PROVIDING NEWS AND INFORMATION TO MASSAGE THERAPY PROFESSIONALS IN NEW ZEALAND

MNZ MAGAZINE

massage new zealand

ISSUE 2 2021

Cancer and Oncology Massage

BONUS: CHAPTER EXCERPT FROM HANDS IN HEALTH CARE

WHAT IS ONCOLOGY MASSAGE? • THREE MTS SHARE THEIR EXPERIENCES IN ONCOLOGY MASSAGE • A PATIENT'S PERSPECTIVE • WORKING WITH WOMEN AFFECTED BY BREAST CANCER • BARRIERS TO THE ADOPTION OF ONCOLOGY MASSAGE • RESEARCH: A SERVICE EVALUATION ON PROVIDING MASSAGE TO PATIENTS UNDERGOING TREATMENT FOR CANCER IN A HOSPITAL SETTING

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EDITORIAL

Kia ora members,

This issue is hefty as the focus is equally large – cancer and Oncology Massage. Cancer has affected all of us in some way – through first-hand experience, or someone close to us either living through or succumbing to some form of cancer. As massage therapists, we are going to deal with clients who have received some form of oncology treatment. We hope this issue gives you better insight into how we can work with these clients more effectively and appropriately.

Our first piece is an introduction to Oncology Massage (OM) from Wellington degree-qualified RMT and OM practitioner, Bernie Withington, who thoughtfully shares her own perspective. We are fortunate to have personal viewpoints from three other massage therapists, who are also all practicing Oncology Massage – Tess O'Toole (Christchurch), Anna Barton (Auckland), and Meaghan Mounce (Canada). These three reveal the paths they took to discover, train, and perform Oncology Massage, in a variety of clinical settings. Meaghan also has a unique perspective of being a cancer survivor as well.

We are also honoured to include what we hope to be our first "patient perspective" article. Nicky shares her story of breast cancer diagnosis and treatment, and how massage therapy helped her through.

We have an informative and thorough piece by Natalie James, Lead Nurse at Breast Cancer Foundation NZ who writes about working with female clients with breast cancer. Natalie covers pathology, treatment and the role that massage therapy can play. We are delighted to have this contribution from the Breast Cancer Foundation NZ and take this opportunity to remind members to check out their website for further resources. Melanoma NZ also provides a useful guide to spotting concerning spots (excuse the pun) on clients, that should be checked by a doctor or skin specialist. As massage therapists we see more of our clients' bodies than virtually anyone else does, so it makes sense for us to know what to look for.

David Bailey, of Oncology Massage Limited in Australia, talks about the challenges he sees with oncology massage being accepted within healthcare organisations. He raises some important questions for this area within our profession.

Dunedin-based RMT Vicki Scott conducted a study into hand and foot massage in an oncology day unit. This small study provides not only promising results but adds to the growing evidence to support massage therapy – something we encourage you all to consider undertaking.

In our regular A&P column, Becky Littlewood provides a detailed explanation of the lymphatic system. Carol Wilson writes about prostate cancer in our Pathology column, detailing the causes and risk factors, as well as implications for massage therapy. We provide you with a good range of online resources to check out in our useful Sites & Online Resources column and some books to check out in our Book Reviews section. Ruth Werner, our favourite Research Update columnist, recently presented at the Oncology Massage Summit at the Northwestern Health Sciences University, alongside Dr Niki Munk. They presented their reviews of some recent research about massage therapy and cancer – perfect timing for this issue! Ruth shares those reviews with us and reminds us of the importance of reading past the abstract.

And finally, we are privileged to publish an entire chapter of the second edition of ***Hands in Health Care: Massage therapy for the adult hospital patient***, provided by Handspring Publishing. Written by Gayle MacDonald and Carolyn Tague, who are both well-known and highly respected in the field of hospital massage therapy, this excellent book covers a range of highly important topics relevant to any therapist working or considering working within hospital settings, including palliative care. Handspring Publishing have also provided MNZ members with a 10% discount on this book. You can find out more inside this issue and we encourage you to explore their website for other excellent publications.

We hope this issue inspires and encourages you to consider this demanding, but worthwhile specialty.

Happy reading!

Odette & Rachel

ARTICLE SUBMISSION AND ADVERTISING SPECIFICATIONS

SUBMISSION DEADLINES

The MNZ Magazine will be published:

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

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

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

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

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

- **Word count (not including references): Standard article 250-1000 words, feature article 1000-2000 words.**
- **Font - Arial size 12**
- **Pictures - Maximum 4 photos per article, send photo originals separate from article (do not provide images embedded in Word document), each photo must be at least 500k**
- **Please use one tab to set indents and avoid using double spacing after fullstops. The magazine team will take care of all formatting**
- **We prefer APA referencing (see http://owll.massey.ac.nz/referencing/apa-interactive.php)**

Co-editors – Rachel Ah Kit, Odette Wood

magazine@massagenewzealand.org.nz

coeditor@massagenewzealand.org.nz

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Helen Smith
president@massagenewzealand.org.nz

Vice-President
Bernie Withington
vice-president@massagenewzealand.org.nz

Treasurer
Tania Kahika-Foote
treasurer@massagenewzealand.org.nz

Education Officer
Doug Maynard
education@massagenewzealand.org.nz

AHANZ Representative
Iselde de Boam
ahanzrep@massagenewzealand.org.nz

Publicity Officer
Ali Sullivan
publicity@massagenewzealand.org.nz

Research Officer
Vacant
research@massagenewzealand.org.nz

Regional Liaison Coordinator
Vacant
regional.liaison@massagenewzealand.org.nz

NON-EXECUTIVE POSTS

Magazine Co-Editors
Rachel Ah Kit
magazine@massagenewzealand.org.nz

Odette Wood
coeditor@massagenewzealand.org.nz

Upper North Island Regional Coordinator
Vacant
upperNIrep@massagenewzealand.org.nz

Lower North Island Regional Coordinator
Vacant
lowerNIrep@massagenewzealand.org.nz

South Island Regional Coordinator
Vacant
sirep@massagenewzealand.org.nz

Iwi Liaison
Vacant
Iwi@massagenewzealand.org.nz

NZQA Liaison
Doug Maynard
education@massagenewzealand.org.nz

Education Sub-Committee
Pip Charlton, Dawn Burke, Shelley Moana Hiha, Joanna Tennent, Mark Gray

Publicity Sub-Committee
Vacant (requires 3 members)

Conference 2021
conference@massagenewzealand.org.nz

STAFF

Executive Administrator
Nici Stirrup: 027 778 2954
admin@massagenewzealand.org.nz

General Administrator
Esther Shimmin: 0800 367 669
membership@massagenewzealand.org.nz

Finance Administrator
Sarah Duckworth
accounts@massagenewzealand.org.nz

PRESIDENT'S REPORT

Dear MNZ Members,

By the time you read this, several of the projects that the MNZ Executive Committee has been working on will have been completed, or be much further down the track.

Our Education Officer, Doug Maynard and his highly involved Education Sub-Committee worked diligently on the NZQA qualifications review and are now moving towards the review of the MNZ Scope of Practice document.

Our AHANZ Representative, Iselde de Boam led a group of interested MNZ members who provided input into the NZIER report – "Hidden in plain sight: Optimising the allied health professions for better, more sustainable integrated care". MNZ members also helped provide funding for MNZ's input into this report. It was an important opportunity for MNZ to be a part of the push for more inclusion of allied health professions into the health system. Hopefully by now, a formal presentation of the NZIER report has been made at Parliament and would have been shared with members.

Christy Munro stepped down from the role of Vice-President in May to embrace motherhood. She was heavily involved in creating the concept of working groups to enable the Executive Committee to pursue the goals of governance that we developed in last year's strategic plan. We have been working on implementing new communication processes and systems to bring these working groups together and support them and their projects this year and beyond.

The Executive Committee has worked diligently on changes to the Constitution to enable an overhaul of the structure of the Executive Committee and the executive roles. By the time you read this we will have held a Special General Meeting to present the necessary remits to be voted on by the membership. We will be communicating outcomes of the meeting to membership shortly.

We are delighted to have announced an 'in person' AGM this year to be held on Saturday, 18th September in Wellington. Look out for updates and further information via email in the weeks leading up to the AGM.

We are also looking at holding a virtual MNZ Conference this year, potentially in October. Our Publicity Officer, Ali Sullivan has been supporting the conference working group to develop this project and will hopefully be able to confirm further details soon.

Implemented changes to the MNZ Constitution will enable us to pursue the 'work' of MNZ. We aim to continue the promotion of massage therapy to the health sector and the public, to create more benefits for members in upcoming projects and develop strategic goals further to enrich our professional massage therapy community and industry.

Helen Smith

ADMIN REPORT

Nici Stirrup
Executive Administrator

Esther Shimmin
General Administrator

Dear MNZ Members,

We hope you are enjoying all the winter wonders that New Zealand brings this time of year. It has been great to witness a steady flow of membership renewals in the past four months. We would also like to welcome all new members and hope that you enjoy reading the MNZ Magazine. If you have any questions about membership or the organisation, then feel free to contact us anytime.

A reminder regarding First Aid training - maintaining a current First Aid certificate is an MNZ membership requirement. Once you have completed a course, please upload your certificate, and log it as CPD via your MNZ account: - https://www.massagenewzealand.org.nz/Site/members/cpd/my-cpd.aspx.
St John provides MNZ members with a 5% discount. Visit the MNZ website Preferred Suppliers for more details on this discount and other special offers for members: - https://www.massagenewzealand.org.nz/Site/members/resources/preferred-suppliers.aspx.

MNZ staff and Executive Committee have been working hard together to bring about some key changes to the executive structure and roles. We should have just held our virtual Special General Meeting to propose these changes to membership.
We hope you were able to attend and take part in the meeting. It is important to us that members stay involved and are kept informed about key changes in the organisation.
We will be announcing outcomes of meetings via email so please keep an eye on your inbox. News articles are also posted on the MNZ website so you can view historical information and keep up to date with current news - https://www.massagenewzealand.org.nz/Site/members/news/.

We are getting close to our 2021 Annual General Meeting (AGM) which takes place on Saturday 18th September in Wellington. Meeting information can be viewed here on the Events page https://www.massagenewzealand.org.nz/tools/events/list.aspx?SECT=events. The AGM is a great opportunity for membership to hear about strategic planning, finances and any further proposed changes to the MNZ Constitution. Elections are held for members of the Executive Committee. Members are encouraged to review the information prior to the meeting and provide feedback and input for the organisation's goals. Updates and information are provided via email and posted on the News page https://www.massagenewzealand.org.nz/Site/members/news/. Please send your RSVP including apology to Nici at admin@massagenewzealand.org.nz by 20th August. CPD hours are available for attending the workshop and AGM.

We look forward to seeing you and hearing from you in person this year at the AGM.

MEMBERSHIP UPDATE

As of the 1st of June 2021, we have a total of 395 members. This is an increase on the same time last year. We are thrilled to see a good recovery from the impact of COVID-19 on massage therapy during 2020.

