis, and randomized controlled trials), seven Level II (two groups, nonrandomised studies), and eight Level III studies (one group, nonrandomised studies) that encompassed over 5,000 participants.

Sensory stimulation interventions included light, aromatherapy, massage, and Snoezelen rooms. (If you've never heard of a Snoezelen room I highly recommend you look it up – it sounds pretty darn cool.)

Massage was classified as a tactile sensory stimulation intervention. Three Level I articles supported massage for improving sleep, agitation, and short-term mental health, but noted its limitations for improving anger and depression. Massage was primarily administered to the hands/arms or back.

The scoping review found strong evidence for the use of massage in managing dementia behaviours.

Comparative Efficacy of Interventions for Aggressive and Agitated Behaviors in Dementia[2]

You may recall that there was quite a bit of media surrounding the release of this study in October 2019.

Here are some examples of that reporting:

https://medicalxpress.com/news/2019-10-non-pharmacologic-treatments-effective-psychiatric-symptoms.html

https://cosmosmagazine.com/biology/dementia-patients-do-better-without-drugs-to-ease-behavioural-symptoms

Unfortunately, this study is so recent that I have not been able to access the full paper. However, it is a large meta-analysis of controlled trials comparing interventions for treating aggression and agitation in adults with dementia. After screening nearly 20,000 citations, 163 studies were included involving 23,143 patients. Aggression and agitation were the main two outcomes analysed in the review. The mean age of patients was over 70 in almost all of the included trials, with 65% living in a nursing home or assisted living facility.

Nearly half (46%) of the included trials were at high risk of bias due to missing outcome data in the reporting.

The meta-analysis concluded that nonpharmacologic interventions seemed to be more efficacious than pharmacologic interventions for reducing aggression and agitation in adults with dementia. For patients with physical agitation, massage and touch therapy were more efficacious than usual care or caregiver support.

Manual massage for persons living with dementia: A systematic review and meta-analysis[3]

This meta-analysis examined the mean changes in behavioural and psychological symptoms of dementia, comparing manual massage with no physical contact.

The analysis included 11 RCTs encompassing 825 persons living with dementia. There was a fair amount of heterogeneity in the types, and application of, massage. Four studies investigated aroma massage, one investigated aroma acupressure, two investigated massage therapy, two investigated acupressure, one investigated acupressure in combination with a rivastigmine patch, and one investigated a massage therapy and acupressure intervention group. Two of the studies applied massage on the hands, two on the feet, one on the lower limbs and, and one on the shoulders, arms, and neck of the patients. One study did not describe localisation of massage application.

The results suggested that manual massage improve behavioural and psychological symptoms of dementia and depressive symptoms.

In terms of implications for clinical practice, the authors' recommendations are unequivocal:

"… by massaging patients with dementia, healthcare professionals may help to reduce symptoms and, in turn, reduce the use of sedative medication with dangerous side effects. Thus, health care professionals should be encouraged to apply manual massage in persons living with dementia during routine care. Furthermore, as manual massage is easy to apply, it might be a useful strategy to be used by family caregivers in the hope of ameliorating changes in behaviour and mood of the relative living with dementia. It could be used to reduce the caregivers ' burden. Therefore, manual massage should be an integral part of family caregiver education programs."

Hospital and hospice-based massage

The dementia studies featured above predominantly took place in aged care facilities. The three studies I discuss below feature hospital and hospice settings, including a systematic review of massage therapy in Intensive Care.

Effects of massage on outcomes of adult intensive care unit patients: a systematic review[4]

This review examined 12 studies involving adult, critically ill ICU patients, irrespective of primary diagnosis at admission. Participants in the comparison group were required to be ICU patients receiving standard care or other regular interventions without massage therapy.

The exclusion criteria comprised studies involving participants under 18 years old; non-ICU patients; interventions combining massage with some other modality that did not report the effects of massage separately; complementary therapies other than massage; and "back rub" interventions.

The research designs included eight RCTs and four quasi-experimental designs. The eight RCTs included an experimental group that received a massage intervention and a control group that received routine care. In some cases, patients in the control group were either resting undisturbed in the bed with the presence of a researcher/nurse at the bedside or were receiving a hand-holding intervention.

