REGISTERED MASSAGE THERAPISTS ASSOCIATION OF BC

RMTBC

The RMTBC REVIEW

Massage Therapy in BC

TREATING DIVERSE POPULATIONS

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INSIDE

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REGISTERED MASSAGE THERAPISTS
ASSOCIATION OF BRITISH COLUMBIA

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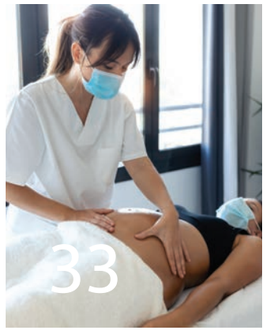

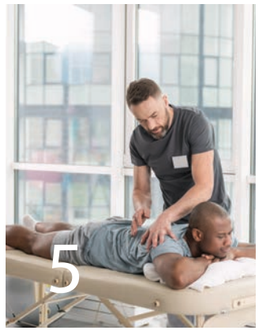

THIS ISSUE

GUEST ARTICLE

MASSAGE THERAPY IS HEALTH CARE. START ACTING LIKE IT.

It's unpopular to say, but being human is a chronic condition.

All humans, even the most fit and healthy of us, are living in bodies that will break down eventually.

Some bodies will break down more slowly than others and all will do so in different ways, but whether you provide massage in a nicely outfitted corner of your basement or in the fanciest of the fancy hospitals, you are working with people who are either in a state of disease or who will be at some point. That is simply the truth.

If you are occupying a professional space — and I'm not talking about your practice space, I'm talking about how you present yourself to your clients and how you think about yourself as a practitioner — as a massage therapist, you are providing health care. As such, your clients' expectations of your ethical standards and behavior should be high.

Article by
Cal Cates, LMT

WHAT DO YOU EXPECT

IN TERMS OF COMMUNICATION, SAFETY, PRIVACY, ETHICS WHEN YOU SEE A DOCTOR? HOW ABOUT A PSYCHOTHERAPIST OR A DENTIST?

Do you want them to know about and understand the latest science and research about their discipline — or do you want them to guess and tell you what worked for them when they had a stomach problem?

Think about this.

Are you providing the same level of professionalism and responsible attention that you expect of others you trust with your health?

Stay in Your Scope

Your clients may not know it, but they want you to behave like a health care provider and to treat them as the most trusted of their providers would. Which means, if you are a massage therapist, your clients are paying you to do a lot.

They certainly want you to make them feel better.

They want you to listen and to care about what they're saying and even about what they're not saying.

They want you to be perceptive and curious and, possibly above all else, to know what you don't know.

This last bit is a place where massage therapists really fall down. Our clients want a lot from us, but they do not want us to be dieticians or personal trainers or life coaches; at least, not while they're on our massage tables, interacting with us as their massage therapist. They may think they want these other things, but they don't realize that armchair dietary advice, life advice and workout tips are things best delivered by their nosy neighbor ... and then forgotten.

It's our job to realize that.

We do this thing where we decide that our "n of 1" which means, "It worked for me, so that's proof it works," is enough to empower us to share our lived wisdom about carbs, keto, ballistic stretching, circuit training, aromatherapy alarm clocks or whatever else.

It's not.

We are not Louise Hay. We are not Dr. Oz. Let's just feel the relief in that.

Just Be Good at Massage

As massage therapists, we often become very familiar and comfortable with our clients over time. This trust is actually part of what's therapeutic about massage therapy, but this also makes it easy to think, "Well, I wasn't telling them about kale smoothies as a massage therapist. I was just telling them as 'me.'"

The fact that we are their massage therapist lends a sometimes unintended weight to any health-related advice we offer. We have to know this and it has to matter.

We dilute our effect when we creep out of our scope. Let's just be good at massage therapy when we're in the role of massage therapist. When we are good at massage therapy, we are doing so much more than we may think.

We are supporting one of those humans I mentioned earlier; the ones in the breakable bodies.

We are speaking kindly (I hope) to the nervous system in a way that allows the whole body to simply "do better." We are spending an hour of our time easing the experience of another person.

All of this happens, even if (and maybe especially if) we hardly open our mouths and definitely if we stay solidly within the bounds of massage therapy's scope.

Let that be enough. It's a lot.

LET'S MAKE A PACT TODAY TO STOP DOING SOME REALLY COMMON THINGS THAT ARE HURTING OUR PROFESSION AND OUR CLIENTS:

- *Making claims for which we have no scientific proof: "massage releases toxins"; "I'm lengthening your IT band."*
- *Blaming the lack of research on big pharma: "The pharmaceutical companies don't want people to know how effective massage is, but we wouldn't even need pain medicine if massage was available to everyone the way medicines are."*
- *Making treatment plan recommendations with our wallets instead of our brains: You have a client who has chronic shoulder pain. After the first session, they ask you when they should come back. You think two weeks or even three is probably a good starting place, but rent is due at the end of next week, so you tell them to come next week ... before your rent is due.*
- *Repeating advice we read on Facebook: "If you rub your arthritic knee with turmeric, you won't need surgery"; "A pickle a day will prevent Alzheimer's disease."*
- *Saying, "That's what I learned in massage school" as a rationale for treatment plans or in support of outdated and inaccurate physiological explanations. Such as: "Never massage a woman in the first trimester of pregnancy" and "clients are sore after a massage because your work released lactic acid in their muscles"*

Watch What You Say

What happens in our offices is not research. The successes and failures on our tables are useful and they will help us build a body of knowledge that will, indeed, support us in making better and more effective treatment choices over time, but we have to be responsible in how we employ this knowledge and certainly in how we talk about it.

Maybe you do a thing that "always" helps people with hip pain. This could be the beginning of a case series. It could be the beginning of a hypothesis or an actual research question, but it leads very easily to what's called specious reasoning.

Merriam Webster defines specious as "superficially plausible, but actually wrong. Misleading in appearance, especially misleadingly attractive." When the "evidence" makes us look good or feel good, it's tempting to just run with it, but this is not a responsible way to understand our work.

In the classes I teach, I sometimes illustrate this point with what might seem like a silly trope. I point at my wristwatch and I say, "This watch repels tigers." As you might expect, students laugh, but they laugh uneasily because it's obviously a setup of some kind.

They just can't tell what kind exactly, so they wait.

After a few moments, I lean in, smile and say, "Wanna know how I know?" I wait just a second or two longer and then motion around the surrounding area triumphantly, "See any tigers?" They all laugh because clearly the absence of tigers proves nothing in this fourth-floor classroom in a suburban city in the Midwest, but this is what we're doing when we tell clients about the results they can expect based on our experience with our own injuries or with the bodies of other people we've touched.

Our office is not a place where strictly scientific evidence can be gathered, so share the data you gather in a way that leaves room for discovery and question.

You Should Already be Busy

If the body is our scope, we must commit to learning all of the body's systems in functional, contextual, relevant and factual detail. That will keep us plenty busy without ever mentioning the wonders of asparagus or cayenne lemon water.

If you'll excuse the cliché, we are the ones we've been waiting for.

We will not transform health through policy; not by creating it and not by hating it. Nobody else cares about massage therapy enough to save us from ourselves. The kind of change that will elevate this profession and the opinion of this profession that is held by those outside of it will be the result of collective action, individual investment and empowerment to create and hold a high standard.

It's unlikely that we're gravely injuring anyone with our lay advice and flimsy theories, but to assume that we're not harming people, or better yet, to assume that we're actually caring for them responsibly and ethically is myopic at best.

Please consider that what we're really harming is the massage profession.

Cal Cates, LMT

Cal Cates is a massage therapist and executive director of Healwell, which provides massage therapy in hospitals, conducts research and provides advanced, clinical education. Experience in hospitals around the U.S. has informed their blend of nerdiness and authenticity to create opportunities to be more effective, more human and more flexible. (Lauren is gender fluid and uses the pronouns they, their and them.)

EDITORIAL

EQUITY, DIVERSITY, & INCLUSION IN THE MASSAGE THERAPY PROFESSION

This article was first published by the International Journal of Therapeutic Massage & Bodywork, highlighting important work in the field of Registered Massage Therapy and diversity.

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KEYWORDS: minority groups, ethnic groups, health occupations, health services accessibility, African Americans, massage therapy, primary health care

It has been documented that there are disparities in who seeks massage therapy in the United States. Yet, there are few conversations about race and ethnicity of the massage therapists who provide these services. We must examine the diversity, equity, and inclusion within the massage therapy profession and consider how the profession can improve the landscape for clients/patients and for those who feel called to work within this field.