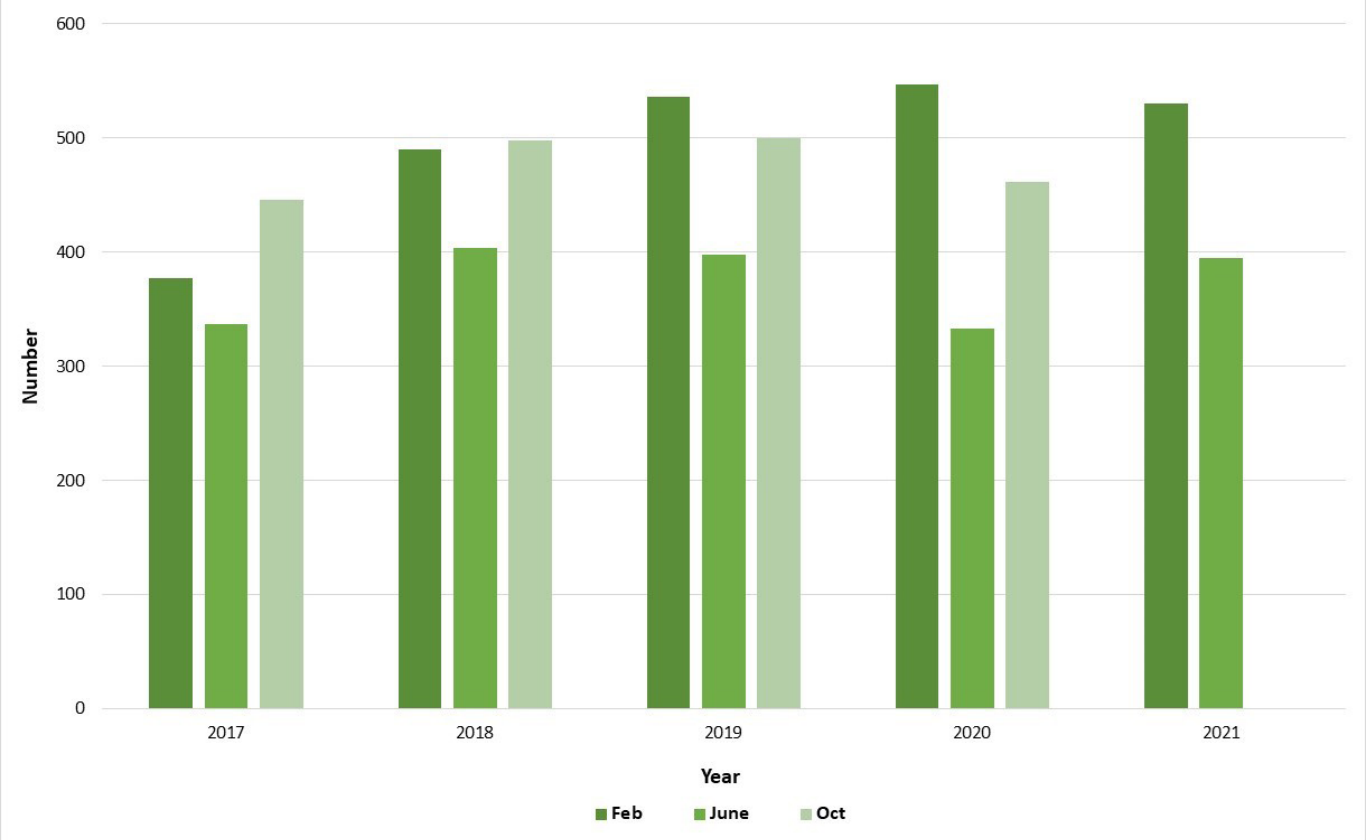
June 2020	June 2021
RMT: 274	RMT: 353
SMT: 48	SMT: 30
AFF: 11	AFF: 12
Total: 333	Total: 395

We have seen a number of student members graduate and upgrade to practicing RMTs. Congratulations to all students who have just finished. Please do remember to upgrade your membership to RMT! Please do encourage any student therapists you know to join and enjoy the benefits of membership and graduate renewal fees.

And finally, remember to keep logging your CPD via the members' area of the website and to maintain your first-aid certification.

For any membership or CPD queries please contact Esther at membership@massagenewzealand.org.nz

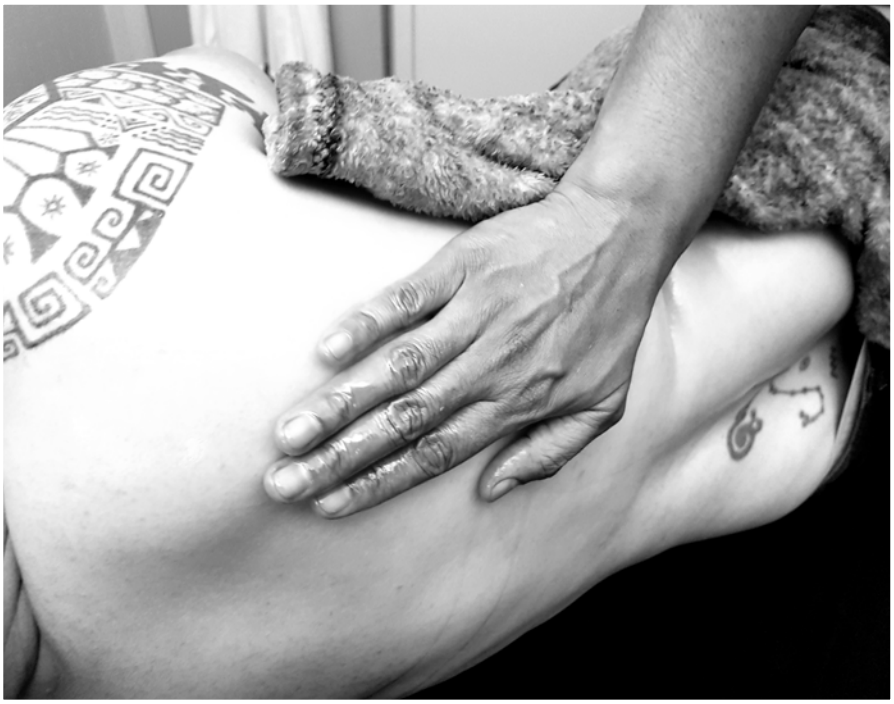
MNZ MEMBERSHIP FIGURES 2017 - 2021



WHAT IS ONCOLOGY MASSAGE?

ONE THERAPIST'S PERSPECTIVE OF ONCOLOGY MASSAGE.

By Bernie Withington, BHS(NMT), RMT



Oncology Massage ('OM') is an adapted form of gentle, slow massage that is designed to reduce symptoms of treatment for cancer patients or those with life limiting diseases. Despite being established internationally in the early 2000s, according to Oyston & McGee (2012) it was more than a decade before it was embraced by Australian massage therapists, and later for New Zealand massage therapists.

There are several clinical considerations to be undertaken when working with this population of clients, which are taught by the highly qualified facilitators at Oncology Massage Limited, Australia ('OML'). Although we take clinical considerations into account for all our clients and this may seem pretty straightforward, there are a number of aspects that require consideration. Achieving a cohesive balance of each aspect is essential.

HEALTH HISTORY AND PRE-TREATMENT CONSULT

The health history form for an oncology client is comprehensive including date(s) of diagnosis, treatment received, side effects from any of the treatment, it essentially requires them to re-tell their story. Whilst it is optimal for the massage therapist to have as much health information as possible, it is likely to have an emotional impact on the client having to re-tell their story, so an empathetic and cautiously patient approach in the consult prior to a session will serve the therapist well.

The pre-treatment consult of a cancer client requires the therapist to be conscientious and consciously present, listening to the client with all of your senses is essential. Some clients are too tired and fatigued to answer a lot of questions, their breathing may be quick and shallow and voice quiet or raspy. If their caregiver is doing most of the talking, paying attention to the body language of the client is going to give the massage therapist a number of cues about how the session will proceed.

TREATMENT FOR ONCOLOGY CLIENTS

There are few occasions when we are not able to provide some sort of treatment for oncology clients. Depending on the fragility or skin sensitivity of the client, the treatment may be as subtle as a series of holds named 'Bone marrow support sequence' ('BMSS'). BMSS was created by Eleanor Oyston, founder of Oncology Massage Limited / Oncology Massage Training, Australia. Eleanor has been providing massage therapy for cancer patients since 2002, and at that time had spent more than 30 years in medical science and research.

BMSS is "systematic touch, in a particular sequence around the body, is thought to stimulate the immune system through the principles of deep relaxation" (Oncology Massage Ltd, 2015). The placement of the therapist's hands is part of the training along with the basic rules of the sequence. This is just one of the sequences therapists learn from OML.

Treatment plans for oncology clients are individualised not just for the sequence and pressure of touch, but the duration, which may vary considerably, depending on what they are experiencing physically, emotionally, mentally, physiologically, spiritually, and what their current tolerances are. This may change as they progress through their treatment.

OML teaches three levels of pressure, not including the gentle holds. The three pressures are taken from Tracy Walton's massage therapy pressure scale, of which there are five (Walton, 2010) "light lotioning, heavy lotioning, and medium pressure" are simply referred to as OM1, OM2, and OM3. The remaining two pressures are not used in oncology massage as the pressure is too strong.

During their medical treatment regime, some oncology clients experience pain, fatigue, nausea, dizziness, depression or anxiety, OM "reduces the side effects experienced from conventional treatment of cancer and the symptoms of the disease process itself" (Cassileth & Vickers, 2004). Taking all of the side effects into consideration, and the stage of treatment the client is at, the duration of the session may need to be reduced to as little as 15-20 minutes.

If the OM client has come to the clinic, they may need some assistance with getting on and off the table. Asking the client what position they sleep in will assist in planning the treatment and how to work with the client.

HOSPITAL, HOSPICE OR HOME

Some OM therapists offer a mobile service and may treat a client in hospital, at hospice or even the home of the client. Often, when visiting clients in hospital or at home it is at the request of family or carers. Hospital visits require agreement from the medical team to ensure there are not extra protocols they require the therapist to follow, i.e. wearing a mask, gloves, gown, but also not to interrupt medication administration. The therapist is responsible for knowing how to adjust or move the bed without disconnecting any medical devices, checking whether any IV lines are inserted, or where any catchment bags are.

Hospice visits are much the same as hospital visits, with the exception that some hospices have massage therapists on staff. If this is the case, it is professional courtesy to speak with the either the medical staff, the employed massage therapist or both. This ensures protocols are adhered to, and whether it is appropriate to see the client while in hospice care. Everyone wants what is best for the client and having a respectful relationship with other health professionals is important.

Visiting a client at home creates a shift in the dynamics between the therapist, the client and their family. Maintaining professionalism and not becoming too familiar if there are multiple visits can be challenging or even confronting, especially during end of life.

THERAPIST'S MINDSET

OM training has an important role in preparing a therapist for OM, as they are confronted with their own mortality when working with cancer clients (Oyston & McGee, 2012). When a therapist is working with OM clients, it is imperative they do so without ego. Enter the session with a clear mind, calm breath, soft voice, conscious listening and an open heart. Be humbled by the absolute privilege of spending time with someone who is facing possibly one of the most challenging health experiences of their lifetime, some of whom may succumb and transition away from this lifetime.

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AUTHOR BIO

Bernie Withington BHS (NMT), RMT L7 is a massage and lymphatic therapist who began retraining in massage in 2015, undertaking the certificate in relaxation massage at NZCM, Wellington as a part time course while working full time. She commenced full time study in 2017 and continued part time every year until completing the degree in 2020.

Bernie completed OM1 and OM2 training in 2018, MLD in 2019 and DLT in 2020; all contributing to her intention to work with oncology and health compromised clients.

In 2020 she opened Waiora Collective, a practice of complementary therapies and holistic health practitioners in Porirua.
www.waioracollective.co.nz

MY EXPERIENCE AS AN ONCOLOGY MASSAGE THERAPIST

By Tess O'Toole, RMT

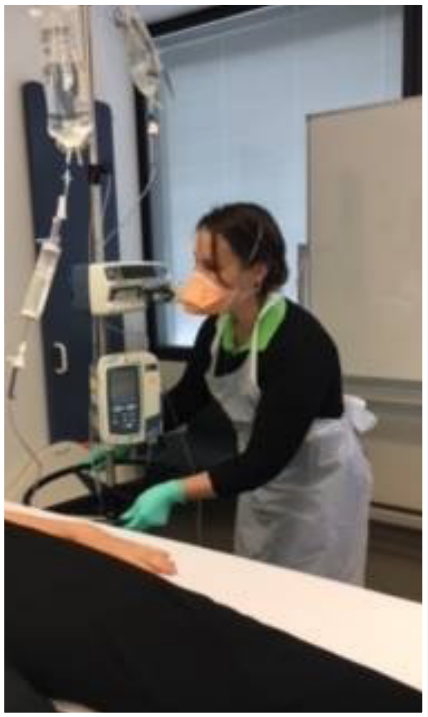
Oncology Massage (OM) is a hugely rewarding modality as well as an incredibly challenging one. Safe therapeutic touch during a person's cancer diagnosis, treatment and even palliative care can provide them with some normalcy in what can otherwise be a disruptive, painful, scary, and uncertain time in a person's life or the life of those around them.

I investigated massage therapy 17 years ago as I was always interested in biology - I was very young when I fell into the massage study path but found that I did, and still do, enjoy it immensely. I delved into personal training to better understand movement and enjoyed working in conjunction with physiotherapists and osteopaths for rehabilitation. I've worked in several massage clinics and gyms before opening my own multi-room clinic BodyCentral in Christchurch in 2015. I've always enjoyed the level of education, variety, psychology, problem solving, connection, importance of touch, normalizing massage as a modality/ maintenance tool and solidifying its niche in allied health.