The type, frequency, duration and mode of massage delivery were quite heterogeneous across the selected studies. The most common body areas involved were upper and lower limbs and back. In two of the studies, full body massage was performed, while only one study included massage of the scalp.

There was also substantial variation in who administered treatment. In two studies, massage was provided by family members after training. In other studies, massage was provided either by a physiotherapist or massage therapist, research personnel or an ICU staff member. Eight of the studies described specifics of the massage technique, such as application of light or deep pressure. Duration varied between 5 to 60 minutes and number of massage sessions delivered 1–3 sessions or sessions repeated over 2–3 days.

Outcome measures from these studies included vital signs and haemodynamic measurements such as blood pressure, heart rate and oxygen saturation; anxiety; pain; sleep quality; consciousness; and muscle tension. One of the most intriguing results was from a study that showed that the improvements in vital signs were only seen after the second massage session, suggesting that participants needed to be familiar with the intervention to reap the benefit.

The authors of this study concluded that massage interventions appear to be helpful for improving a number of outcomes in ICU patients. Massage showed favourable effects in haemodynamic parameters, and in reducing pain and anxiety.

Therapeutic massage to enhance family caregivers' well-being in a rehabilitation hospital[5]

This is a randomised feasibility study where 38 family caregivers of paediatric or adult patients receiving treatment at a rehabilitation hospital were randomised to receive either one massage per week or three massages per week for two weeks (lucky bastards). The study design was mixed methods, using both quantitative pre- and post-intervention questionnaires and qualitative analysis of a semi-structured exit survey.

This study is particularly interesting because it is a rare example of massage therapy research that uses a standardised protocol for a 55-minute massage. This protocol is outlined in full in the study. However, the use and sequencing of specific massage techniques (e.g. stroking, kneading, gliding, percussion, effleurage, petrissage) were at the discretion of the massage therapist to allow for treatment individualisation based on client needs and therapist preference.

Somewhat amusingly, specific post massage instructions to subjects were to drink water throughout the day! Why? Oh the humanity …

The two licensed massage therapists who gave the treatments were both employees at the rehabilitation centre.

Participants identified specific physical benefits of massage, including pain relief, tension release, stopped muscle spasms, improved sleep, and physical relaxation. Nearly every participant reported that the massage program improved their mental health by decreasing their feelings of anxiety and helping them to let go of stress during a very difficult time. Significantly, they also indicated that the massage program was critical to them slowing down and implementing self-care. Another significant benefit of the program was that it positively affected participants' feelings about the hospital and the health care team caring for their family members.

Interestingly, there was no between-group difference in the outcomes: those receiving the lower dosage massage (once per week) experienced the same reduction in psychological distress as those receiving the higher dosage (3 times per week).

The findings of this study suggest that massage services would not only be welcomed but also beneficial for improving the psychological wellbeing of family caregivers to patients in medical rehabilitation. The lack of between-group differences in outcome has implications for practice, especially since time commitment and scheduling concerns were noted among caregivers in the higher dosage group.

Interdisciplinary Perspectives on the Value of Massage Therapy in a Pediatric Hospice[6]

This is an incredibly interesting, small phenomenological study that explored professionals' perspectives on the value of providing massage therapy to support children in hospice care, their families and staff. It was conducted at Canuck Place Children's Hospice in Vancouver, where students at West Coast College of Massage Therapy complete a supervised clinical placement, delivering an average of 496 supervised treatments each year to individuals in care, families, volunteers, and the hospice care team. That's a pretty sizeable in-hospice program!

The research participants comprised six clinicians who had experience with the massage therapy practicum at Canuck Place. Semistructured individual interviews were conducted to explore the experiences, beliefs, and perspectives of the clinicians regarding the value of massage therapy in the hospice.

The major themes that emerged from the interviews were grouped into three categories: practical support, physical support and psychosocial support. The clinicians who were interviewed expressed joy at seeing children, families, and staff enjoy and benefit from a massage. Massage was seen as a gift that clinicians enjoyed receiving and offering. Making massage therapy available in the hospice was thought to reinforce the organisational belief that self-care is important.