Although the diversity of the profession and those who seek treatment are rarely discussed, this paper explores these issues and offers possible solutions to expand the diversity of the profession and patient population.

It is now the middle of June 2020, and it has already been quite a year. The Covid-19 pandemic caused most in the massage therapy profession to shut down in March/April either due to statewide mandates, personal choice, employer decisions or a combination of these or other reasons. This time of uncertainty led to the launching of a new study, Project COPE: Chronicling healthcare providers' Pandemic Experiences, which is gathering insights to all types of health professionals' experiences, including massage therapists, during this unprecedented time in our history. This project also led to a new collaboration between a fourth-year medical student (OB) and her professor (ABK), one Black and one white.

At the beginning of our project we spoke about how during this time of shut down, one of the prime ways for individuals to manage stress (massage therapy) was not available. We suspected that this was impacting many, including this medical student who regularly receives massage therapy. It appeared that the uncertainty of when massage therapy practices would re-open was causing stress not only for patients/clients but also for the massage therapists who were out of work.

"While one new person on a team who is Black cannot be expected to provide perspectives for all Black people, even one person's ideas can help to shift the team."

As we were beginning our work together, we also had a very frank discussion about race. While the research team was very interprofessional and multi-institutional, it was all white. While some aspects of diversity were clearly present, the main missing one was race. To be explicitly clear, we discussed how, while one new person on a team who is Black cannot be expected to provide perspectives for all Black people, even one person's ideas can help to shift the team. Our work together began in April and continued to progress. The pandemic continued but states began to open up. Students were again allowed in the clinical environment, and massage therapy was being offered again. And then it was May 25th, and George Floyd was murdered by a police officer, and the world seemed to finally take notice.

There seems to be a shift in society, and more and more people are beginning to wake up to the reality that Black and Brown people are treated differently in the United States. Princeton University has provided a link to sources concerning Black Lives Matter: Policing and Incarceration.[1] Included in the information they offer is a map of all the locations worldwide that have held protests, and as of June 14, nearly 3,500 protests have occurred since May 25, 2020. While it is long overdue, now we must examine the diversity, equity, and inclusion within the massage therapy practice and consider how those in the profession—from researchers, to educators, practitioners, and associations—can improve the landscape for clients/patients and for those who feel called to work within this field.

INVESTIGATING DIVERSITY

United States Massage Therapy Patients/Clients

To begin, we need to consider who are receiving massage therapy in the US. Studies have indicated that there is both a gender and racial disparity in who seeks out massage therapy.[2–4] Results from the National Health Interview Survey (NHIS) which specifically asked questions about complementary and integrative health (CIH) utilization in 2002, 2007, and 2012 showed there was a widening gap in who sought these services by race/ethnicity.[3] While non-Hispanic whites were increasing usage of CIH, Hispanic adults and non-Hispanic Black adults saw a decrease in usage.[3] Considering the data from the 2012 NHIS only, Sundberg et al. found those who were living in the Western part of the United States, non-Hispanic white, and female were more likely to report receiving massage therapy within the last year compared to males, minority populations, and those living in areas other than the Western US.[2] The 2017 NHIS CIH supplement did not include questions about massage therapy. In 2019 and 2020, NHIS included questions about chronic pain management with massage as a management option; those data are yet to be reported. While the most recent data on massage therapy usage by race/ethnicity in the US is from 2012, the three time points do allow us to see a trend in the US showing racial and ethnic minorities accessing massage therapy services less often than non-Hispanic white individuals.

Massage Therapists in the United States

Who receives massage therapy though is only one piece of the equation; we also need to consider who is providing massage therapy. If Black people do not receive massage therapy as often as their white counterparts, then it is not too difficult to imagine that there may be a low number of Black massage therapists, especially when media reflects this disparity. For example, a quick investigation of "massage therapy" in Google images will overwhelmingly provide pictures of white women both giving and receiving massage. These images are a reflection of the profession and the patients who generally receive treatment. This is further reinforced by other media that largely excludes the Black community and instead highlights the middle-upper class white woman surrounded by candles and flower pedals enjoying her day at the "spa." The bottom line is that representation matters. When you do not see yourself included in the field, you are less likely to pursue a career in the field. When you consider these factors alone, it is no wonder that there are not many black massage therapists in the field. When there is little experience in or exposure to the service, it is hard to imagine or realize the career opportunities available.

The US Bureau of Labor Statistics provides some information about the state of massage therapy in the country indicating that 83.6% of the profession are women and over 70% white.[5] Compared to other professions that are either in a similar category (health-care support occupations) or similar field (CIH), massage therapy is more similar in racial/ethnic demographics to chiropractors and physical therapy assistants than to other health-care support professions (Figure 1).[5] For massage therapy, these 2019 data show an increase of 3.3% for Black/African Americans compared to a report of diversity in health occupations from 2011–2015 from the US Department of Health and Human Services.[6] The racial/ethnic makeup of a profession is important because when there is a diverse workforce there can be improvements in patient satisfaction and access to care for those from minority populations.[6–9]

Disparities in Treatment, Access, and Education

From the above information it is clear that not only are there fewer Black people getting massage therapy but there are also fewer Black massage therapists. We believe these two observations are inextricably linked. The lower numbers of Black people receiving massage likely contribute to the low numbers of Black massage therapists in the field in a cyclical manner. The lack of personal exposure leads to fewer exploring or even realizing the professional opportunities available. Therefore, in order to begin discussing the lack of Black representation among massage therapists, we must first examine why Black people receive less massage. We think there are three main factors driving this observation: economics, education, and access.

First is economics. The Black community may not access massage therapy services as much as other communities because massage may be seen as a "luxury." In a recent podcast, Benny Vaughn explains his belief that in the African American community massage is something that "only rich people do..."[10] Therefore, massage may be a service many believe they cannot afford. Furthermore, Black communities are disproportionately economically disadvantaged[11] so they will be less likely to seek a service that is deemed as indulgent because they feel that they must prioritize "essential" needs.

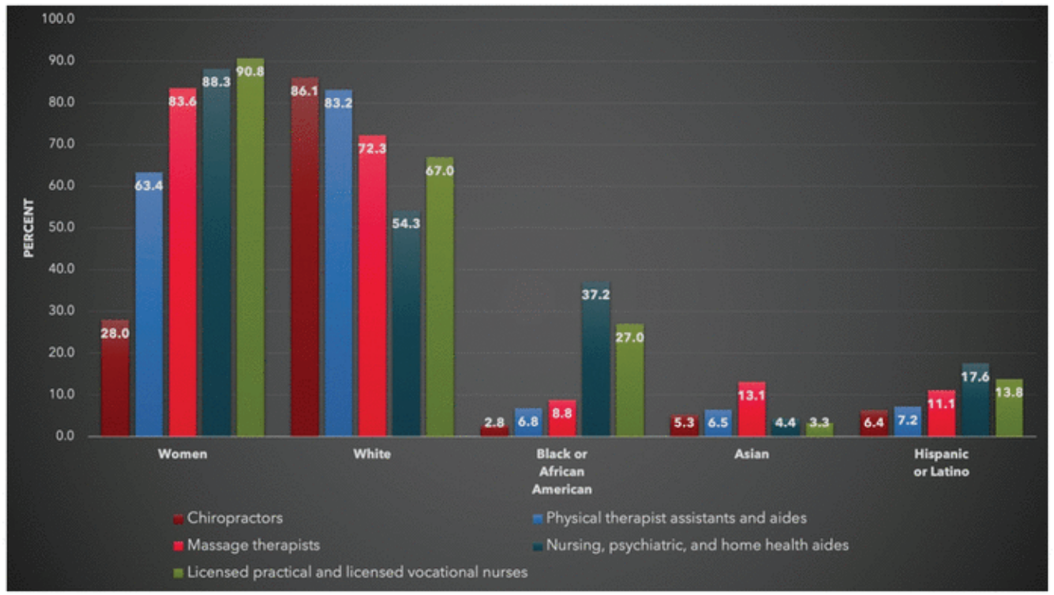
Although, it has been reported that 21% of US adults received a massage in 2019, and that consumers believe in the efficacy of massage, the racial breakdown of these numbers is not clear.[12] There is probably even more of a gap in education in the Black community, considering the tendency to have lower levels of health literacy in general when compared to white communities.[13]

Finally, Black people in the United States may be receiving less massage due to lack of access to treatment. The states with the highest concentration of massage therapy jobs (Hawaii, Colorado, Alaska, Washington, and Nevada)[14] do not have a large population of African Americans.[15] The public may also not be aware of different types of locations where they might receive massage therapy as it is generally portrayed in the media as available in luxury/spa type locations. Many may not know how to access lower cost options such as franchises or independent massage therapists. Furthermore, there may not be accessible massage therapy practices in lower income neighborhoods, though that has yet to be explored.