When I started training in OM five years ago, it was so foreign to me as I was primarily a deep tissue therapist, but I'd been seeing it come up in health history forms more often and didn't know how best to adapt. And then I had a close family member diagnosed with cancer. He had yearly relapses and further treatment until he was diagnosed with stage 4 melanoma and suffered a stroke from metastatic brain tumours which paralysed him and propelled him into palliative care. Despite my training in massage, he'd not often asked for massage, so I assumed he didn't really like it. But during his treatment and palliative care in hospice, he asked daily for foot massage. It became a way we connected, a way to help him using my skill set, and made me realise how important touch was in the context of life-threatening illness. And surely there's more you can do than massage hands and feet!

I found a company called Oncology Massage Limited (OML), based in Australia. They were the only training facility I could find that was offering OM training in New Zealand at the level I was interested in, so in 2016 I did their first introductory course in Auckland. The facilitators teaching the course were science-oriented and educated, but non-judgemental and nurturing. It was a perfect combination for me. I completed the OML Foundation programme 1 and 2, which enabled me to practice clinically. The following year I continued to the OML Advanced programme at Olivia Newton-John Cancer Care Centre at Austin Hospital in Melbourne, where I trained and massaged in each cancer ward of the hospital including end of life care. I've been able to work within the medical system at Christchurch Hospital, alongside nursing staff, and collect data to aid in the provision of more alternative therapies for cancer patients during their hospital stay. More recently I've been assisting on OML courses, with the intention to help teach the courses here in New Zealand.

The training offered by OML is a combination of theory and practical. It is important to learn about cancer in terms of how it develops and is treated. Cancer is so common now, I think every therapist should be educated on the effects of treatment such as surgery, chemotherapy,



immunotherapy, and radiotherapy and how best to adapt massage to suit, or when to refer to someone more specialized.

OM differs to "regular" massage in several ways (MacDonald, 2014):

- New techniques ensure treatment supports a potentially inhibited lymphatic system or avoids the risk of treatment related fatigue.
- Gentle massage targets different receptor cells to elicit the most useful state of recovery and calm in the body - the relaxation response.
- Intake considers side effects from surgery and treatment and ensures that pressure and positioning are appropriate for each client.
- Training prepares therapists emotionally for the reality of working with people going through cancer treatment and after effects.

During treatment, clients become very accustomed to receiving "medical

touch", and while it is provided with care, it can differ from the nurturing, therapeutic touch that OM offers. For some clients it provides some normalcy in the foreign and rapid landscape that is cancer treatment; it can be a change in their everyday routine; for others it is an outlet for their experiences to a non-involved party. Clients can be massaged at any stage, and I've had experience with all of them – directly after diagnosis and before their first stage of treatment, during all kinds of treatment, while hospitalized, during their palliative stage toward end of life, as well as patients years after recovery.

It's a hugely rewarding modality as well as a challenging one. You must solidify your boundaries, be prepared for good and not so good news, let go of your programming around your responses, be careful of your biases and opinions, alter your previous training and be open to not getting 'results'. The hardest part of OM is that you do create relationships with clients, some of whom suffer tragedy, some become palliative and some of whom are the same age or have life similarities with you. You must take great care to ensure your own emotional health is sturdy so you're able to continue to provide a service without any transference of previous experiences with cancer/death.

You can always provide therapeutic touch. And people who have cancer are exactly that. People. Who have cancer. The more accessible, scientifically backed, and non-judgemental this service is, the better we can understand how best to treat and support people who come to our clinics.

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AUTHOR BIO

Tess O'Toole is the owner of BodyCentral Clinical Massage Therapy in Christchurch and has been practising Oncology Massage in clinical, hospital and palliative settings since she trained in 2016.

A PERSONAL JOURNEY TO A PROFESSIONAL CAREER: OH THE PLACES YOU'LL GO!!

By Anna Barton, RMT, Lymphatic Drainage & Oncology Massage Specialist

It is a great honour to be able to share my journey of how I got the privilege of working as an oncology massage therapist at Dove House on a casual basis for three years. Dove House is a charitable trust, the only one of its kind in New Zealand, supported by Dove Hospice shops. Set in a tranquil setting within the grounds of St Andrew's Retirement Village in Glendowie, Auckland, Dove House is an outpatient facility offering nursing input complementary therapies, counselling, clinical and emotional support. It also provides group support and activities to palliative patients, those with life threatening illness, their families, carers and the bereaved. Included in Dove House services is a private three-bed palliative care unit, situated within the 24-hour care unit of St Andrews Village for patients with palliative care or respite needs. Dove House services are available to anyone of the above mentioned criteria who can physically make it into Dove House, no referral needed. They can be referred by professionals involved in their care, or they can self-refer. (You can find out more about Dove House at the link at the end of this article).

Dove House is a place that I never thought I would be working in when I started my remedial massage journey at the New Zealand College of Massage in 2009, graduating with my Diploma in Health Sciences in 2010. As I am sure many of you can relate, our work evolves with not only hands-on experience and hunger for learning, but also with life. And it is life that brought me to oncology massage and to Dove House, and I am very grateful for that. It was a personal journey that sparked my interest in learning and working in oncology massage, 8 years into my RMT career. I loved where my RMT career was taking me, not only with my hands-on work and continuing education including full training in lymphoedema therapies, but also running a busy clinic in Auckland CBD with some of the most amazing and skilled therapists working alongside me.

Then one day my life changed in a moment, when my partner was diagnosed with glioblastoma multiforme, stage 4 terminal brain cancer. For the following 22 months, cancer was a rude awakening and became our world. Sadly, my partner lost his fight, 14 months longer than he was given I might add, during which I witnessed the most inspiring and strong drive to beat his cancer.

In that 22 months, both my partner and I were lucky enough to be patients of Dove House on recommendation from a colleague who was working there at the time. We both received oncology massage and counselling for each of our separate journeys that came with his cancer. As it happens, I received my training with Australian-based Oncology Massage Training (link at the end of this article) levels 1 and 2 at Dove House. When I was eventually signed off as a patient, I was offered casual work in their body therapies team as an oncology massage therapist. I was fortunate to work alongside a skilled and experienced team of massage therapists, lymphoedema therapists, as well as learning from nurses and psychotherapists specialising in this area of the health system. All being a huge part of building my confidence and experience within the world of oncology.

While sad, traumatic and life changing, along with so many other adjectives I know many of you can relate to with loved ones either lost to, or battling life-threatening illness. This experience of finding myself as primary carer to my partner, all while continuing my work as an RMT/ business owner, has steered me in the direction of where I now find my passion in my work today, in the world of oncology.

A typical day at Dove House starts early, with a meeting including the entire team of body therapists, psychotherapists, and nurses, each getting the opportunity to discuss the patients we are scheduled to see that day. Patients are shared amongst the different departments, allowing the opportunity to offer input or feedback that may add to

each patient's therapy that day in order to ensure they each get the most out of their session. This makes for a very personalised service, in an otherwise large organisation. This is also reflected in feedback Dove House receives from their clients - that they feel so lucky to be so cared for in a place that feels like home. With cake and tea included.

Typically, a massage therapist will see five patients in a day at Dove House, each allocated to a one hour session. That hour includes consult, allowing the patient time to be on and off the table according to their abilities. This means that hands-on time is usually around 30-40 minutes and even sometimes much less. As any massage goes, the treatment is applied according to the patients' needs that day, bearing in mind any restrictions or contraindications they might have, whether they are undergoing any treatment that may be affected with massage, such as chemotherapy or radiation, ports, or positioning that is uncomfortable for the patient. These considerations are a large part of the learning in oncology massage training, as well as applying massage safely. We also learn there is always some kind of touch therapy that we can offer, no matter where they are at in their journey or treatment, which very often may only end up being in the form of extended hand holds in a series some of you may have learned, known as "the bone marrow support sequence", where there is no circulatory effect. Or maybe simply a nurturing foot or hand massage. This type of massage can often make their day, their week, their entire journey. Lesson learned from an RMT: never underestimate the power of simple nurturing touch.

At Dove House notes are kept for each of the clients with access to all there is to know from timelines, stages of disease, diagnosis and treatments, as well as notes from previous body therapy and counselling they have received at Dove House. Most patients under the care of Dove House, while varying in wellness, be it in

survivorship, undergoing or in-between treatments, or palliative, are all well enough to physically come into their therapy. Dove House also offers a small allocation of mobile therapies in the homes of local patients who are not well enough to physically come in, as well as in Dove Wing, the three-bed palliative care unit on the grounds. As previously mentioned, Dove House also offer services to close family and primary carers as well as the bereaved. I personally found this a very rewarding part of my work at Dove House, given my own experience in receiving therapies in this capacity. As many of you may have experienced in your own personal lives, caring for a loved one going through a cancer journey or life-threatening illness, no matter the prognosis, is a particularly difficult on the carer too on so many levels. So being able to offer care to this group was very rewarding.

While my main focus in writing this is to share my overall positive outlook in working within the oncology field, both within the team at Dove House and in my private practice, it is important to mention that oncology massage does not come without difficulties or hurdles. Particularly when first stepping into this field, the obvious being the emotional effects of working with clients who are experiencing hardships, physically and emotionally. Hardships that some of us can only imagine, or possibly had never considered. Yes, this can be confronting and upsetting, and difficult to not take that home with you. Another hurdle, on a business level, is that clients can sometimes cancel last minute due to poor health or emergencies. Something we as therapists have to accept case by case. This obviously can be difficult on a financial level if you are working in private practice.

As with most hurdles, these difficulties do become easier to handle with time and experience. I would recommend seeking some sort of supervision or mentoring to help deal with these difficulties on a personal level, and also to grow your skills. At Dove House, supervision is offered and scheduled into each therapist's calendar. It is regarded as a high priority and help is always available from the team if needed.

I now primarily work from my private practice, offering oncology massage and manual lymphatic drainage/ lymphoedema therapies. Bringing with me all the experience and skills from working at Dove House. While I was lucky to have that experience, this work can of course be integrated directly into your own private practice, especially if seeking advice or mentoring. I suggest you find out more information on how to do this from your training provider.

So overall, the field of oncology is a place I am personally so grateful to have evolved to and it is a field in which I wish to remain. I am open to where else it may take me and my learnings. As I always say, and am sure you can relate, the more we learn about our magnificent and intelligent bodies, the more there is to learn!

In sharing my journey of events into the world of oncology, not only personally but professionally too, it is my wish to invite you to consider exploring oncology massage training, even if only to add as another tool to your kit. I will be blatantly honest, starting my career in remedial massage many years ago, I never saw myself in the field on of oncology. Not only finding myself with the most honourable and humbling experience of working with the team and patients of Dove House, but also in my private

practice where I now treat clients mainly with oncology massage and manual lymphatic drainage. My client base consists mainly of those undergoing treatment, or with complications from their treatment such as lymphoedema, palliative clients and even survivors. Back then, I simply put this field of work in the 'too hard basket' where I presumed this area would be too difficult and draining emotionally. Where in fact, I now find myself opened to a world I had no idea would come to be, with knowledge and experiences that I find myself fortunate to be a part of.

After finishing a shift at Dove House, after a full day of massaging clients who are going through things we only hear about, I would leave literally energised and humbled, a most unexpected feeling to what I had presumed. The difference I get to make to each patient's day, or to their overall journey. Giving them something to look forward to, often only with simply nurturing touch, when they are otherwise receiving the very opposite, of mostly being aggressive or painful, or simply no touch at all.

While I still have so much to learn, and so much yet to experience in this field, this keeps life and work beautifully interesting, as well as giving me motivation to keep evolving in my practice, for myself and for the care of clients in need of our services.

LINKS

Dove House, Dove Hospice
https://www.dovehospice.org.nz/what-is-dove-hospice

Oncology Massage Training
https://www.oncologymassagetraining.com.au/index.php?content=49

AUTHOR BIO

With a background of 12 years working as a level 6 remedial massage therapist, at her private practice Body Matters in Auckland CBD, as well as 3 years working casually at Dove House (Dove Hospice), Anna now specialises in manual lymphatic drainage (MLD), with full Lymphoedema training undertaken in New Zealand and Australia. Also fully trained in Oncology Massage, Anna has the knowledge and skills, as well as a personal experience, of the journey one goes through with cancer, and she loves to make a difference with gentle touch therapy for those who are at any stage of their cancer or treatment. She continually keeps up to date with upskill training to improve her knowledge and practice. You can find out more about Anna and her clinic at www.bodymatters.co.nz

HOW TO GAIN YOUR MASSAGE DEGREE THROUGH SIT BLENDED DELIVERY

For Massage practitioners who have a diploma in massage and want to upgrade to a degree qualification, it's now possible to complete Year 3 of the Bachelor of Therapeutic and Sports Massage (BTSM) through blended delivery at Southern Institute of Technology.