The clinicians also valued massage therapy for its role in supporting staff and caregivers' physical comfort, as well as for injury rehabilitation and injury prevention. But perhaps most significantly of all, massage was perceived to be a way of fostering dignity, connection within oneself, and connection with another and providing valued moments for relaxation and comfort.

I think the best way to encapsulate the ebullience that oozes out of the clinicians who were interviewed for this study is to hurl a series of quotes in your general direction so here goes:

"Being able to promote self-care for all family members, the ill child and the siblings. It's important. When they are here is the time that they need it the most."

"I've seen how it helps people that are going through a very stressful time or a stressful day or just even a stressful afternoon come back from there just looking like wow, like wow! That is exactly what I needed and they can get right back into it and have a better perspective."

"We had an ambulatory child hunched and in obvious discomfort. After the massage, it was like his bones had just melted a little bit and he was just so comfortable. It was just a delight to see in him. It didn't last long, maybe a couple of hours, but in his skin I'm sure that felt like a lot. For me as an outsider of that whole scenario, it was so pleasurable to see him in less discomfort."

If this study piques your interest even just a little, I heartily recommend you read the full article. Guaranteed to melt the heart of even the most hardened sceptic and it's open access to boot. You can download it from here:

https://journals.lww.com/jhpn/fulltext/2019/08000/Interdisciplinary_Perspectives_on_the_Value_of.13.aspx

Pregnancy massage

The narrative around pregnancy massage somehow remains a bit of a hot mess. Persistent myths still abound about the safety of treating pregnant women with massage therapy, in spite of quality research and evidence that consistently shows that the risks are extremely low.

The side effects and mother or child related physical harm from massage during pregnancy and the postpartum period: an observational study[7]

This is an Australian study conducted by one of our very own, Dr Sarah Fogarty, who has been researching pregnancy massage therapy for the past few years.

It is an observational study of 101 pregnant and post-natal women (up to six months post-natal) who received massage at one of two massage clinics located in Sydney and Melbourne between December 2016 and December 2017. The main presenting complaints of the cohort were lower back pain (33.7%), hip pain (23.8%), shoulder pain (20.8%) and pelvic pain (18.8%).

The two massage therapists who performed the treatments had treated over 700 pregnant clients, worked in a practice that focused on pregnancy and post-natal massage, and had undertaken specialised training in pregnancy and post-natal massage.

The study found that 40% of participants experienced one or more post-massage side effects, the most common being post-massage soreness and tiredness/fatigue. There was no mother or child related physical harm as a result of massage. Significantly, 97% percent of the cohort received a full body massage including the feet, which kinda blows that whole "avoid certain points on the feet during pregnancy" chestnut to pieces. However, the authors point out that the study was not sufficiently powered to determine the safety of pregnancy massage.

A Pilot Study of Partner Chair Massage Effects on Perinatal Mood, Anxiety, and Pain[8]

This is a tiny pilot study involving only 12 pregnant women, no blinding and freakin' enormous risk of bias but I have decided to feature it in this overview because it provides an interesting counterpoint to Sarah Fogarty's study.

This study examined the effects of a chair massage given by partners on perinatal mood, anxiety and pain. That's right. While the previous study involved massage therapy provided by therapists with specialised training, the people providing treatment to their pregnant partners in this study received a one-time training in how to give a 10-minute chair massage protocol. The training lasted less than an hour. The massage techniques taught were intended for relaxation, support, and pain management. Skill level: expert (cough)!

Couples were asked to perform the 10-minute protocol at home, twice weekly for eight weeks, for a total of 16 study sessions.

Although the sample size for this study was miniscule, the design addresses some of the key barriers to health care seeking and gaps in understanding health outcomes by adapting the intervention to the use of standard household equipment (a chair), in-home training, and less delivery time. The significance of managing perinatal mood, anxiety, and pain at home, promoting the health of families, and providing an accessible complementary treatment is what makes this research a bit more compelling.

At baseline, the pregnant women in this study showed an average mood score of approximately 8 points—a score considered to be near, but below, the threshold of nine or 10, consistent with clinical concern. After eight weeks of partner-delivered chair massage, perinatal mood scores had decreased to an average of 4.5 points, no longer of clinical concern.