While economics, education and access are just a few factors we believe may be contributing the trends described above, there may be additional factors at play. Unfortunately, these issues are not unique to massage therapy. We see similar patterns in medicine with only 5% of active physicians

"This is further reinforced by other media that largely excludes the Black community and instead highlights the middle-upper class white woman surrounded by candles and flower pedals enjoying her day at the spa."

Figure 1 Percentage of individuals within select occupations in 2019 by gender and race/ethnicity from data the US Bureau of Labor Statistics(4)



"The bottom line is that representation matters. When you do not see yourself included in the field, you are less likely to pursue a career in the field."

in the US identifying as Black or African American in 2018.[16] Barriers to matriculation and retention in medical education include but are not limited to the cost of applying to medical school, the lack of available guidance or mentorship and, finally, inadequate support from medical school administration. Could these same barriers exist in massage therapy education? To date, there are gaps in the literature pertaining to this very topic which provides opportunity for further investigation in order discover ways to support and increase diversity in the field of massage therapy.

Solutions

First for patients, one way to address the lack of education and access is to integrate massage therapy into more primary health-care settings, similar to the way physical therapy, occupational therapy, and speech therapy has been incorporated. Having your doctor discuss the benefits of massage therapy with you and then actually refer you to an in-house massage therapist could help drive home the point that massage therapy is indeed important. Stussman and colleagues did find that physicians are recommending CIH to patients and of the modalities recommended, massage therapy is recommended more than others.[17] However, it is not known to whom these approaches are recommended. It may be that CIH and massage in particular are only recommended to white patients. Once there is more collaboration between massage therapy and medicine, the focus should then be placed on the affordability of services.

In the iterative process of increasing more Black patients, there also needs to be a way to increase the number of Black massage therapists. One way in particular could be to have increased presence and recruitment efforts at career fairs in predominantly Black high schools. There could also be more courses offered at technical/vocational education programs that could provide students more exposure to coursework in medical terminology, body mechanics, professional ethics, anatomy, and physiology. Some high schools offer vocational programs for students interested in early childhood education, computer science, cosmetology and more, and massage therapy could be integrated into these programs. Attention to the cost of massage therapy education will need to be considered within this context. These types of efforts could provide early exposure to the field, garner interest, and start students on the tract to licensure.

Once there are more Black massage therapists. there needs to be more outreach into the communities to let people know about the availability of services and therapists. In the aforementioned podcast, Benny Vaughn indicated that once he employed a Hispanic therapist in his clinic, the number of Hispanic patients increased exponentially.[10] By increasing the diversity of the profession, we may also then increase the diversity of those who seek massage therapy.

Finally, as researchers and research participants, we need to track and continue to examine who is receiving and providing massage therapy based on multiple demographics including race/ethnicity. For those participating in research, it is vitally important that there are truthful answers when asked about race/ethnicity. For example, when asked about race/ethnicity a past responder in one of our studies selected the option "another/not listed". This participant then filled in the blank provided to expand on this selection with "there is only one race, the human race". Answers such as these do not allow us to track the success or failure of diversity and inclusion efforts.

The diversity of the massage therapy profession and those who seek massage therapy treatment are not topics that are often discussed, in our view. We need to consider who is at the (massage) table and who has been traditionally excluded. Once we start recognizing these inequities, we can work to dismantle them and bring others to the table for work and for treatment.

"One way to address the lack of education and access is to integrate massage therapy into more primary health-care settings, similar to the way physical therapy, occupational therapy, and speech therapy has been incorporated."

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PRACTICE

MASSAGE THERAPY EFFECTIVENESS IN REHABILITATION ON HUMERAL SHAFT FRACTURE IN A CHILD: A CASE STUDY

INTERNATIONAL JOURNAL OF THERAPEUTIC MASSAGE AND BODYWORK—VOLUME 15, NUMBER 1, MARCH 2022

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KEYWORDS: child; humeral fracture; massage; rehabilitation

OBJECTIVES: This case report aimed to explore the process and outcomes of a seven-week massage therapy treatment on post-surgical intervention to reduce humeral shaft fracture.

PARTICIPANT: An active 9-year-old girl who recently moved in the region and who underwent two surgeries following a humeral fracture with displacement after a fall at school.

INTERVENTION: The treatment used various techniques such as manual lymphatic drainage (MLD), myofascial release (MFR), therapeutic massage, and neuromuscular techniques (NMT) in conjunction with the physiotherapist rehabilitation programme to help the client recover both physically and emotionally from the trauma. Evaluation of the outcome measures (OM) took place throughout the study and after the four-week interim that followed the intervention period.

RESULTS: The massage therapy intervention indicated improvement regarding range of motion (ROM) and muscular strength. The clients' progress using the Patient-Specific Functional Scale (PSFS) indicated a gradual evolution to reach almost a 95% gain, and the Upper Extremity Function Index (UEFI) also showed improvement in everyday activities with a 21.5% positive change. The Child Outcome Rating Scale (CORS) and subsequent Child Session Rating Scale (CSRS) monitored therapeutic progress and indicated improvement on biopsychosocial (BPS) aspects throughout the treatment.

CONCLUSION: The client felt strong and more confident after each massage intervention. A combination of techniques and the child's empowerment positively affected the client's overall wellness and confidence to return to activities.

This article was first published by the International Journal of Therapeutic Massage & Bodywork, highlighting important work in the field of Registered Massage Therapy and patient rehabilitation.

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"There are significant differences in the type of injuries sustained by children compared to adults."

INTRODUCTION

Musculoskeletal conditions and injuries are common throughout one's lifetime and represent the most significant need for rehabilitation globally.[1] Fracture with a displacement of the bone appears in 20% of fracture cases, and Open Reduction and Internal Fixation (ORIF) surgeries are needed to secure the bone in position.[2] The World Health Organisation noted in 2019 that "between one in three and one in five people (including children) live with a musculoskeletal pain condition."[1] Nearly 20% of children who present with an injury have a fracture, with an estimated 27% of girls sustaining a fracture during childhood.[3] Fractures occur more often in the paediatric age group than in adults; however, proximal humeral fracture (PHF) is relatively uncommon in children.[2,4]

In New Zealand, the 2016 provisional number of injuries estimated that 194 children under the age of 15 suffered from serious (fatal and non-fatal) fall injuries; falls and motor vehicle crashes are the most frequent causes of fractures.[4,5]

This case study will explore the effects of massage therapy on a child diagnosed with a humeral shaft fracture resulting from trauma, presenting with limited range of motion (ROM) and muscle weakness in her left arm. To see the effectiveness of massage therapy post-surgery, the therapist has performed seven 45-minute interventions. The study started with an initial assessment before the hands-on treatment began and ended with a follow-up session four weeks after the final massage therapy intervention.

METHODS

Client Information

The client is a right-handed, 9-year-old girl. Both she and her parents describe herself as having excellent general health. The client is active and usually spends about five hours a week doing various physical activities and helping her parents at home.

In January 2020, she moved from another region before the school year started. She socialised rapidly, and almost started a new activity when the country entered lockdown due to the Covid-19 pandemic.

In May, she fell off the top of a jungle gym, head, and shoulder first. The diagnosis was metaphyseal-diaphyseal fracture with displacement of the left humerus, her non-dominant side. After two surgeries, no further surgical intervention is expected as she ages.

She has never experienced massage therapy before but has received hands-on treatment from a physiotherapist as part of the post-surgery rehabilitation programme. She also mentioned suffering from mild contact eczema.

		Initial Measures	*Normal Range*	*Normal Range[a]*	*Mid-Treatment Session 4*	*Final Measures Session 7*	*Follow-Up Measures*
GHJ	F	125°	160°-180°	168° ± 4°	145°	155°	155°
	E	50°	40°-60°	68° ± 8°	60°	60°	75°
	Abd	148°	160°-180°	185° ± 4°	160°	165°	165°
	Add	38°	30°-40°		35°	35°	35°
	MR	110°	70°-80°	71° ± 5°	105°	88°	88°
	LR	21°	80°-100°	108° ± 7°	20°	31°	31°

[a]Paediatric measurements 18 months to 19 years old.
F = flexion, E = extension, Abd = abduction, Add = adduction, MR = medial rotation, LR = lateral rotation.