SIT's Year 3 of the BTSM comprises of four papers, suitable for massage therapy professionals who hold both a New Zealand Diploma in Wellness and Relaxation Massage (L5) 120 credits AND a New Zealand Diploma in Remedial Massage (L6) 120 credits, or the equivalent.

Becky Littlewood – BTSM Graduate

Wellingtonian Becky Littlewood wanted a degree in Massage Therapy, but after studying the first two years in Wellington, she couldn't justify the cost involved in attaining that third and final year. Through SIT offering Blended Delivery of the Year 3 BTSM, and the Zero Fees Scheme, Becky was able to complete her degree, and has gained a long list of achievements in the process.

"When distance learning was offered for Level 7 at SIT, I jumped at the chance! Working to pay for flights and accommodation was a lot easier than adding to my student loan", she said.

Year 3 can be studied full-time over one year or part-time (usually completed within 3 years). Part-time study is recommended if the student has other commitments greater than 20 hours per week.

Becky's year of study consisted of: Three face-to-face teaching blocks at SIT - blocks are of one week's duration each (March; August; November), and compulsory; Massage Therapy clinical practice in her own community, and online learning and tutorial classes.

She said Level 7 is more of an academic than practical year, and she had a productive period developing a range of life skills which will benefit her career in the future.

"I have written my first research article, which has been really exciting".

She's also written: a case report, business plan, clinic management report, a blog, magazine article on reflective practice, professional development and industry participation reports, special populations report; produced a workshop, delivered a seminar, designed and presented a research poster, completed clinical reasoning challenges, and worked with athletes.

SIT ZERO FEES SCHEME

The programme is eligible for the SIT Zero Fees Scheme. Choosing SIT and the Zero Fees Scheme enabled Becky to achieve her goal of a Bachelor's qualification, because it's been affordable.

"Zero Fees has been hugely helpful. Without it, I would not have had the opportunity to complete my degree".

BLENDED DELIVERY

Blended delivery format gives students the flexibility to remain in their home town massage therapy clinics and communities. It has worked well for Becky, allowing her to carry on with her life and achieve her goal of a degree.

"Blended delivery has been fantastic, I've been able to study around my work and family commitments and whilst the workload has been high at times, it has ultimately been manageable with some extra-long hours thrown in".

During the face-to-face learning blocks at SIT, Becky enjoyed interacting with students on her course, utilising campus facilities and discovering Invercargill.

"I've had the opportunity to visit and get to know Invercargill, and also to get to know my fabulous classmates, who are from all over NZ".

NZ'S FIRST MASSAGE THERAPY DEGREE AND RESEARCH CENTRE

In its twentieth year, the BTSM was the first named massage degree programme to be approved in New Zealand. Experienced teachers and their depth of knowledge are a key component of this well-regarded qualification, as are small class sizes, enabling a true 'hands-on' approach to massage therapy education, and tutors who are accessible to students.

SIT established The NZ Massage Therapy Research Centre (NZMTRC) in 2009, to foster massage therapy research in New Zealand. The NZMTRC aims to promote research and teaching across the wider massage community and provide access to New Zealand-based research findings.

The body of work after 20 years - from research conducted by SIT massage therapy staff and students - has resulted in: 2 PhD theses, around 12 publications in academic journals, numerous articles in the Massage New Zealand magazine, over 70 research posters (accessible via NZMTRC), and numerous conference presentations,

including a keynote address at the 2016 International Massage Therapy Research Conference.

Also, importantly for building capability and capacity, there is ongoing encouragement for graduates and peers to engage in Master's and PhD-based research activities and publication of research findings. Research activity has and continues to inform the local, national and global massage therapy industry, as well as informing teaching.

BTSM BENEFITS – GRADUATE PERSPECTIVE:

- Consolidation of learning
- Breadth and depth of knowledge and clinical application
- Growth as a professional
- Work readiness
- Greater Credibility

Becky said the highlight of the course has definitely been the tutors.

"They are amazing, very knowledgeable and hugely supportive. They impart high-quality teaching and are truly inspiring".

In terms of future goals, Becky says her year studying through SIT has given her everything she wanted, and more.

"I'm looking to develop new branches to my massage practice, and being able to explore these ideas through the work I completed at SIT has really helped… studying through SIT has given me the confidence I needed to make this happen".

Applications are being taken now, apply online at:

https://student.sit.ac.nz/mySIT/onlineenrolment.aspx?course=4649&_ga=2.54918635.1536751499.1598304145-199155054.1589757828

More information link: https://www.sit.ac.nz/programme/course/Bachelor%20of%20Therapeutic%20and%20Sports%20Massage

Information on RPL: https://www.sit.ac.nz/Prior-Learning

Material fees for the year's study are around $1,050.

Further information is at: https://www.sit.ac.nz/programme/course/Bachelor%20of%20Therapeutic%20and%20Sports%20Massage.

Contact Jo Smith for enquiries about Year 3 of the programme: jo.smith@sit.ac.nz

LESSONS FROM A MASSAGE THERAPIST TURNED CANCER PATIENT

By Meaghan Mounce, BSc., RMT

I have been interested in helping cancer patients for a long time. Little did I know I would become one myself. It seems everyone has been touched by cancer. Here is my story.

At 36 years old, I was enjoying life with a one-year-old daughter, a wonderful husband and a busy and successful massage therapy career. During a self breast exam I discovered a lump. I had a mammogram, an ultrasound and an immediate biopsy (three actually) of my right breast. I knew that day that it was cancer. I was told I would be having surgery within a month.

My immediate reaction from being diagnosed with breast cancer at only 36-years-old was anger. I was very angry. My next thought was of my career and my finances. I was a self-employed Registered Massage Therapist in Nanaimo, British Columbia, Canada. I did not have critical illness insurance, nor did I contribute to unemployment insurance. Any time off I needed would not have any income.

I met with my cancer surgeon quickly after my diagnosis. Because of my lifestyle, my career and my young daughter, we decided on a single radical mastectomy of right breast and lymph node removal. I would also have a tissue expander placed under my right pectoralis muscles to make space for a breast implant during breast reconstructive surgery. I was told I could not lift anything heavy for at least four weeks, meaning I could not carry my daughter, nor could I massage.

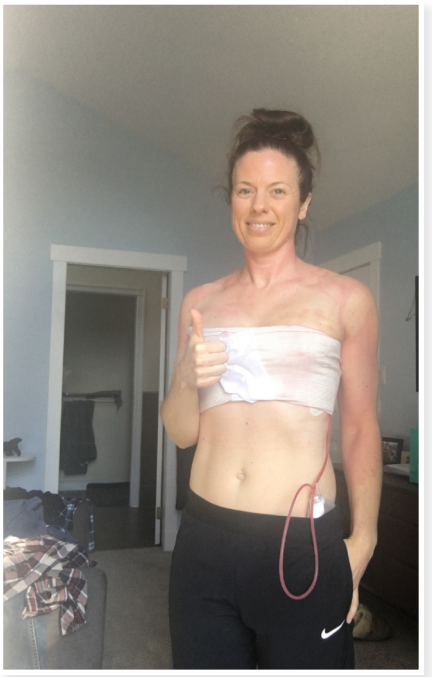
The surgery was successful, my right breast, nipple and several lymph nodes were removed. I was determined to be back at work as soon as I was able. I diligently moved through range of motion exercises for my right shoulder and regained full range of motion four weeks after surgery. I went back to work. I picked up my daughter. I lifted weights at the gym.

Working on my range of movement

My breast cancer was estrogen and progesterone positive, meaning the cancer cells were fueled by these hormones. I began hormone treatment to decrease estrogen production and prevent estrogen from binding on its cell receptors. I was told I will be on this medication for the next ten years. I would not be having a second child.

With my right breast removed, I no longer wanted my left breast either. I had a hard time seeing the difference on my chest and I also wanted to further decrease the chance of having a breast cancer reoccurrence. I still had a lot of life left to live!

Four months after my first mastectomy, I had a prophylactic mastectomy of my left breast. I no longer had breast tissue or nipples. I was left with scars and pectoralis muscles with tissue expanders beneath. Again, I was told I needed to take four weeks off work. Four weeks off lifting weights at the gym. Four weeks off lifting my daughter. Determined, I was back at work again four weeks after my second mastectomy.



After my second mastectomy

One year after my cancer diagnosis had breast reconstruction surgery. My perky pectorals were formed! I am now 38-years old and will remain on hormone blocking therapy for the next several years. I have learned some lessons during my cancer journey that I hope will help others when treating cancer patients and caregivers.

FIX TO SURVIVE

As a cancer patient you ride an adrenalin high from appointment to

appointment. From surgery to surgery. You wait for results. You tell your story over and over. The primary focus of cancer surgery, treatment and life after cancer is to cure the patient from disease and prevent or slow reoccurrence or metastasis. A team of health care professionals try to fix cancer patients to survive.

Once the surgeries and treatment end, the real healing begins. A cancer patient may no longer want to be 'fixed'. Massage therapy considerations should be based on the patient's goals. Certainly, some patients will want to work on regaining range of motion after surgery or decrease lymphedema or long-term side effects from radiation. Some patients may want to bring back body awareness and feel confident after life altering surgery. Many cancer patients have forgotten what it feels like to be touched in a safe, nurturing way.

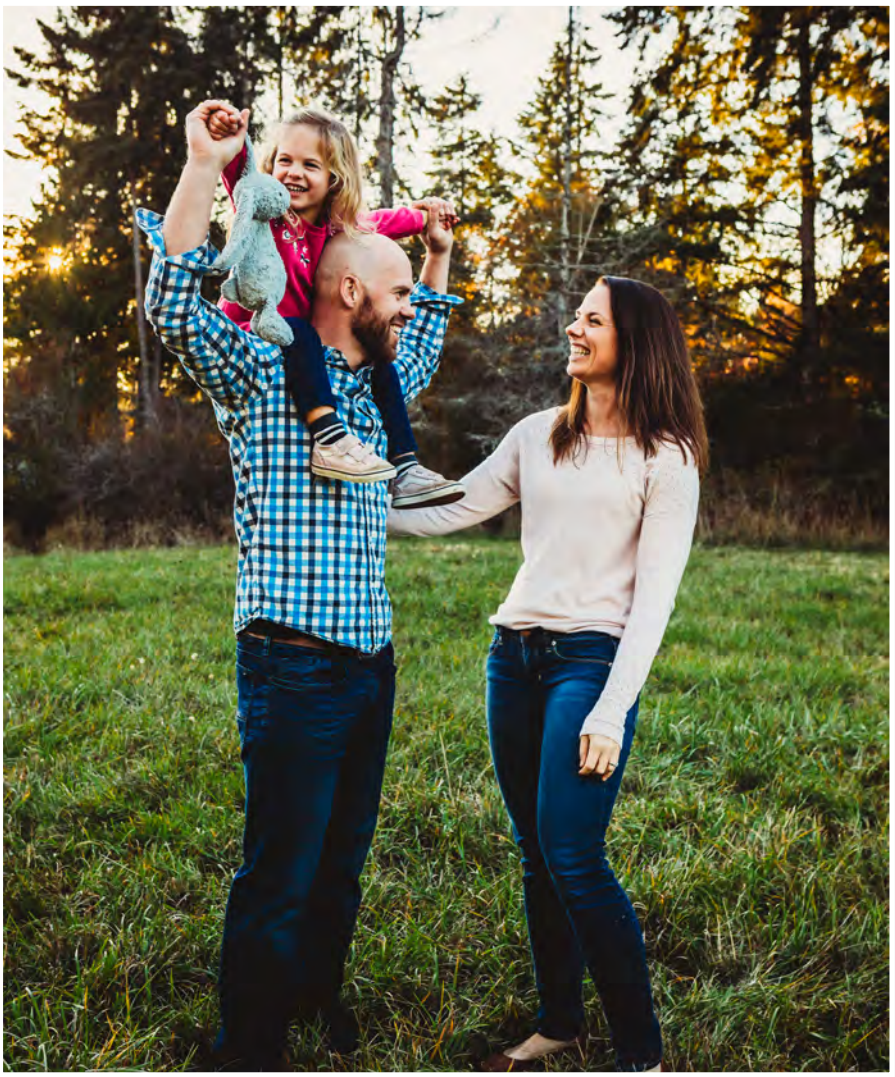
Most cancer patients will seek massage therapy treatment after active treatment has finished or during end-of-life care. Consider the patient's goals rather than their cancer diagnosis.