At baseline, pregnant participants self-reported average anxiety score of 22.5 points, indicating a sample with more symptomology than the general population (19 points) of females at 32 years of age. After the chair massage intervention, average anxiety scores decreased, demonstrating scores (15.5 points) which is lower than symptomology reported in the general population of women the same age.

There were no statistically significant reductions in pain. Regardless, those are some pretty solid gains on the mood front from a protocolised chair massage delivered by someone who not only lacks specialised training in pregnancy massage but indeed lacks formal training in any kind of massage.

A wise man once said to me that we would never be able to fully regulate massage because you'll never stop parents massaging their babies. Studies like this also remind us, thankfully, that we will never be able to stop partners from massaging each other. There's a hell of a lot of pregnant women surviving completed untrained rubs from their loving spouses. Long may this continue no matter how hard it is to kill off the myths about massage during pregnancy.

Osteoarthritis of the knee

Efficacy and Safety of Massage for Osteoarthritis of the Knee: a Randomized Clinical Trial[9]

This RCT received a fair amount of media coverage so you might be familiar with it. We featured some of the reporting on AMT's public Facebook page.

I wanted to include it here because it represents such a brilliant challenge to our cognitive biases around specificity of treatment and techniques. All the therapeutic benefits reported in this trial arose from a generic, full body Swedish massage – no remedial techniques, no specific work on the knee, no jiggery, no pokery, no sucking or pricking, no tissue torture, no heroic therapeutic narrative.

It's also a pretty big study. Five hundred fifty-one people were screened for eligibility, 222 adults with knee osteoarthritis enrolled, 200 completed 8-week assessments, and 175 completed 52-week assessments. Eligible participants were individuals with radiographically established knee osteoarthritis who met American College of Rheumatology criteria, were at least 35 years old, and had a baseline score of 40 – 90 (out of 100) for knee pain on the visual analog pain scale.

Subjects were randomised to one of three study arms: Swedish massage, light-touch, or usual care. This design assessed the initial and long-term effects of an 8-week course of weekly massages and the utility of biweekly maintenance dosing. Swedish massage was compared to weekly light-touch treatments (active control) and usual care (passive control) at 8 weeks (primary study endpoint), 16 weeks, and 24 weeks.

Participants randomised to receive Swedish massage received 60 minutes of whole-body massage, which followed a standardised protocol. The light-touch protocol involved the massage therapist gently placing their hands in a specified sequence on the major muscle groups and joints of the participant for 60 minutes.

The data collected from this study indicate that 8 weeks of massage provided a statistically and clinically significant improvement of osteoarthritis symptoms. At 8 weeks, massage significantly improved WOMAC arthritis index scores compared to light-touch and usual care. Additionally, massage improved pain, stiffness, and physical function WOMAC subscale scores compared to light-touch and usual care.

After 52 weeks, massage maintained the same improvements that were observed at eight weeks but there were no additional benefits.

To paraphrase another wise man's comments in this very yearbook, wouldn't it be kinda funny if it turned out that all our fancy techniques and tools were bested by basic general massage? Haha, oops.

Post burn scarring

Randomized controlled trial of the immediate and long-term effect of massage on adult postburn scar[10]

I wanted to include this burn scar study in the overview partly because it contains a statistic that blew my head off: manual massage therapy is a treatment modality that 81% of burn therapists and 100% of pediatric burn therapists in the United Kingdom report using for burn scar. Given the ubiquity of massage therapy in the treatment of burns scars, it seems like a pretty sound idea to test for therapeutic benefit. The objective of this study was to examine the changes in scar elasticity, erythema, melanin, and thickness immediately after a massage therapy session and after a 12-week course of treatment compared to usual care.

The theory behind using massage for burns scars is that, by manually applying mechanical forces to the scar, there is a realignment of the extracellular matrix proteins and/or a reduction in edema resulting in increased pliability and reduced thickness of the tissue.