Table 1 Shoulder Joint Goniometry: Active Range of Motion [29,30]

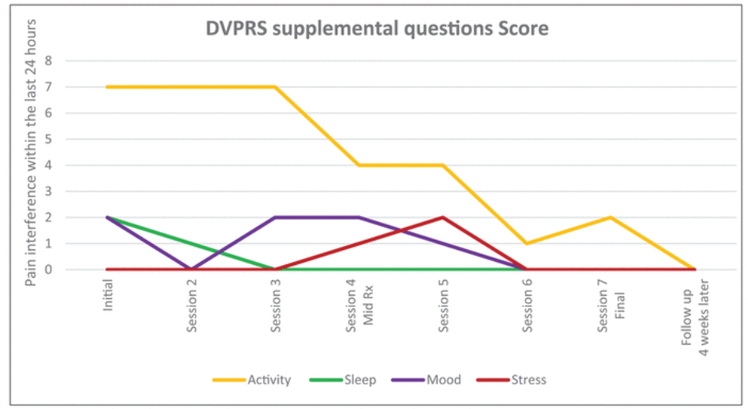

Figure 1 Defense Veteran Pain Rating Scale supplemental questions screening throughout massage therapy interventions and follow-up session. No pain/discomfort is indicated with a 0 on the scale up to 10, where the worst pain/discomfort possible is felt. Rx stands for treatment.

Clinical Findings

The client was no longer complaining about pain; however, weakness in isometric resisted tests at the glenohumeral joint (GHJ), and tissue stiffness resulting from the surgeries, resulted in reduced active and passive ROM in the left shoulder area (Table 1). The massage therapist used the Defense and Veteran Pain Rating Scale (DVPRS®; The Defense and Veterans Center for Integrative Pain Management, School of Medicine, Uniformed Services University, Bethesda, MD) to identify the progression of pain since the injury and to assess the state of mind of the young client. The client stated her pain was maximal at the time of injury, and described the pain as achy radiating on the entire anterior left arm. After the two surgeries, the pain had gone completely. Continuing with the DVPRS® supplemental questions, the client mentioned being affected by mood, and activities such as putting her jacket on, running, and having trouble writing in class even though she is right-handed (Figure 1). The child and her parents did not mention any predisposing factors about the case.

ROM tests performed at the GHJ, elbow joint, and scapula indicated compensatory patterns. Isometric resisted tests indicated weaknesses at the GHJ in all planes but in extension, and weaknesses in protraction and retraction at the scapula. The physiotherapy exercises noted in Table 2 corroborated these findings. Numbness and tingling were also present in posterior and anterior aspects of the hand, a typical clinical presentation after trauma to the shoulder.[6] However, an assessment for nerve pathologies was performed. The upper limb neurodynamic test of the median nerve, done passively with the shoulder instability technique, showed nerve pain when shoulder was laterally rotated, and forearm supinated. The upper limb neurodynamic test of the radial nerve, done passively, showed nerve pathology when shoulder medially rotated, and forearm pronated (see Table 3).[7]

Date of Prescription	*Programme*
27.07.2020	1. Standing: GHJ circles: 5 repetitions, clockwise and anticlockwise
	2. Standing: "Robot": scapula elevation and depression, to repeat with elbow flexed and GHJ slightly abducted
	3. Standing: "Spider" up the wall, relax at the top, and control to descend: 5-10 repetitions
	4. Supine: GHJ "Pull over" hold overhead/as far as can be for 5 seconds, 5-10 repetitions
4.08.2020	1. GHJ abduction with lateral rotation: 5 repetitions
	2. GHJ forward rotation: 10 repetitions
11.08.2020	1. Standing: "Spider" up the wall, stretch at the top for 5 seconds: 5 repetitions
	2. Using a stick: GHJ flexion: 10 repetitions; GHJ abduction with lateral rotation: 10 repetitions
	3. Hand weight (500 g): GHJ flexion to 90° then elbow flexion up to eye level, control to descend: 10 repetitions
17.08.2020	1. push-ups on knees: 5 repetitions
24.08.2020	No physiotherapy session—no exercises given
31.08.2020	1. Sitting: scapula protraction and retraction using towel and the back of a chair
07.09.2020	1. Supine: "Fly", GHJ horizontal abduction with weight (500g): 10 repetitions
	2. Push-ups on knees: 5-10 repetitions

GHJ = glenohumeral joint.

Table 2 Physiotherapy Rehabilitation Exercises

Table 3 Assessment for the Massage Therapy Intervention

Intervention Date		*Objective Assessment*	*ROM*	*Orthopaedic Tests*	*Subjective Assessment*
Pre-intervention 31/07/2020	No intervention	Palpation, Observation	Active ROM at GHJ (+ goniometry), scapula, and elbow joint all planes, Resisted ROM at left GHJ and scapula, Passive ROM at left GHJ	Painful arc test (-), Upper limb neurodynamic of median (+) and radial nerves (+)	UEFI, PSFS, CORS
Sessions 2-3[a]	Pre-intervention	Palpation, Observation	Active ROM at GHJ, scapula, and elbow joint all planes, Resisted ROM at left GHJ and scapula, Passive ROM at left GHJ	Upper limb neurodynamic of median (+) and radial nerves (+) Apley's inferior scratch (+), Cross over (-), and Hawkins-Kennedy tests (-), and Drop arm (+), Gerber's Lift off tests (+)	UEFI, PSFS, CORS
	Post-intervention		Resisted ROM at left GHJ and scapula, Passive ROM at left GHJ	Upper limb neurodynamic of median (-) and radial nerves (-), Apley's inferior scratch (-), and Drop arm (+), Gerber's Lift off tests (+)	CSRS
Mid-treatment (21/08/2020)	Pre-intervention	Palpation, Observation	Active ROM at GHJ (+ goniometry), and scapula, all planes, Resisted ROM at left GHJ and scapula	Apley's inferior (-) Drop arm (+), Gerber's Lift off tests (+)	UEFI, PSFS, CORS
	Post-intervention		Resisted ROM at left GHJ and scapula, Passive ROM at left GHJ	Drop arm (+), Gerber's Lift off tests (+)	CSRS
Session 5-6[a]	Pre-intervention	Palpation, Observation,	Active ROM at GHJ, scapula, and elbow joint all planes, Resisted ROM at left GHJ and scapula, Passive ROM at left GHJ	Drop arm (-), Gerber's Lift off tests (-)	UEFI, PSFS, CORS
	Post-intervention		Resisted ROM at left GHJ and scapula, Passive ROM at left GHJ	Drop arm (-), Gerber's Lift off tests (-)	CSRS
Post-intervention (11/09/2020)	Pre-intervention	Palpation, Observation	Active ROM at GHJ (+ goniometry), and scapula, Resisted ROM at left GHJ and scapula, and Passive ROM at GHJ all planes		UEFI, PSFS, CORS
	Post-intervention		Resisted ROM at left GHJ abduction, medial and lateral rotation and scapula retraction, Passive ROM at left GHJ abduction, medial and lateral rotation		CSRS
Follow-up session (09/10/2020)	No intervention	Palpation, Observation	Active ROM at GHJ abduction, medial and lateral rotation, and scapula retraction	Apley's inferior (-), Drop arm (-), Gerber's Lift off (-)	UEFI, PSFS, CORS

[a]Session 2 (08/08/20), session 3 (04/08/20), session 5 (28/08/20), session 6 (04/09/20).
ROM = range of motion, GHJ = glenohumeral joint, UEFI = upper extremity functional index, PSFS = patient-specific functional scale, CORS = child outcome rating scale, CSRS = child session rating scale, (-) = negative results, (+) = positive results.

"[The intervention] considered the evolution of the strengthening exercises prescribed."

Bilateral palpation showed various points of tightness and tenderness on the client's left arm, left upper chest, and neck (Table 3). Nothing has been found on the client's dominant side. Interestingly, pain appeared only during palpation, which indicated presence of latent myofascial trigger points.[8]

The child's skin colour and temperature were standard bilaterally. There were presence of light swelling, redness, and irregular contour of the scars, especially at the site of the humeral shaft. The child also presented with eczema patches located away from the site of injury.

A physical assessment noted some observations about postural behaviour, with bilateral elevation of shoulders, increased lordosis, and kyphosis, and anteriorly rotated left GHJ.

The client presented with no pain and the DVPRS® assessment tool showed only significant impact on the activity aspect (Figure 1). The therapist identified areas of weakness, and reduced ROM at the GHJ, elbow joint, and at the scapular level.