CARING FOR THE CAREGIVER

From the age of 10 until I was 20 years old, I watched my mom battle breast cancer. In the final stages of her life my Dad and I helped dress her and move her from chair to bed. We cooked the meals. We cleaned the house. Roles changed in our home.

Caregivers have a big ask. They must be a primary support system, both emotionally and physically. They take on more roles at home, while potentially having to be the primary income earner. Often caregivers do not make time for themselves. Offer caregivers a safe space to relax or share their frustrations grief and anger.

Through life experience my goal is to educate other massage therapists to feel confident in providing a safe space for cancer patients and caregivers. Today, I am proud of my journey and my body and I hope that sharing my story helps others.



Loving life with my family

AUTHOR BIO

Meaghan Mounce is a Registered Massage Therapist and fitness instructor in British Columbia, Canada. She holds a Bachelor Science with a major in Biology and has completed several continuing education courses in Oncology Massage.

Meaghan is passionate about strength training, movement and the outdoors. You can find her in the gym or outdoors hiking, biking or paddle boarding with her husband and four-year-old daughter. Meaghan is a breast cancer survivor and advocate and shares her story to raise awareness for breast cancer in women under 40.

NICKY'S STORY – A PATIENT'S PERSPECTIVE

It was March 2016 that I was told I had breast cancer. Stage 3 triple negative breast cancer. This type of cancer doesn't respond to drugs such as Tamoxifen and Herceptin and being Stage 3 needed chemotherapy quickly. I had six months of chemo to try to shrink the tumour, followed by a mastectomy and full axillary clearance – they removed my left breast and all the lymph nodes in my left armpit. I also opted to have the right breast surgically removed too. After that I had radiation treatment, then 3-monthly check-up for the first two years, then 6-monthly check-ups and I'm about to have my final five-year check-up. ***(Editor's note: by the time this issue is published, Nicky will have received her final check-up).***

Nicky receiving chemotherapy

The chemo was really strong, but I didn't find it too bad because I tried to keep my life as normal as possible, doing my same chores, especially my horses. I love my horses. I would go on a Thursday and have chemo, and I would be back at work on the Monday. But I did find that by the Sunday I'd have to ask someone to come in and take care of my horses – mucking out the paddocks, looking after them, feeding them etc.

The first three months were the hardest, because the chemo was the strongest. Then the next three months was weekly treatment with different side-effects – my fingers and toes went numb. They still are a bit numb – some days worse than others.

Then I set myself a goal of clerking at the Christchurch A&P Show. That is basically marshalling on horse-back for the equestrian events and involves three full days of riding. It's something I do every year. I had to put my surgery back by a week, but my surgeon said, "hey if you want to do it, do it". It was important to me to keep doing things that were "normal".

I also decided that I wanted the other, non-affected, breast removed, which my surgeon wasn't that keen on, but I insisted – I didn't need that breast and I didn't want to risk anything. Surgery was mid-November, after the Show. After that it was the results. They said they had "good clearance", and only found a tiny bit in just one lymph node. Based on that and being, what they said was 80% clear, I didn't need radiation. It was up to me. But radiation would take me to between 90-100% clear and I said, "bring it on!"

In January 2017 I started radiation for 25 days. That I found harder than the chemo. With chemo I knew I was getting it, but with radiation I was going in every day and getting "zapped" for just seconds. I thought that when treatment finished, "yay it was over!" It wasn't until it was two weeks after, that I felt like I was burning from the inside out. I didn't realize I was going to go through another six weeks of pain.

Because I had all my lymph nodes removed, they gave me a compression bandage, and I had the work of getting my arm back to being supple and being able to move it and put it above my head. I love my horses and I love my riding and I wanted to keep myself active. I had to get my arm moving to able to ride. If I lost my riding and lost my ability to work my horses, I'd be devastated. So, the big thing was doing my exercises and to keep doing them.

It's important to look after myself as well as having some professional help. After treatment I was offered Cancer Care with a physio I could see who is trained to do the rehab and lymphedema management. But it was a long way to travel from where I live out in the country across town, so I started to look around to find somebody else local that could help me.

Nicky is back competing on her horse again

I found a massage therapist closer to home and it was important to me to find somebody who knew what they were doing, so it took a while to find someone. I found somebody who had received training specifically in oncology massage, someone who's qualified to be able to do it. My therapist was able to work on my scars and help me move my arm more. The massage was pretty gentle to start with, but she would help me stretch too. I felt like I could move my arm more after massage.

This person has been my regular person doing massage and looking after me. They know my body as well as I do. I know that if they felt anything different, they would tell me "This doesn't feel like it normally does", and that's been a benefit for me. It's been like a security blanket for me going through the last 4 years that I've been going to them.

It's been a pretty anxious time for me these last few years, a lot of nerves and some panic attacks about "is it going to come back?" So the massage has also helped relax me. It's nice to have that time for me away from all the other things. As well as knowing that if they felt something that didn't feel right, they'd say something - it gave me the confidence that I have that second backup.

I've also had a routine since the operation, it's something that I do to take care of myself. I sit down every morning, with my cup of coffee, and I massage my arm. It's something I do to help prevent lymphedema. I'm a bit scared of getting lymphedema, because I might not be able to ride my horses. So, I massage myself and my massage therapist is careful of that arm too. No deep pressure. She's given me some massage balm that I use on my arm each morning.

My advice for anyone is do your research. Find someone who is qualified to massage someone dealing with cancer.

WORKING WITH WOMEN AFFECTED BY BREAST CANCER

By Natalie James, Lead Nurse at Breast Cancer Foundation NZ

Massage can be a great complementary therapy for breast cancer patients looking to manage symptoms or deal with the side effects of treatment. But as breast cancer comes with a range of complex diagnoses and treatments, it's important for massage therapists to have a good understanding of a client's goals and preferences, and how these fit in with a patient's overall treatment plan.

#1 cancer for women

As the most common cancer for New Zealand women, more than 3,300 are diagnosed with breast cancer every year – that's nine women a day. Of those nine, one of them will be Māori and one will be under 45. Men can get breast cancer too, around 25 Kiwi men are diagnosed each year.

Breast cancer occurs when abnormal breast cells grow in an unregulated way, usually forming a tumour. Breast cancer is not one single disease and there are various treatment pathways.

9 women diagnosed daily

SIGNS AND SYMPTOMS

While the most common sign of breast cancer is a lump, there are other symptoms to look out for, including:

- Changes in the skin (such as dimples, puckering or dents)
- Changes in breast colour (the breast may look red or inflamed)
- An inverted nipple
- Rash or crusting nipple
- Unusual discharge from the nipple
- Unusual breast pain
- A change in the size or shape of the breast

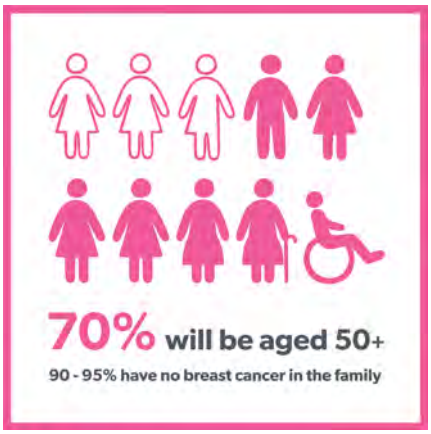
Most breast changes aren't cancerous but it's important to get any changes checked out by a GP without delay. Detecting breast cancer early gives the best possible chance of survival because small, early cancers are easier to treat.

Doing regular breast self-exams is a good way for women to get to know the normal look and feel of their breasts, and Breast Cancer Foundation NZ encourages women of all ages be breast aware. We have information on how to do self-checks and what to look for on our website and our Pre Check app.

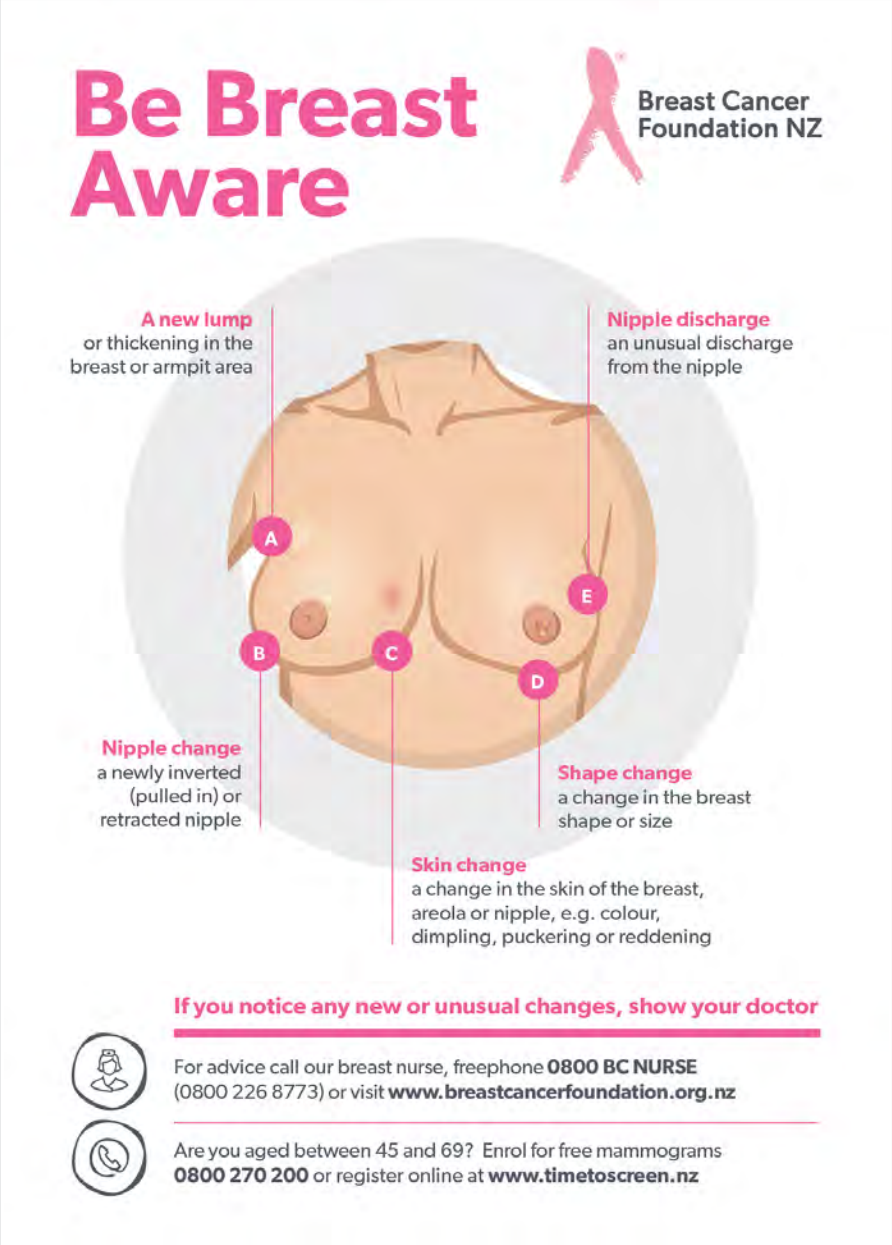
As the risk of breast cancer begins to increase from 40, we recommend women consider having regular mammograms at this age. The chance of surviving breast cancer 10 years or more is 92% when it's detected by mammogram, compared to 75% if a lump is the first sign.

10 year survival rate

Through the national breast screening programme, women aged 45-69 are eligible for free mammograms every two years. People can sign up through BreastScreen Aotearoa's website or by calling 0800 270 200.



70% aged 50+



RISK FACTORS

Since the cause of breast cancer is not fully understood, there is no way to definitely prevent it, but some things can be done to reduce the risk of developing it. Maintaining a healthy weight after menopause, keeping physically active and limiting alcohol consumption are some of the lifestyle choices that can help to lower the risk of breast cancer.

Some risk factors that can't be changed include getting older, family history, hormonal history, breast density, and ethnicity.