This small trial was conducted over a 7-year period in a rehabilitation hospital in Montreal. Seventy participants were enrolled in the study, which consisted of 3 massage treatment sessions per week on a scar site, delivered by trained massage therapists, occupational or physical therapists with extensive experience in treating burns. The study used an "intra individual" design, which meant that the massage scars were compared with a usual care "control" scar on the same person to ensure that the characteristics of the scars were as homogenous as possible: the baseline assessment of scar characteristics at the control and massage site were similar. Usual care consisted of regular application of moisturisers, pressure therapy and gels if the therapists determined they were required, in addition to stretching and strengthening exercises, and activities of daily living training.

There was an increase in scar elasticity with massage therapy with a statistically significant group difference at 2 weeks. However, there were no other significant group differences in elasticity at any other time point. The between-group difference disappeared completely at 12 weeks.

There was also a reduction in scar thickness immediately following massage with a statistically significant group difference at week 3. But again, there were no other significant group differences in thickness at any other time point. The between group differences in scar thickness also disappeared completely at 12 weeks.

The authors concluded that massage therapy has an immediate impact on scar physical characteristics, but no long-term benefit – there is no significant long-term changes in elasticity, erythema, melanin, or thickness of postburn scars following 12 weeks of massage therapy compared to an intra-individual control site.

This seems like an excellent example of natural history perhaps tricking us into believing that our treatment is effective. The immediate changes and between-group differences that occurred around week 2 and 3 may lead us to believe that massage therapy has a benefit, however, these changes turn out to be transient and probably do not result in any long-term therapeutic benefit.

It's a sobering thought.

Health behaviour change

Health Behavior Change and Complementary Medicine Use: National Health Interview Survey 2012[11]

As we all know, complementary and alternative medicine (CAM) cops a bit of a hammering from conventional medical sceptics. One of the arguments against validating CAM is the claim that it delays or prevents patients from accessing conventional medical care. I have pulled this study out of the pile of research published this year because it analyses the positive health behaviours that participants reported that their CAM use motivated: eating healthier, eating more organic foods, cutting back/stopping drinking alcohol, cutting back/quitting smoking cigarettes, and/or exercising more regularly. (The extent to which massage therapy is aligned with CAM or conventional medical care will have to remain a debate for another day.)

It's a large sample - the data analysed was drawn from the 2012 National Health Interview Survey involving 10,201 CAM users living in the United States who identified up to three CAM therapies most important to their health.

Overall, 45.4% of respondents reported being motivated to make at least one health behaviour change after using CAM. Approximately, one third of respondents reported being motivated to exercise more regularly (34.9%) or to eat more healthily (31.4%); 17.2% of respondents reported being motivated to eat more organic foods; 16.6% of smokers reported being motivated to cut back or stop smoking cigarettes; and 8.7% of alcohol drinkers reported being motivated to cut back or stop drinking alcohol.

Although survey respondents self-reported being motivated by their CAM use to change health behaviours, it's worth noting that it remains difficult to establish whether CAM use directly and independently motivates behaviour change, or whether being predisposed to make health behaviour changes drives the choice to use CAM.

It's also worth noting that use of massage therapy showed the lowest levels of association with reported motivation to make positive health behaviour change.

Perhaps unsurprisingly, diet and exercise/movement interventions showed the most significant impacts on motivation to change health behaviours. There may be some takeaways for us here in terms of ensuring that there is always an active element in our treatment plans that foster an internal locus of control in our clients.

This is an incredibly interesting open access article, chock full of great references that challenge the narrative around CAM therapies and conventional medicine. I highly recommend you take the time to have a read of the full study.

Professional Identity

"I am a healthcare practitioner": A qualitative exploration of massages therapists' professional identity.[12]

Since the recent announcement that the Department of Education is funding a new Advanced Diploma qualification under the Health Training Package, discussions about professional identity have raged in various social media forums. Before the qualification has even been developed, the issue of what it should be named has fuelled much of this chatter.

I must admit, the conversation leaves me wondering in true Carrie Bradshaw fashion – if such a significant percentage of massage therapists are desperate to disassociate what they do with the term "massage" where does that leave the massage-going public who inconveniently appear to still love massage?