Orthopaedic testing of the client's ability to perform movements and assessing the possibility of glenohumeral pathologies came back negative.[9,10] However, the Drop Arm test was positive indicating a possible supraspinatus tear. It could also show myofascial trigger point referrals limiting the child to hold the arm in the abducted position; however, the child was able to sustain the abducted position with the Full Can test. The Gerber's Lift-Off sign indicated weakness for the subscapularis tendon, the child being unable to resist the therapist's pressure by extending the elbow.
Also, the Apley's inferior scratch test indicated limitations in shoulder medial rotation and adduction and highlighted a winging scapula.[7]

Thus, a treatment plan for rehabilitation following left PHF was sought, focusing on reducing the compensating pattern imposed on the scapula and helping increase the ROM at the GHJ. Having the young client's full attention throughout the entire intervention determined the massage treatment choices and the duration of sessions.[9,11]

Informed Consent

The child and her parents received information about the case study and gave informed consent to participate. It provided a detailed explanation of what a massage intervention entails, how pressure is used, and how different techniques can be applied. A parent attended all interventions.[11]

Practitioner Descriptor

The practitioner is a qualified remedial massage therapist who qualified in 2019. She continues professional development pursuing studies to obtain a bachelor's degree in therapeutic and sports massage. The qualifications programme and additional training covered the techniques used. Although the therapist has previous experiences in sports and remedial massage treatments with many people, this is the first experience with a child.

Therapeutic Intervention

The massage intervention happened 19 days after the sling was no longer necessary, and the massage practitioner had received the physiotherapist consent to participate in the child's rehabilitation.[12]

The massage therapist was aware of the physiotherapy treatments, and the strengthening exercises prescribed (Table 2). The physiotherapist was not involved in the decision-making regarding the massage therapy intervention; however, the massage intervention was designed not to impact or interfere with the physiotherapist's interventions, and considered the evolution of the strengthening exercises prescribed (Table 2). The initial session aimed to discuss the purpose of the massage intervention and the treatment plan. It also included a thorough explanation regarding the findings and the results from the outcome measurement (OM) tools: Patient-Specific Functional Scale (PSFS), Upper Extremity Function Index (UEFI) adapted to the client's age, and Child Outcome Rating Scale (CORS) to capture therapeutic progress and the client's state of mind (Table 3).

Treatment consisting of seven sessions of 45 minutes each has included OM tools to aid in tracking progress, along with the Child Session Rating Scale (CSRS) to assess the client-therapist relationship (Table 3). Through the treatment, techniques have evolved to follow assessments findings, including study of the physiotherapy exercises prescriptions which evolved overtime to build strength (Table 2). The treatment also considered tissue changes, from the client's responses to previous massage sessions, and the client's confidence and trust gained through the massage experience with the therapist. The client adopted a seated position in sessions 2 and 3 to manage the stress related to her first experience with massage therapy, and gave consent for the treatment to continue using the massage table once she felt more comfortable (Table 4). There was a minimum five-day interval between massage therapy sessions to allow for tissues to heal and adapt to the treatment in conjunction with physiotherapy work.[9,11]

RESULTS

Treatment Outcomes

The treatment has helped in the process of muscle balance awareness and coordination, especially at the scapular level.

The treatment relieved the child from the neural discomfort mid-intervention. The intervention benefits appeared to plateau regarding the active range of motion at the GHJ even though there were continuous postural adjustments throughout the sessions (Table 3). The passive ROM improved dramatically, with only signs of apprehension in GHJ medial rotation. The resisted isometric ROM progressed, but weakness was present in GHJ abduction, and GHJ medial and lateral rotation.

The Drop Arm, Apley's inferior and Gerber's lift off tests improved with time; however, a sign of a winging scapula persisted.

The scars' shapes and colour evolved positively in both humeral shaft and anatomic neck of humerus areas.

Session[a]	*Position*	*Techniques and locations*	*Interval*	*Objectives*
2,3	Seated	MLD: Left upper limb lymph nodes and vessels	10 min.	Clears debris, reduces swelling, helps bone regrowth [15,20,27]
		MFR: Left rotator cuff muscles subscapularis excluded, left upper arm	10 min.	Lengthening fascia, increases tissue mobility and breaks adhesions, restores elasticity[9]
		Effleurage: Left rotator cuff muscles subscapularis excluded, biceps brachii, upper fibre trapezius, levator scapula	5 min.	Spread oil, increases venous flow and lymphatic flow, analgesic effects[9]
		Petrissage: Left supra- and infraspinatus, upper fibres trapezius, left upper arm	5 min.	Decreases hypertonicity and muscle guarding, stretches fascia, increases range of motion and circulation to nerves[9,15]
		Effleurage: Left upper arm, upper anterior chest	1 min.	Finishing stroke[9]
4,5,6	Prone	MFR: Left rotator cuff muscles subscapularis excluded, left upper arm	10 min.	Lengthening fascia, increases tissue mobility and breaks adhesions, restores elasticity[9]
		Effleurage: Bilateral rotator cuff muscles subscapularis excluded, upper arm, coracobrachialis, pectoralis major and minor, trapezius, latissimus dorsi	5 min.	Spread oil, increases venous flow and lymphatic flow, analgesic effects[9]
		Petrissage: Left rotator cuff muscles subscapularis excluded, posterior and lateral upper arm, trapezius	5 min.	Decreases hypertonicity and muscle guarding, stretches fascia, increases range of motion and circulation to nerves[9,15]
		Stripping: Left infraspinatus, teres major and minor, posterior and lateral upper arm, latissimus dorsi	8 min.	Lengthen shortened sarcomeres, stretches small sections of myofascial tissue[9]
	Supine	Petrissage: Left biceps brachii, coracobrachialis, anterior chest	2 min.	Decreases hypertonicity and muscle guarding, stretches fascia, increases range of motion and circulation to nerves[9,15]
		Frictions: Humeral and anterior chest scars	1 min.	Reduces joint restriction and fibrous adhesions, improves blood supply[9,15,22]
		Pin and stretch and passive eccentric glides: Left pectoralis major	1 min.	Stimulates proprioceptors, stretches muscles fibres, decreases muscles tension.[9,11,22] Stimulates reflexes, reciprocal inhibition allowing more movement by reaching a new resting length[15]
		Effleurage: Bilateral anterior chest and neck	1 min.	Finishing stroke[9]
7	Side-lying	MFR: Left trapezius, latissimus dorsi, rhomboids, levator scapula, left upper arm, teres major and minor	10 min.	Lengthening fascia, increases tissue mobility and breaks adhesions, restores elasticity [9]
		Effleurage: Left trapezius, latissimus dorsi, rhomboids, levator scapula, left upper arm, pectoralis minor, teres major and minor	5 min.	Spread oil, increases venous flow and lymphatic flow, analgesic effects[9]
		Petrissage: Left rhomboids, levator scapula, latissimus dorsi, trapezius, left upper arm	5 min.	Decreases hypertonicity and muscle guarding, stretches fascia, increases range of motion and circulation to nerves[9,15]
		Stripping: Left biceps brachii, triceps brachii, deltoid, teres major and minor	5 min.	Lengthen shortened sarcomeres, stretches small sections of myofascial tissue[9]
		Frictions: Left humeral and anterior chest scars, anterior medial aspect of scapula	2 min.	Reduces joint restriction and fibrous adhesions, improves blood supply[9,15,22]
	Prone	NMT protocols: Left supraspinatus, infraspinatus, upper fibres trapezius, levator scapula	8 min	Removes soft tissue restrictions, restores proprioception[28]
		Effleurage: Bilateral erector spinae	1 min.	Finishing stroke[9]

[a]Session 1: no therapeutic intervention; Session 8: follow-up assessment.

Table 4 Treatment Plan

Follow-Up & Outcomes

Four weeks post-massage therapy intervention, the new measurements taken at the GHJ indicated improved active ROM on extension (Table 1). The passive and resisted isometric ROM evolved positively; however, some neck and scapular adaptations appeared during GHJ abduction and medial rotation.

The PSFS showed an increase in the client's perception of her ability to go back to activities by 93% (Figure 2). The UEFI (adapted) score of the client's overall ability to perform usual activities of daily living (ADL) increased from 52 to 63 (scale up to 68 to correlate client's age), which equates to a 21.1% increase (Figure 3). Four weeks post-intervention, the client reported no pain and no change regarding the impact of the shoulder rehabilitation in the mood, sleep, and stress aspects of the DVPRS® biopsychosocial (BPS) questions since the last massage treatment. However, the child-specific OM, CORS, and CSRS indicated an improvement from the initial session and highlighted benefits after each session (Figure 4, Figure 5).

The parents also saw progress in the child's sleep pattern and confidence regained in playing again.