Contrary to popular belief, most breast cancers are not hereditary – around eight in 10 women with breast cancer don't have any family history of the disease. Women who inherit an altered gene are considered at high risk of developing breast cancer and can be referred for genetic testing to determine a possible plan for risk-reducing options.

TYPES AND FEATURES OF BREAST CANCER

Early breast cancer is divided into two main types – pre-invasive and invasive. The first is where cancer cells have formed inside the walls of the breast ducts but haven't invaded the surrounding tissue. This is known as Ductal Carcinoma in Situ (DCIS) and while it's not life-threatening, if left untreated it may eventually become invasive cancer.

Invasive breast cancer means that cancer cells have spread into the breast tissue and potentially also nearby lymph nodes. Invasive ductal carcinoma is the most common type of breast cancer, occurring in roughly 80% of cases.

The second most common type, invasive lobular carcinoma, is where cancer cells in the lobules have spread into surrounding breast tissue. It occurs in 8-10% of all cases and can be difficult to detect as cells tend to form in single-file strands which don't cause as much distortion of the breast tissue.

Tumours are also classified according to their expression of hormones (oestrogen and progesterone) and the HER2 growth factor receptors. Hormone receptor positive breast cancers use hormones to help them grow. Around 70% of breast cancers are oestrogen receptor positive (ER+) and/or progesterone receptor positive (PR+) and will require specific treatment to either lower hormone levels or block their effects.

Some breast cancer cells have a receptor on their surface which binds to HER2 – a protein which stimulates cell growth. This occurs in around one in five breast cancers and tend to be more aggressive and less receptive to hormone therapy. HER2 positive breast cancer previously carried a bleak prognosis, but the development of targeted treatments has significantly improved outcomes.

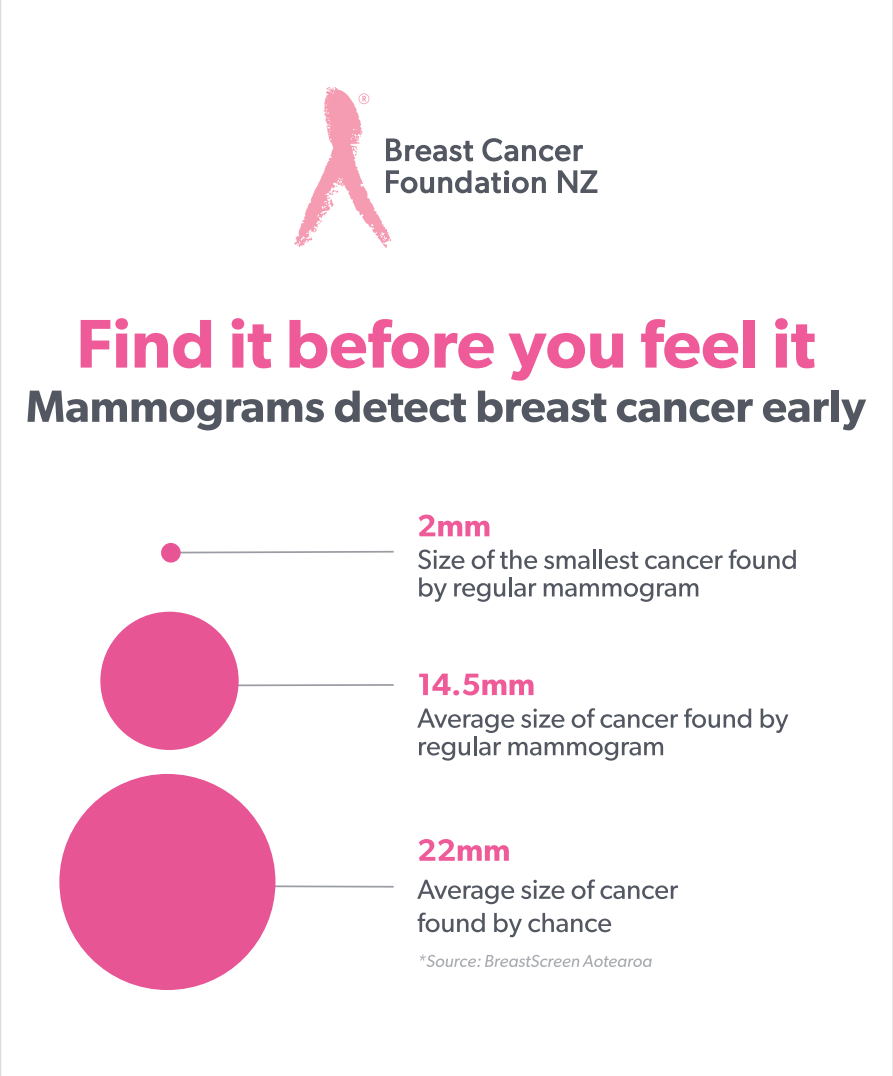
Triple negative breast cancer (TNBC) is a less common form that tests negative for oestrogen, progesterone and HER2 receptors. Occurring in around 15% of all breast cancers, it's more common for pre-menopausal women and those who have inherited a faulty BRCA gene. Māori, Pacific

and Asian women have a higher incidence of TNBC than Pākehā.

Pathology reports will identify the type of breast cancer, size of the tumour, number of tumours in the breast, and the grade of the tumour (which identifies how abnormal the cells are and how rapidly they're dividing). This information helps to determine the best treatment plan.

Breast cancer stages, from 0-4, define the size of the cancer and how far it has spread. Stage 3 is called locally advanced, and often means the cancer has spread to lymph nodes or the chest wall. Locally advanced breast cancer is curable, and will be treated aggressively.

Advanced breast cancer (ABC), also called Stage 4, metastatic, or secondary breast cancer, is when breast cancer has spread beyond the breast and lymph nodes to other parts of the body. ABC is most commonly found in the bones, lungs, liver and sometimes the brain. It can occur months or years after a diagnosis of early breast cancer but it can be diagnosed at the same time as the original breast cancer. Although there currently is no cure for ABC, with the latest treatments some people may live with it for many years.



BREAST CANCER TREATMENT

Treatment options for early breast cancer include surgery, radiotherapy, chemotherapy, hormone treatment and targeted therapy. A specialist team will meet to review a patient's pathology results, plan a course of treatment and explain to the patient their expected outcomes and possible side effects.

The first step in treatment is usually surgery to remove the cancer from the breast, although high-risk patients are increasingly offered neoadjuvant (chemo-first) treatment. Depending on the size and location of a tumour, a surgeon may recommend either breast conserving surgery (also called lumpectomy, partial mastectomy or wide local incision), or removal of the whole breast – a mastectomy. In some cases, women may be able to choose which option is preferable for them.

After a mastectomy, patients are usually offered breast reconstruction surgery which may involve a breast implant, a procedure that uses the patient's own tissue, or a combination of both. Reconstruction may be done at the same time as mastectomy or at a later date. Some women may prefer to have the cancer removed and treated before making any decision about whether to have breast reconstruction.

Subsequent treatments are given as needed to reduce the risk of recurrence. Following a mastectomy, radiation therapy is less likely to be needed. For women who have had a lumpectomy, radiotherapy is used to treat malignant or pre-cancerous cells remaining in the breast, chest wall and axilla (underarm). It's usually given once surgery wounds are healed, or once chemotherapy has been completed.

For patients who are at high risk of cancer returning, chemotherapy is offered. Chemotherapy uses anti-cancer drugs to destroy cancer cells throughout the body and there are a range of drugs that work in different ways. Side effects of chemo vary depending on the type of drug given, dosage, frequency of treatment and the general health of the patient. Common side effects can include hair loss, infertility, nausea and vomiting, nerve damage, weight gain, sore mouth or ulcers, fatigue, and skin and nail changes.

Hormone treatment (also known as endocrine therapy) for people with hormone receptor positive breast cancer usually starts after surgery or once chemotherapy is finished, and is prescribed for five to ten years. There are three types of hormone treatment and the choice prescribed is determined by age, degree of recurrence risk, and general health. While hormone treatments are the most effective treatment for ER+ and PR+ breast cancer, only around half of patients stay the course because of a number of challenging side effects including joint or muscle pain and stiffness, fatigue, insomnia, hot flushes and mood changes.

Unlike chemotherapy, which targets all rapidly dividing cells, targeted therapies for certain types of breast cancer attack specific receptors that control the growth of cancer cells and are less likely to harm healthy cells. Some of the common targeted therapies include Herceptin, Ibrance, Perjeta, and Kadcyla.

For people diagnosed with ABC, treatment may be offered to control the growth and spread of the cancer, relieve symptoms, and improve quality of life. Options usually include one or more of the above-mentioned treatments.

THE ROLE OF MASSAGE THERAPY IN BREAST CANCER

Studies have shown that massage may offer both physical and emotional benefits for women with breast cancer. It's been found to be beneficial with pain, fatigue, stress and anxiety. It can also help to improve sleep quality and reduce nausea.

Some people worry that massage can encourage breast cancer cells to spread around the body, but there's no evidence of this. While light massage is generally safe for people with breast cancer, it can pose potential risks, so there are some considerations therapists should be aware of.

Depending on a patient's treatments and overall health, certain types of massage may need to be avoided. Deep massage, or any type of massage that involves strong pressure, shouldn't be used on clients undergoing chemotherapy and radiation, or those with advanced breast cancer. Chemo drugs can cause a drop in red and white blood cells, so with deep massage there is a risk of bruising. Since deep massage can be taxing to a system already vulnerable from chemotherapy and radiation, it's not recommended for people currently in treatment.

For clients who have had radiation, therapists should avoid touching sensitive skin in the treatment area, as even light touch can be uncomfortable. Massage oils may make already-irritated skin feel worse.

The risk of infection can be greater after breast cancer treatment due to a lowered white blood cell count. Certain treatments can also cause osteoporosis or bone loss.

Lymphoedema is common complication after breast cancer surgery, where swelling develops in the arm caused by a build-up of fluid in the tissue. Massage therapists should avoid the affected arm as traditional massage can worsen lymphoedema. A technique called manual lymphatic drainage should only be carried out by practitioners who are trained and certified in lymphoedema.

For therapists interested in specialising in oncology massage, Oncology Massage Training is a nationally accredited non-profit organisation providing the awareness and expertise to work safely with clients with a history or diagnosis of breast cancer.

Taking the time to understand a breast cancer diagnosis, treatment and symptoms, and adjusting techniques to suit a client's needs can certainly play a role the wellbeing, strength and resilience of a breast cancer patient.

We have a wealth of information on our website, which would be an excellent tool for any massage therapist wanting to stay up-to-date with specialist breast cancer knowledge. Find out more at breastcancerfoundation.org.nz

DO A SKIN CHECK.
IT COULD SAVE YOUR LIFE.

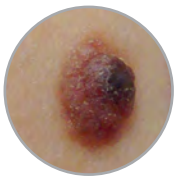
You can:

- Do a self-check
- Ask your GP or a specialist (dermatologist, surgeon or plastic surgeon) to check you with a dermatoscope

No matter what your complexion, undertaking regular skin checks is one of the most effective ways of detecting melanoma early.

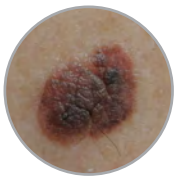
And as a massage therapist, you may be the first to spot something of concern on a client that needs follow-up by a doctor or specialist.

WHAT TO LOOK FOR.
AN A-G GUIDE TO MELANOMA.



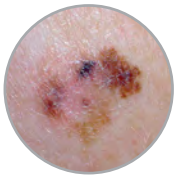
Asymmetry

One half is different from the other half



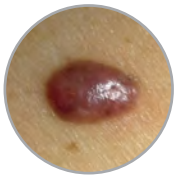
Border irregularity

The edges are poorly defined e.g. notched, uneven or blurred



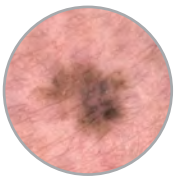
Colour is uneven

Shades of brown, tan and black are present (there may also be white, grey, red, pink or blue)



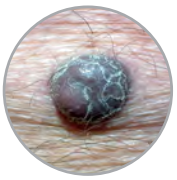
Different

Looks different from other spots, freckles or moles ("ugly duckling")



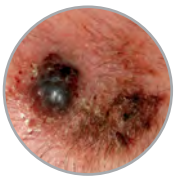
Evolving

Any change in growth; new, elevated or painful



Firm

To the touch



Growing

Most are larger than 6mm and keep growing

These images are indicative only. Look for the type of behaviour described, rather than trying to match your lesion to the images shown.