This qualitative study provides some interesting insights into how registered massage therapists in Ontario view their professional identity. It explores the perceived division between those who identify as healthcare providers and those who identify as service providers. Sound familiar? This split appears to underscore the arguments we continue to have in Australia around professional title and branding.

This might also sound familiar:

"Massage therapists described a desire to be recognized as healthcare professionals, but feeling like an outsider in the healthcare system. Some of these feelings stem from actually being outside of the publicly funded healthcare system. Although there are many healthcare professionals who work outside of a hospital setting, massage therapists talk about feeling separated from most healthcare professionals. This is not helped by the lack of involvement of massage therapists in interprofessional education, both in their own education and that of other healthcare professionals."

This qualitative exploration clearly shows we have much in common with our Canadian cousins.

Massage and interoception

Are the antidepressive effects of massage therapy mediated by restoration of impaired interoceptive functioning? A novel hypothetical mechanism.[13]

It's really a bit of a heinous mistake to leave what I would consider to be the most important published article of 2019 till I am the better part of 5000 words into this overview. Ack!

This paper is not an RCT or a study but rather a hypothesis that seeks to explain a possible underlying mechanism for how massage therapy alleviates the symptoms of depression. I have been expecting someone to articulate this hypothesis for a few years now and it seems the moment has arrived.

But don't just take my word for it, here is the epic abstract from this article:

"Interception is an individual person's sense of the physiological condition of his/her entire body. Recent research has shown that depression is associated with impaired interoceptive accuracy. Treatments that can improve disturbed interoception are scarce in clinical practice and could complement established therapies. Accumulating evidence suggests that massage therapy significantly alleviates symptoms of depression. However, the mechanisms underlying these effects have remained unclear.

"We are going to propose a novel mechanism linking these antidepressive effects to a massage-induced modulation of interoceptive states. Particularly affective massage therapy applies slow, rhythmic, and caress-like touch that stimulates C tactile (CT) afferents in the non-glabrous skin. CT mediated touch elicits responses in interoceptive brain areas (e.g. the insular cortex) that have been associated with abnormal interoceptive representations in depressed subjects. Thus, we hypothesize that antidepressive effects of massage therapy are mediated by restoration of the impaired interoceptive functioning through stimulation of CT afferents or related interoceptive structures. If our proposed mechanism is valid, massage is probably one of the most ancient interoceptive treatments."[14]

As the abstract implies, this article incorporates some pretty hefty neurophysiology but it is completely worth the price of admission. It's hard to overstate its significance in terms of helping to support the role and relevance of massage therapy in an increasingly overstretched health care system struggling to come up with a meaningful response to a mental health epidemic. It also reinforces the increasingly impossible-to-ignore evidence that the traditional canon of basic, light long strokes that form the foundations of our massage therapy practice are the most effective tools we have in even the most extended toolbox. Back to basics …

Please have a look at this article. You can use SciHub to crack it open.

The therapeutic relationship

The Psychotherapeutic Relationship in Massage Therapy[15]

You know it's been a pretty cool year in massage therapy research when you get to feature two pieces of research by AMT members. Tim Clark's Masters' Thesis examined the psychotherapeutic relationship in massage therapy and this paper reporting on his qualitative masters research is the best argument you could hope to find for investing in self reflection and self awareness as a practitioner.

Tim's article is also the perfect way to round out this overview of a year in massage research because it amplifies and underscores the strongly emerging theme of many of the current investigations – the psychotherapeutic effects of massage therapy are the new black of massage research. It turns out that the emperor's new clothes are actually the emperor's old clothes after some loving repair and a good hot wash. Our research focus is rapidly shifting away from the purely biomechanical dimensions of massage therapy as we re-embrace our holistic roots and systematically explore the psychosocial dimensions of our gorgeous craft.

The queen is dead. Long live the queen.

About the author

Rebecca Barnett has been at the coalface of professional advocacy for 12 years. Her proudest achievements include the release of the AMT Code of Practice in 2013 and the establishment of AMT's classified massage therapy research database. She's still not sure whether to be proud of, or horrified by, those nine stressful months of negotiation with Medibank Private back in 2014. The resulting baby was one that only a private health insurer could love.

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