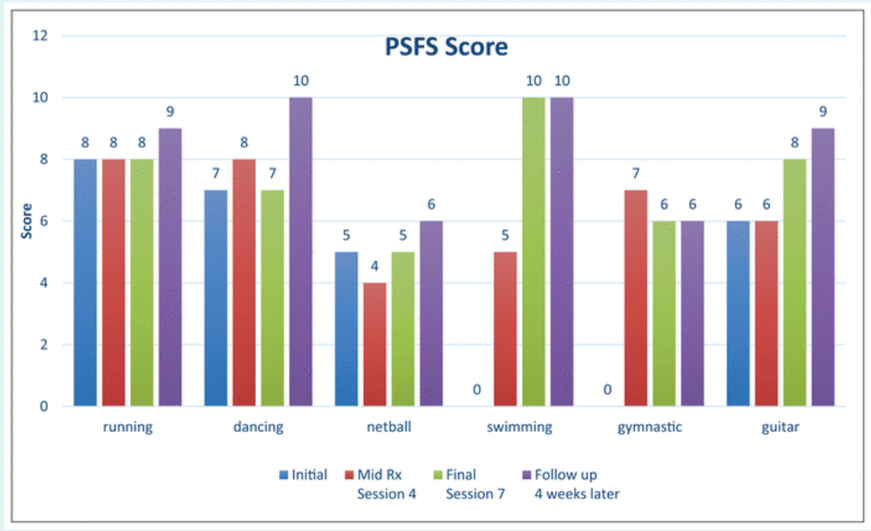

Figure 2 Patient-Specific Functional Scale (PSFS) progress throughout massage therapy interventions and follow-up session. The higher the score the easier to perform activity at the same level than before injury (scale up to 10).

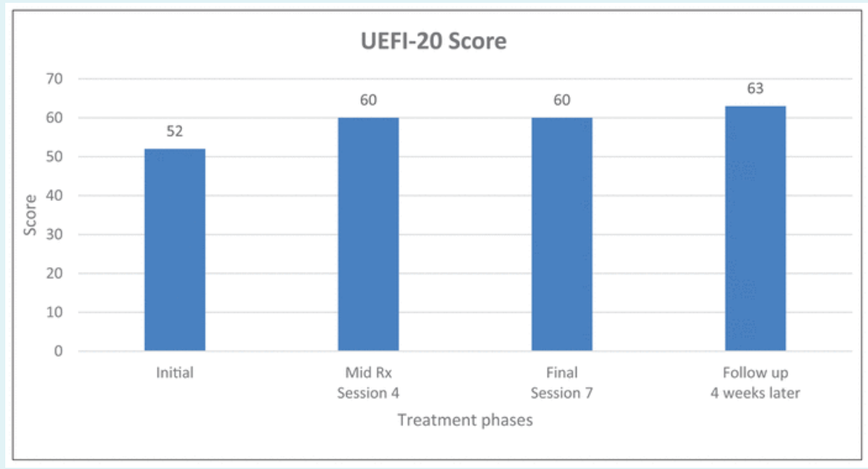

Figure 3 Upper Extremity Functional Index (UEFI-20) improvement (score=68). The greater the score the higher the functional status. UEFI adapted to child's activity of daily living (ADL).

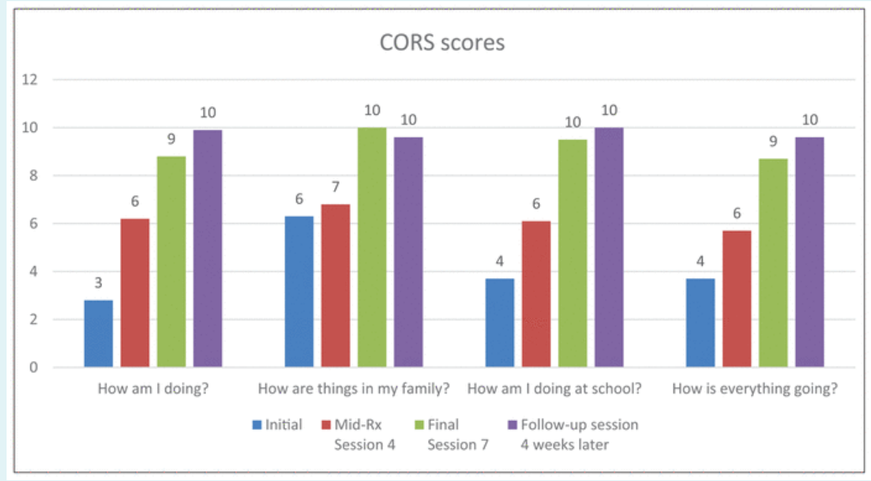

Figure 4 Child Outcome Rating Scale (CORS): Wellbeing self-assessment. The greater the score the better the state of mind.

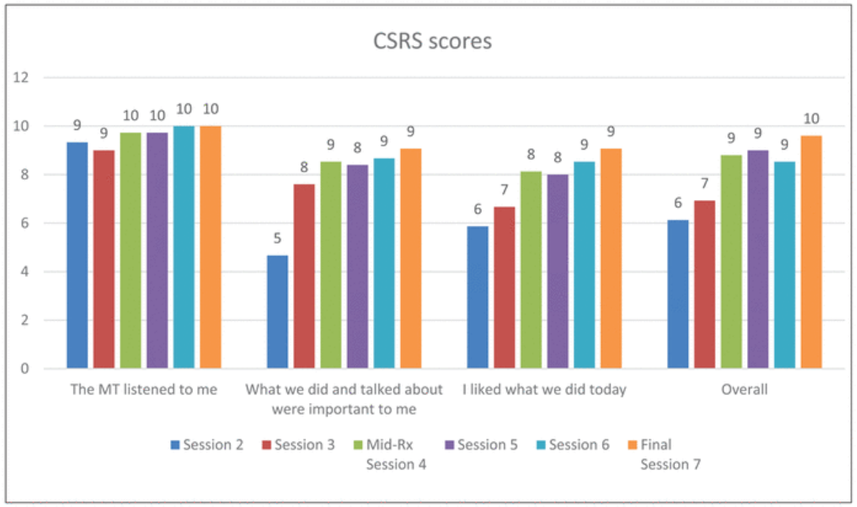

Figure 5 Child Session Rating Scale (CSRS): How was our time together today? The greater the score the better the experience. MT stands for massage therapist.

DISCUSSION

A PHF typically happens after a fall, followed by pain in the related arm or shoulder in children. About 5% of all fractures are humeral shaft fractures.[13] Despite humeral shaft fractures occurring in all age groups, researchers identified a bi-modal distribution in children with humeral shaft fractures primarily occurring in children younger than three or older than twelve.[13,14] The client, who was a 9-year-old, represented an exception to the latter. However, the client presented with a mechanism of injury and a PHF, representing 30% of cases in this site of injury.[13] The rehabilitation programme, including massage therapy intervention, should be done carefully and as soon as possible to avoid potential disturbance on the developing skeleton even if the children often respond well to treatment and make a remarkable recovery.[4,11]

A Child Is Different

There are significant differences in the type of injuries sustained by children compared to adults.[15,16] These are due to the physiology of growing bone that is less stable and manages to bow rather than break in response to trauma, leading to fracture types not seen in adults.[4,13] Even though the child bones are not yet fused or ossified, the massage intervention is not much different from providing massage for adults.[9] The therapist employed a gentle approach to reduce stress from being touched on the trauma's site, and to develop connection and trust with the young client.

The clinical approach to the child will require greater attention on first establishing rapport with the child.[15] The feeling of empowerment is beneficial for the recovery process. The treatment may therefore be more valuable, as the therapist addressed the questions directly to the young client with comprehensive vocabulary and later clarified any point with the parents especially considering the child was receiving her first massage.[17,18]

The therapist decided on a 45-minute appointment to keep the child's attention.[9,11] However, the client was encouraged in the recovery process to be motivated to return to play. The child's willingness to participate in the case also presented an advantage in the rapid evolution of the recovery.[19]

The hands-on intervention considered the age of the client entering a transitional phase to puberty, dealing with emotions and physical changes. The therapist used a draping method not different from that used with an adult.[9]

Skin

The progressive approach of techniques used allowed the therapist to address the physical discomfort related to the injury and tackle skin sensitivity issues the child may have had. Massage interventions were performed outside the areas of eczema to prevent aggravation of contact dermatitis.[20] The choice of lubricant helps lower the chance of skin irritation, and the risk of absorption of toxic agents is influenced largely by the barrier properties of the child's skin.[21] The therapist used a natural beeswax to minimize contamination from allergens, and to allow a better drag and a firmer grip for the remedial work.