Melanoma images: Dr Anthony Tam and DermNet NZ

Visit **melanoma.org.nz/early-detection** for more information

0800 4 MELANOMA (0800 463 526)
info@melanoma.org.nz

Melanoma New Zealand

BARRIERS TO THE ADOPTION OF ONCOLOGY MASSAGE

By David Bailey, Managing Director - Oncology Massage Limited

TOUCH

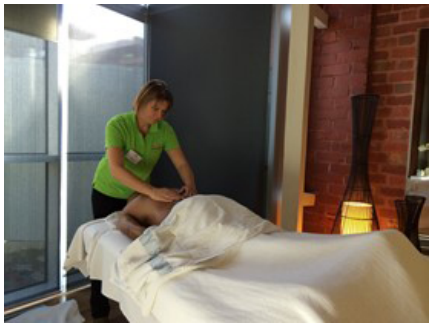
Touch was probably the first sense to develop in our earliest evolutionary history. It is the first form of communication between individuals - it predates the written word, it predates the spoken word, and is not unique to humans.

Touch is arguably the only sensory stimulation that we cannot live without. From the beginning of life to the end of life, it conveys compassion and care. It is the first connection between a parent and a newborn child and it is probably the last connection between that child and their parent when the latter passes away.

Touch is the simplest and most reassuring form of communication between us - between humans and animals, between the old and the young, between the happy and the sad, and between the well and the not so well.

ONCOLOGY MASSAGE

If done properly, OML's oncology massage[1] modality provides a powerful and effective non-invasive intervention for symptom alleviation and control. It is inexpensive, free of



negative side effects, and greatly comforting.

Oncology massage can provide relief from chronic pain, constipation, bloating, scar tightness, lymphoedema, and some muscular and skin conditions - as well as relief from the less obvious conditions such as stress, anxiety, depression, insomnia, loneliness, and disconnection. It is also perhaps the only time during the roller-coaster of medical treatment that the focus is on the person rather than their condition.

So, if it is that wonderful, why aren't qualified Oncology Massage Therapists everywhere? Let's consider some of the barriers to the greater adoption of oncology massage in healthcare organisations.

TRANSITION FROM CURE TO CARE

Our clinical experts are problem solvers who pull out all stops to cure a patient in frail health. But, as Virgil the Philsopher said some 2100 years ago, "aegrescit medendo" ["the cure is worse than the disease"]. Sometimes, the best we can do is ensure that the patient is comfortable and symptom-free for as long as possible.

At the 2019 Oceanic Palliative Care Conference, the often abrupt transition from clinical treatment to palliative care was highlighted. There was a change in the patient experience from doctors, nurses and machines that go "ping" to palliative care workers, complementary therapists, and pain medication.

My recent personal experience with hospitals and aged care suggests that another palpable change is the relative availability of funds for, and access to, complementary therapies. Within reason, it should be the case that whatever works best for the comfort of the patient is deployed.

Integrated patient-centred care would suggest that cure and care have a parallel rather than a serial role to play. Sadly it is not always seen this way. The organisations where this cultural change has happened, or is happening, tend to be few and far between. It too often depends on the whims of individual managers, facilities, or organisations.

PROFESSIONAL BIAS

In Australia, remedial massage therapists are not considered to be "allied health professionals"[2] , who are defined as "university-qualified practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses" and "who often work within a multidisciplinary health team to provide specialised support for different patient needs"!?!

The practical implications of this bias are more than just linguistic. Our graduates are lumped in with "other "massage" practitioners". Have a read of "Not All Massage Is Created Equal"[3] by OML Course Facilitator and ATMS 2020 Therapist of the Year, Amy Tyler. They also affect a patient's ability to claim the services we provide against their private health

insurance, and the way healthcare organisations make decisions about the services that they provide to people in frail health. On behalf of our Community of Practice, and the clients we serve, we must challenge outdated views of the value of remedial massage therapy (including oncology massage).

VOLUNTEERING

OML is often approached to provide volunteers for oncology massage. If funding is mentioned, we are told that "our other volunteers don't get paid - and we don't want to lose them by paying you". Strange - I think our graduates are highly-qualified professionals who have invested significant time and expense in developing their capabilities - not volunteers?

In one hospital, well-meaning but unqualified volunteers (without gloves) were until recently, providing hand and foot massages for cancer patients undergoing chemotherapy. That same hospital asked our graduates to provide free massages for their staff! For those of you out there volunteering your services, you may wish to take a look at these OML Guidelines on Volunteering[5].

A CALL TO ACTION

As members of the Oncology Massage community, we need to make our voices heard. We need to maintain and develop the discipline of Oncology Massage. We need to demonstrate the value of the services we provide, and engage with those who seek to stand in our way.

We need to tell our stories and, with their permission, tell the stories of our clients. We need our institutions to take an integrated patient-centred approach to improving the lives of people in frail health. And finally, we need to make more room in healthcare budgets for care, not just cure.

As a society, we can surely care for all of our most vulnerable people, but we cannot always cure them.

Oncology Massage Limited (OML) is a not for profit training organisation based in Australia. OML has a standardised approach to teaching qualified Remedial Massage Therapists, Myotherapists, Bowen Therapists, and Beauty Therapists how to adapt their techniques to improve the quality of life for any person in fragile health, especially those with a history or diagnosis of cancer. OML has been delivering Courses in New Zealand since at least 2011. We have 182 New Zealand students on our database - past, present, and prospective - of whom 141 are actively practising. COVID-willing, we hope to see you soon!

www.oncologymassagetraining.com.au

1. http://naturalmedicineweek.com.au/2021/04/09/how-oncology-massage-differs-from-other-massage/
2. https://ahpa.com.au/allied-health-professions/
3. http://naturalmedicineweek.com.au/2021/04/09/not-all-massage-is-created-equal/
4. https://www.atms.com.au/
5. https://www.oncologymassagetraining.com.au/userfiles/Guidelines%20-%20Volunteering%20as%20an%20Oncology%20Massage%20Therapist%20v2.pdf

Editors note: We are delighted to publish the following piece of original research. We hope this encourages you as massage therapists or students, to consider undertaking research. This also includes writing up a case study. Which is also a timely reminder of the Massage New Zealand Case Report Contest https://www.massagenewzealand.org.nz/Site/news/case-report-contest.aspx

There are plenty of resources to help you understand research, how to plan and carry out a study, and how to integrate research into your practice. Here are a few:

- Research and Massage Therapy – online course from AMTA
- Massage Therapy: Integrating Research and Practice – by Trish Dryden and Christopher Moyer (also available on Kindle)
- Massage Therapy Foundation Case Report Hub - articles, podcasts and free webinars to guide you through the process

A SERVICE EVALUATION ON PROVIDING MASSAGE TO PATIENTS UNDERGOING TREATMENT FOR CANCER IN A HOSPITAL SETTING

Vicki Scott, RMT

People with cancer suffer pain, fatigue, nausea, and anxiety as a result of the disease and treatments. Oncology massage is proving to help alleviate these symptoms. Post-White et al. (2003), found that therapeutic massage and healing touch helped to alleviate these symptoms. Gentile et al. (2018) also found that massage and touch also provided immediate relief from pain.

There are many types of cancer treatment, and they can range from one specific treatment to a combination of treatments depending on the type of cancer and how advanced it is. The most common treatments are surgery, radiation therapy, chemotherapy, immunotherapy, targeted therapy, hormone therapy, stem cell transplant, and precision medicine.

The side-effects of the cancer treatments are vast and relative to each individual, although some are consistent with the treatment. Common side effects are anaemia, loss of appetite, bleeding and bruising, constipation, diarrhoea, oedema, fatigue, flu-like symptoms, alopecia, lymphedema, problems with memory or concentration, issues with the mouth and throat, nausea, vomiting, pain, peripheral neuropathy, skin and nail changes, sleep disturbance and urinary and bladder problems (Cancer Research UK, 2020).

A cancer diagnosis can impact a person in many ways including emotional distress, fear, uncertainty, security issues, self-esteem issues, anxiety, stress, self-integrity issues, shock, body image issues, loneliness, isolation, and relationship problems.

The research on stress shows that stress can reduce healing, increase blood pressure, restrict blood flow and heart rate (Yaribeygi et al., 2017). The effects of cancer treatment on a person depend on their previous medical history, type of cancer treatments, length of time in treatment, prior fitness level, age-related issues, support network, mental & emotional status, and nutrition (Canadian Cancer Society, 2020). Curt et al. (2000), looked at the impact of cancer-related fatigue on the lives of patients and concluded that fatigue is common among cancer patients who have received chemotherapy. They also found the fatigue had substantial adverse physical, psychological, and economic consequences for both patients and caregivers. In their study on the influence of symptoms of disease and side effects of treatment on compliance with cancer therapy, which interviewed 107 patients, Richardson et al. (2019) found nausea, fever, and pain were the most common side effects of chemotherapy.

Oncology Massage is massage that has been adapted to safely nurture and support the mind, body, and spirit of a person who is dealing with cancer (MacDonald, 2014). Oncology Massage is designed to consider the physical and psychological elements that the patient is experiencing, and it can help alleviate pain, nausea, fatigue, insomnia fear, anxiety, and isolation (Macdonald, 2014). A study examining therapeutic massage during chemotherapy and patient's perceptions of pain, fatigue, nausea, anxiety, and satisfaction by Robison and Smith (2016) reported a statistically significant reduction in all four complaints. Similar results were found in a study by Çankaya and Saritas (2018) which looked at

the effects of classic foot massage on vital signs, pain, nausea, and vomiting symptoms and found a significant decrease in pain scores and incidents of nausea and a positive effect on blood circulation.

THE EVALUATION

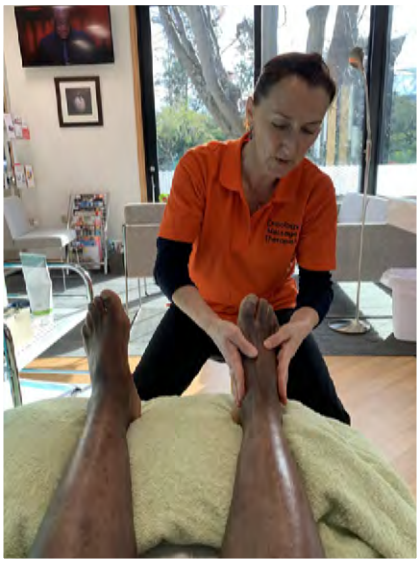
The proposal for this study was to undertake a service evaluation on massage provided to patients undergoing chemotherapy treatment in a private oncology clinic, as well as incorporating a qualitative study on the benefits to patients. Participants completed a pre-treatment and post-treatment survey each time they received a massage. The survey requested the participant to rate their levels of pain, fatigue, anxiety, nausea, and depression on a scale: none, mild, moderate, strong, or severe. It also asked them to state three words describing how they felt before and after massage treatment. There was also an area for additional comments.

A service evaluation assesses the effect of the treatment provided in meeting patient expectations. It is designed to look at the service implementation to see if the desired outcomes are achieved. Results can be used to make decisions around whether to discontinue or continue the service, adjusting techniques used, revising the physical environment where treatment takes place, or changing the treatment time (Moule et al., 2017).

A routine was quickly established with staff identifying who was ready for a massage and advising the therapist. All patients were happy to participate in the evaluation and complete all relevant documentation. In total there were 22 massages of thirty minute duration, given over 26 weeks.

The initial protocols were as follows.

- The practice was limited to massage of the hand and feet. This was manageable as all the participants were in the same room and seated in chairs.
- Treatments ranged from 10 to 30 minutes. This was a suitable timeframe as it was long enough to stimulate the relaxation response yet not over tiring for the recipient.
- Participants remained seated as they were receiving the chemotherapy direct into their veins through a port that is inserted just under the skin. This made moving around limited for them.
- For massage on the feet, the feet were elevated. Patients sat in chairs that could be reclined, a pillow was placed under their feet and a towel was placed over the pillow. This created comfort for the patient and allowed for the towel and pillowcase to be changed after each treatment.
- For massage on the hands, the same protocol as for the feet was followed, the pillow was placed under the lower arm and hand.



The massage therapy was very well received with most patients taking up the opportunity to have a massage while receiving chemotherapy. Once it was established as a weekly event more people took up the option.