Assessments & Results

The fracture has impacted the surrounding soft tissues, involving imbalanced patterns. A rehabilitation done appropriately should correct the compensations and increase coordination of muscles' activation around the joint.[11,22] Even though the pain was no longer a factor, the physical assessment indicated the main muscles at the GHJ and neck were involved in the compensating patterns. Other muscles were identified as problematic due to the postural adaptation to protect her arm while wearing the sling. The ROM did plateau with minimal change at lateral rotation, but there was a significant improvement on the GHJ extension. Passive ROM did not indicate a joint restriction of the GHJ, but some limitations in the quality and the quantity of movement augmented with signs of apprehension particularly in the sagittal plane. The resisted isometric ROM improved, but there were some postural adaptations involving the neck and scapula. Thus, maintaining a strengthening programme of the shoulder girdle which follows the child's progress seems inevitable to correct the new posture adopted in addition to increasing ROM.[12]

The DVPRS® showed some limitations regarding the client's absence of pain and very slight BPS disturbances. Nevertheless, the use of the CORS and CSRS allowed integration of a deeper understanding of the BPS issues with an adapted language for the client age, giving enough information on the course and the results of the sessions.[23,24] The child sometimes had difficulties with concentration during assessments and wanted to receive massage as soon as possible; this could reflect the scores in the CSRS. The UEFI assessment tool presented challenges because of its design to assess the client's dominant hand and items related to adults' ADL; thus, the UEFI scale was reduced from 80 to 68 items to correlate with the client's age. The PSFS has excellent validity; the tool was easy to conduct and indicated to the child the progress made.[25,26] After the study, the young client felt more confident and fearless in her short-term return to play.

Techniques

The therapist chose at first to use manual lymphatic drainage (MLD) to approach the child within the new massage therapy environment, and reduce swelling and promote bone regrowth.[9,27] It had been an effective technique initially; however, it was of limited use in the remaining treatment sessions. The myofascial release technique (MFR) had shown positive outcomes regarding the scars' adhesion, the improved range at GHJ, and the gentle touch to build up a trust relationship with the young client.[9,11] MLD and MFR techniques were both appropriate for addressing the young client's discomfort, preventing fear of touch at the shoulder, and did not present any contraindication to the case.[11] Later in the treatment, the therapist incorporated neuromuscular techniques (NMT) to correct future imbalances, especially around the neck area and at the anterior aspect of the chest.[9,28]

While the implementation of the physiotherapy exercises showed improvements in ROM by strengthening, massage therapy delivered ease of movement by relaxing and lengthening the muscles and minimize scar adhesions from the surgeries.[9] Massage intervention allowed the tissue to be more pliable from tissue being hypertonic from a shortened position with the immobilization, and the strengthening exercises resulted in a more effective rehabilitation programme than physiotherapy as a unique intervention.

Client Perspective

It was complicated to gain a clear answer from the client. Her parents and the CORS measurements tool exposed the actual benefits of the treatment. The future looks promising, since children heal faster than adults and their bodies have not yet reached their full development. Considering the voluntary participation and application to her recovery, the client has a limited chance of significant issues related to the humeral fracture.

CONCLUSION

This case study looked at the effectiveness of massage therapy for the rehabilitation of a 9-year-old girl with a humeral shaft fracture after a fall. The progression of discomfort with daily and sporting activities, sleep patterns, and the positive increase in ROM at the GHJ justified that massage therapy was beneficial when used in conjunction with physiotherapy intervention. Additionally, the massage therapy experience and assessment tools indicated improvement in the biopsychosocial aspects of the client's life and her empowerment in the rehabilitation process.

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CONFLICT OF INTEREST NOTIFICATION

The author declares there are no conflicts of interest.

SOURCE

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MASSAGE THERAPY EFFECTIVENESS IN REHABILITATION ON HUMERAL SHAFT FRACTURE IN A CHILD: A CASE STUDY

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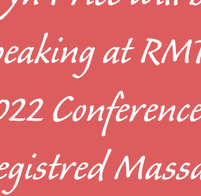
SPEAKER INTERVIEW

ERYN PRICE, RMT

Eryn Price will be speaking at RMTBC's 2022 Conference on Registred Massage Therapy & Rehabilitation

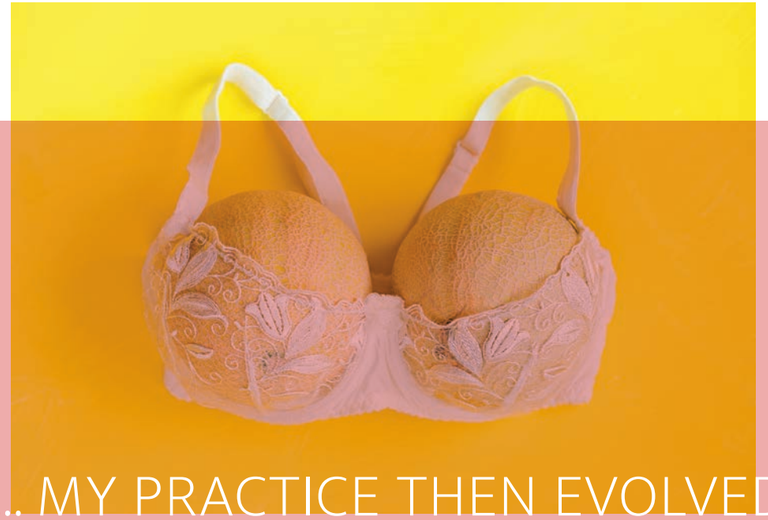
Please tell us a bit about how you entered the profession.

15 years ago, I was trying to support myself as a newly divorced mother with a young son through a part-time energy healing practice, which was insufficient for the task. I was working in a multidisciplinary clinic at the time, who had RMTs as a part of the staff collective.



Eryn Price, RMT

Eryn graduated with honours from WCCMT in 2010 and is now on a mission to create a heart-centred network of highly trained professionals comfortable and inspired to work with the breast surgery demographic, so people all over the country can access the resources they need.



"... MY PRACTICE THEN EVOLVED INTO TREATING OTHER FORMS OF BREAST/ CHEST SURGERY."

I saw the amount of knowledge and skills the RMTs had, plus how easy it was for clients to come when they could claim the treatments on their benefits, so knew it would be a valuable next step in my healing career.

It built on the skills I had already developed as a healer such as mindfulness, intention and listening, worked well with my essential nature and supported alternative healing practices. Plus, I thought I could probably make a good living at it, so all told, I decided RMT school was the right move for me and now that I'm 11 years into professional practice, I'm sure glad I took that step!

What have been some big challenges in your career?

Having hyper-mobile hands has been a huge challenge, because the level of pain in hands & forearms I started experiencing right away in school that continued for the next 7 or so years was proving debilitating. At one point I couldn't even lift a tea cup without two hands for the amount of pain it caused. Couple the pain with a lack of inspiration, meaning and purpose in my career, I almost had to pack it in within 3-4 years of entering professional practice, which was very disheartening. I knew I needed a new way to practice, as well as greater inspiration and motivation if I was going to make it as an RMT, and not keep crying on the couch at the end of the day because I was so burnt out and hurting. Then I started working with breast cancer patients and had an epiphany very early on that showed me with crystal clarity this was the demographic I was meant to support. It offered very deep meaning and purpose - working with people going through significant challenges, who really valued having a mindful person in their corner, providing resources they were severely lacking. Plus it was a lot easier on my body, as working on breasts after surgery requires a much lighter touch than the vigorous sports massage I was doing before. My practice then evolved into treating other forms of breast/chest surgery, such as elective surgeries and Transgender top surgery, and now I've moved into teaching other RMTs how to support this beautiful demographic through evidence-informed CE courses, so I was definitely able to break through the barriers that I thought initially would take me down. Viva la Resilience!

SPEAKER INTERVIEW ERYN PRICE

What advice would you give yourself if you were just starting out in your career?

I'd strongly suggest to myself to be open to a clientele that is of endless interest and fascination, so that each day when you're going to work you're genuinely glad and excited, and the opportunities to learn and grow are continually presented. Also, to find a treatment style that is both sustainable and effective, so your body can keep going with the clientele that fascinates you. I'd tell my younger self that both aspects are needed for an enjoyable, sustainable career. And because I'm me, I also need some deeper meaning and purpose to what I'm doing so that I feel a sense of soul satisfaction in my offerings, so I'd say to myself look for that "holy trinity" of mentally stimulating, physically sustainable and people or a cause that lights your spirit up from the inside out. And then - enjoy!!

What or who is your greatest inspiration?

What inspires me most is living my true purpose, saying "yes, yes and yes again" to my heart's greatest desire, which revolves around living my greatest potential from my highest self, and improving the world around me. How that manifests is endlessly interesting plus the people I've been able to meet, connect with and learn from on this journey are just incredible; they keep me humble and inspired by the choices they make to reshape their lives.

What is my favourite food?

Toast!! I cannot describe the incredible delight of taking that first bite of golden sourdough toast, fully saturated with butter so it's both crispy and juicy when you bite into it. OMG yummmmmmm.....

What is my favourite pastime?

Honestly, it's hard to narrow it down. I have so many loves it's more an issue of being able to fit them all in! Meditation is top of the list, as it provides solutions, insights and direction that are required for me to have a successful life, plus it's nice to have some clear space in your mind. Painting and creativity are also top of the list, as they're like therapy and help me feel like me. Yoga, hiking, paddle boarding - generally outdoor pursuits are also top of the list, vital for my wellbeing on every level. Reading! I love books!! I'm an artist-nerd-visionary-mystic-athlete so it takes a lot of favourite pastimes to satisfy all those aspects of myself :-)

Tell us about your community involvement and volunteerism.

I have 6 - 8 organizations I support monthly that revolve around cancer research, environmental cleanup, 2SLGBTQ+ awareness, the science of consciousness and human potential etc. Plus, there's some horses nearby that I go spend time with, giving them love and attention, helping them be accustomed to people.

In your travels, what has made the greatest impression on you?

Well, I'd have to say my 2.5-year move to England made the biggest impression on me, because that's where my son was born. I'd also have to say 5 weeks in SE India was incredibly eye-opening. I travelled by myself for half of it, and with the other half did an energy healing exchange during the culmination of the 3-year IEHP program I did through Langara College. We travelled to small rural villages doing energy healing treatments, and I got to see so much of the traditional culture over there, which was highly impactful. A month by myself in Maui was also highly impressionable, it was my gift to myself after RMT school was done and I was waiting for my board exam results. Love love love the tropical climate, the crystal-clear ocean and learning to surf - soul food!! <3.

NOTHING PERSONAL: REALITIES OF THE MASSAGE THERAPEUTIC RELATIONSHIP

This article is adapted from: Fitch, P. (2019, 2nd ed.). *Talking Body Listening Hands: A guide to professionalism, communication and the therapeutic relationship.* Ottawa: Algonquin College Press.

Therapeutic relationships differ significantly from personal relationships. While therapists listen to client sharing, they must keep their own thoughts or feelings private. The freedom to share secrets or intimate details only goes in one direction. Clients bring not only their pain and stiffness, but also their unspoken desires for connection, personal history, and attitudes about relationships. Boundaries hold the client experience and help massage therapists to establish their limits to care. Boundaries are essential for the safety of clients and therapist self-preservation. Yet, how hard it is to set a boundary!

NOTHING PERSONAL: REALITIES OF THE MASSAGE THERAPEUTIC RELATIONSHIP

This article is adapted from: Fitch, P. (2019, 2nd ed.). *Talking Body Listening Hands: A guide to professionalism, communication and the therapeutic relationship*. Ottawa: Algonquin College Press.

Establishing therapeutic limits represents one of the most challenging aspects of massage therapy because it demands considerable professional judgment, discretion, and critical thinking. It requires that massage therapists acknowledge the personal while focusing on the therapeutic aspects of care. Therapeutic relationships create an illusion of intimacy that is completely different from personal relationships. Therapists and clients exist in relationship, and the unique needs of both therapist and client unconsciously entwine as the relationship expands or lengthens.

Clients are not expected to understand the subtleties associated with massage therapeutic relationships. They might be forgiven if they confuse the treatment room atmosphere with friendship or even something more intimate. On the other hand, therapists want to create positive experiences for clients so, at times, it can feel uncomfortable refusing the "friendship" that clients may extend. Without clearly established boundaries and limits to care, clients may make assumptions about the therapeutic relationship that are impossible to sustain. Therapists cannot socialize with clients without losing some degree of professional objectivity. If therapists talk about their personal lives, they must monitor carefully how the information they share furthers the therapeutic goals.

There is a natural give and take between therapist and client. While engaging in conversation designed to put clients at ease, therapists may ask questions about the client's work, degrees of stress, ways of relaxing, or family relationships. They may use humour as a way to help clients relax. These back-and-forth conversations are called *interactions*. In business and personal relationships, interactions can be important, informative, and interesting. Yet it is the transactional business relationship that puts the therapist in a position of authority. The exchanging of a fee for service means that the therapist accepts responsibility for all outcomes.

Massage therapy is a business transaction. Although the encounter between therapist and client may seem personal and conversational, it is not a casual interaction. There is a fee for service and money changes hands. No matter how committed therapists feel about their profession, they are in business. Allowing clients to forget this basic fact represents one of the simplest ways that therapists neglect their professional role. When therapists talk about their personal lives, they can forget their role and responsibility within the therapeutic climate. Their personal discussions may result in forgetting the client's needs momentarily. When talking about a frustrating situation, they may press too hard into the client's soft tissue, a physical boundary violation. An interpersonal boundary is crossed when therapists forget the difference between professional and personal conversation. When this occurs, clients may notice that the focus has moved away from them and onto the therapist.

When therapists treat clients like friends, they confuse the clients' understanding of what is appropriate in the clinical environment. If massage therapists forget the transaction and focus on interaction, they may ignore their responsibilities and professional role. By sharing personal information or giving advice on how to solve personal issues, they encourage the illusion of a friendship between therapist and client. On the surface such sharing might seem innocuous and innocent. But in reality, forgetting one's professional role is a first step in what may lead to a series of boundary violations.

Take time to explain boundaries carefully and respectfully. Setting a boundary means to establish the rules of conduct. However, simply drawing a line is never enough. In order to function properly, a boundary must be clearly explained, modelled and even defended if challenged. In addition, massage therapists must take into account the complexities of client history, presentation, and behavior as well as each client's degree of emotional connection when they set limits to care. This means that the strength of a boundary depends on good communication skills where nothing remains unsaid or hidden. If clients misunderstand the purpose of a boundary, they may feel hurt or rejected. If therapists fail to address assumptions, then they allow clients to maintain their misinterpretations of the therapeutic relationship. And if therapists contribute to client confusion about boundaries, then they ignore their ethical responsibilities.

Here is an example of a common type of therapist-client conversation that demonstrates the difference between interactions and transactions. As always, the purpose of massage therapy is transactional because the client pays for the treatment. Within the transaction, small social and conversational interactions exist.

Therapist: "Welcome to my clinic. Please take a seat in the waiting area. Here is a case history form to fill out. When you are finished, please let me know." *(These instructions establish the transaction)*

Therapist: "As we discussed on the telephone, here is the fee schedule for my practice. You've booked in with me for a one-hour treatment. How would you like to pay for that? *(The therapist clarifies the payment and duration of the treatment, reinforcing the transaction)*

"Now that we have reviewed the case history and I have a good idea of what you would like for treatment, I will leave you to get onto the table. Please remove whatever clothing you are comfortable taking off and get onto the table between the sheets. When I come back in, I'll adjust the pillows and bolsters for your comfort." *(Therapist reinforces the transaction further by describing how the treatment will proceed)*

Client: "Thanks. I can't wait for this massage treatment. I'm going on vacation next month but I decided not to wait until then to have a massage. I need to relax now."

Therapist: Oh, how lovely. Where will you be vacationing? *(Therapist comment demonstrates an interaction)*

Client: "Mexico."

Therapist: "How wonderful. Mexico is beautiful. From what you said about the holiday, I guess you are feeling somewhat stressed, is that right?" *(Interaction followed by return to transaction by asking client about her levels of stress)*

When our professional purpose is to help our clients with their stress, injuries and pain, it is essential that we remember the difference between personal and professional relationship. If massage therapists can navigate the difference between transactions and interactions with grace and purpose, they ensure that their communication stays within the bounds of the therapeutic relationship. Taking time to explain boundaries clearly helps clients to know what is expected of them. If we can communicate clearly and compassionately, we help clients to feel safe, respected and supported.

Pamela Fitch, M. Ad. Ed., RMT

Longtime Canadian educator, author and massage therapist, Pam Fitch has been helping therapists examine their professional practice, ethical and communicative challenges for more than 34 years. Pam incorporates critical reflections about our profession with humour, and synthesizes relevant knowledge from other disciplines into her presentations. She has been recognized with several awards for teaching and her text, Talking Body Listening Hands, is used as a required text for professional practices issues in schools across Canada.

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