CHANGES IMPLEMENTED:

Treatment was implemented as outlined above. However, the evaluation highlighted some areas for change in the service provision. This reflected the benefit of doing a service evaluation, allowing factors to be identified and changes to be made relating to the use of massage oil, sourcing of the larger towels and pillowcases, introduction of throws, and therapist removing the patient's shoes and socks.

Massage cream

The use of Moogoo udder cream instead of almond oil. The cream was moisturising and is recommended by oncologists in Australia. It became quite popular with patients with some purchasing some for home use.

Sourcing of towels and pillowcases

The logistics of carrying throws, foot towels, pillowcases, and up to six normal-sized towels to each session was too hard and led to outsourcing the supply of towels and pillowcases.

The throws

Coloured faux mink throws were offered to patients to use during the massage. Blankets have a strong association with protection, relaxation, and sleeping. Emory (2010) stated a blanket can be a source of safety and comfort. Nosowitz (2017) looked at the association with childhood conditioning or transitional object and that the blanket is what we use when we go to bed, therefore, represents security and sleeping. He also mentioned the link between blankets and increased serotonin levels leading to a calming relaxing effect.

At different times, the throws were left with the patient as they were sleeping or resting, and the therapist collected them for cleaning the following week. Occasionally a throw was given to a patient, not because they were having a massage but purely because they were having an emotional moment.

Shoe and sock removal and replacement

This was not originally anticipated; however, it was sometimes easier for the therapist to remove the patient's socks and shoes and replace them after the massage than for the patient to do this themselves. This small, simple act was well received by the patient.

RESULTS

The massage was really well received at the centre, comments from patients included "I look forward to coming", "It is like a spa", "It is wonderful". Others changed their day so that they could have the massage treatment. Recommendations were for the sessions to be longer.

Patients' reflection on how they felt before treatment: "tired", "anxious", "don't want to be here". Reflections post-treatment included "intrigued", "sleepy", "calm", "relaxing", "soothed", "happy", "lovely", "grateful", and "content".

Findings of the surveys showed there was a reduction in ratings for all areas measured, pain, fatigue, anxiety, nausea, and depression. This was useful to give an indication of the effectiveness of the service for the purpose of the evaluation, and to receive approval for the service to continue. However, the survey method was not statistically valid, and results could not be analysed in a meaningful way. This is a limitation of the research which could be improved in future studies by using a recognized outcome measure that is valid and reliable.

WIDER IMPLICATIONS

There are many side effects of cancer and cancer treatment, both physical and emotional, and there is a lot of research around chronic stress and the impact on the body. The service evaluation showed that having a massage while receiving chemotherapy treatment for cancer is beneficial in reducing pain, fatigue, nausea, anxiety, and depression. This was similar to results found by Cankaya and Saritas.

Portillo-Soto et al. (2014) and Sefton et al. (2010) all found massage had a positive impact on circulation. As the fluids of the body flow better, nutrients can get to cells and toxins can be removed more efficiently. Reducing nausea, pain, fatigue, depression, and anxiety will have an impact on the quality of life for all patients. Deng et al. (2012), looked at the relationship between cancer pain and quality of life and found that most patients experience moderate to severe pain, which significantly impaired their quality of life. They also found a correlation of pain to appetite, mood, sleep, fatigue, pain intensity, daily activity, general appearance, and family support. By reducing pain and nausea, the patient may eat and sleep better which will help reduce fatigue and improve mood. Several studies found massage led to an improvement in sleep quality and duration and quality of life, including those by Hsu et al. (2019) and Mystakidou et al. (2007).

The service evaluation, along with other literature, has shown that providing massage in an oncology unit while patients are receiving chemotherapy helps the recipients to relax and aids in reducing the symptoms of pain, nausea, fatigue, and anxiety. Inducing a relaxed state, reducing the impact of stress, will improve the rate of healing, decrease blood pressure, increase blood flow and heart rate (Yaribeygi et al., 2017).

Oncology Massage is gentle enough for use with people with acute and chronic conditions. Growth in public and professional knowledge and promotion of this therapy will allow more people with cancer and other chronic illnesses access to this treatment in both a hospital and private clinical setting.

Oncology Massage is being used in many integrated health centres around the world including the Sloane Keating centre in New York, Solaris Cancer Care, and the Olivia Newton-John Cancer Wellness and Research Centre both in Australia. A research study conducted over a year at the Boston Medical Centre (Rosen et al., 2013) looked at the effect of massage on perioperative pain and anxiety in the placement of vascular access devices, found that massage proved beneficial for alleviating preoperative anxiety in cancer patients undergoing port placement. The options for the use of massage therapy, in the hospital setting, especially Oncology Massage, are many and varied and the benefits are invaluable to the patient and their healing journey.

AUTHOR BIO

My name is Vicki Wilson Scott and I am a RMT and Lymphatic Therapist. My focus is the lymphatic system, oncology massage and scar tissue therapy. I am a certified Casley-Smith CDT and also have certificates in Myofascial Release, Myofascial unwinding and a Diploma in Reflexology. This year I have introduced the Flowpresso to my clinic.

I am passionate about helping people and love continually learning which helps me to offer the best to my clients.

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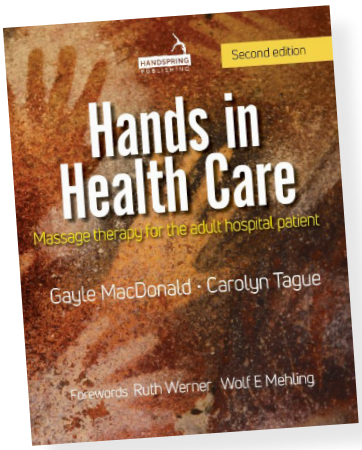

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Carolyn Tague

Gayle MacDonald

The spectrum of caring: Understanding the therapeutic relationship

4

…compassion triggers the momentary yet timeless connection of souls. Without it, there is technique or technology – interesting but not healing.

Rosalyn Bruyere[1]

In order to be truly skillful, a massage therapist must be adept at building a therapeutic relationship with each patient. This way of relating refers not only to addressing muscle tension or physical pain, but also allows for the psychosocial and sometimes spiritual interactions with a patient to be acknowledged. It is a whole-person, patient-centered relationship.

Experts define the **therapeutic relationship** as one in which: "Patients perceive themselves to be in a caring, supportive, nonjudgmental, and safe environment, often during a time of stress. Typically, the professionals in this type of relationship relate in a way that is warm, friendly, shows genuine interest, empathy, and the wish to facilitate and support. This atmosphere creates a climate that leads to more effective communication as well as improvement in patient satisfaction, adherence to treatment, quality of life, levels of anxiety and depression, and a decrease in health care costs."[2]

Boundaries and scope of practice, as discussed in Chapter 3, are foundational. Building on from there, how does the provider–patient relationship become a space of healing and not a space of stasis, or worse, a negative experience? How does a practitioner embrace not only the body, but the mind, heart, and soul? Successful providers master two specific skills in the art of therapeutic relationships: authentic communication and skillful compassion.

Author's note

Before going on, it is important to say that a therapeutic relationship is specific to professional situations. While the strategies from this chapter may have relevance in one's personal life, relationships with families and friends are significantly different and are best not professionalized.

Authentic communication

Everyone has experienced an interaction with a health care provider who is not truly present, i.e., not paying full attention. "How are you?" is often unconscious small talk, asked while the provider's focus is elsewhere. Experiences such as these often leave the client feeling like an inconvenience at best, or ignored and unheard at worst. Establishing habits that eliminate mindless interactions is one pro-active way of developing therapeutic relationships with each patient. For example, in a hospital room, if needing to accomplish tasks prior to the intake questions, a skillful option is for the therapist to first confirm with the patient that the service is wanted, and if so, then explaining the process including any setting up or paperwork to be completed prior to the start of the session. The provider can then assure the patient they will have time to fully check in with them in just a moment. This way, when asking the question "How are you?", the therapist is present, face to face and able to apply the therapeutic active listening skills discussed below. If possible, quietly pull up a chair next to the patient's bed to complete the intake questions. This gives the indication that the touch therapist has time to listen and is truly present.

Tip 4.1 Mastering the art

Developing one's gifts for creating healthy therapeutic relationships will both promote the patient's own healing process and often help prevent the practitioner from experiencing caregiver burnout. According to Drs Chou and Cooley of the Academy of Communication in Healthcare, practitioners that master the art of building therapeutic relationships with their patients are personally more fulfilled in their work and find more successful outcomes in those they serve.[3]

Understanding patients under stress

Patients are often under tremendous stress. In some situations, their stress response may be difficult for therapists to handle, and so recognizing stress responses of patients is a very helpful first step in creating a therapeutic

ARTICLE CONTINUED ON PAGE 48

NEW PARTNERSHIP WITH WINTEC AND TOI OHOMAI A WIN FOR MASSAGE THERAPISTS WANTING TO UPSKILL

High demand for practitioners with a Level 6 massage qualification has resulted in a collaboration between Wintec and Toi Ohomai which has doubled enrolment by putting learners at the centre.

Wintec Centre for Sport Science and Human Performance Director, Greg Smith says the collaboration was developed to remove the barriers to higher study for learners who typically gain employment or go into business after achieving their Level 5 Diploma in Massage qualification, making it difficult to continue their study.

"The focus of this partnership is to allow people from the Waikato and Bay of Plenty to continue to earn while they study the advanced Level 6 Diploma in Remedial Massage and maintain their work/life commitments while advancing their career."

"There's demand for qualified remedial massage therapists so we've changed the way we deliver our Wintec Level 6 massage course to enable massage practitioners to continue to upskill. The collaboration with Toi Ohomai means we have extended our net across the Waikato and Bay of Plenty region to reach more people."

Wintec academic and programme coordinator for massage, Amy Pearce, has worked with the Sport Science and Human Performance team to redevelop the delivery of the Level 6 massage course delivery to make it more accessible.

"We've reshaped the existing course to work with remote learners, so it is delivered mainly online and in a more time-effective manner. The Level 6 Diploma in Remedial Massage is now more accessible through a series of blended learning modules that includes online and face to face learning, practical supervision in the students' home region and some block sessions at Wintec."

Wintec is one of only a few NZQA (New Zealand Qualifications Authority) approved Level 6 Diploma in Remedial Massage providers in New Zealand, and the collaboration has made it possible for Toi Ohomai to deliver Level 6 to the Bay of Plenty community.

Jeni Fountain, Faculty Dean, Health Education and Environment at Toi Ohomai says, "giving people the opportunity and flexibility to earn while they learn and gain an education that is more directly relevant to the changing needs of the workplace is important".

Toi Ohomai Academic Lead, Sport, Ruth Naidoo says their students have been asking about the Level 6 qualification for a few years but until now, it has not been accessible to them.

"We're excited to be able to welcome our massage students back to study at Level 6, and we're supporting them in their enrolment with Wintec. There is a growing demand for massage therapists and an overall greater awareness from the public of the health benefits, which may be a result of the Covid-19 pandemic. Further upskilling puts graduates in a favourable position in this growth industry."

Wintec and Toi Ohomai are part of Te Pūkenga New Zealand Institute of Skills and Technology network which formed a year ago to create a unified Aotearoa-wide organisation where relevant qualifications respond to the changing needs of the workplace and learning fits around people. Te Pūkenga is now New Zealand's largest tertiary educator.

The Wintec and Toi Ohomai team involved in this initiative agree it demonstrates the ability for Te Pūkenga subsidiaries to work together to deliver programmes that create accessibility for their learners.

"We knew there would be interest, but we weren't expecting to double our enrolment numbers. The strong uptake is evidence there is demand and we are looking forward to continuing this opportunity in 2022," adds Smith.

The Diploma in Remedial Massage (Level 6) leads to further career opportunities in remedial massage and wellness therapy, and relaxation massage including working independently, in multi-disciplinary clinic, or with sports teams on injury and recovery.

Find out more about studying massage therapy at Wintec.

Find out more about studying massage therapy at Toi Ohomai.

REGULAR

PATHOLOGY

PROSTATE CANCER

By Carol Wilson, RMT

WHAT IS THE PROSTATE GLAND?

The prostate (Fig 1) is a walnut-sized gland located between the bladder and the penis, and is anterior to the rectum (part of the large intestine). The prostate secretes fluid that nourishes and provides protection for sperm. The urethra runs through the centre of the prostate, from the bladder to the penis, allowing urine to flow out of the body. During ejaculation, the prostate squeezes the fluid into the urethra, and it is expelled with sperm as semen (Prostate Cancer Foundation NZ, n.d.).

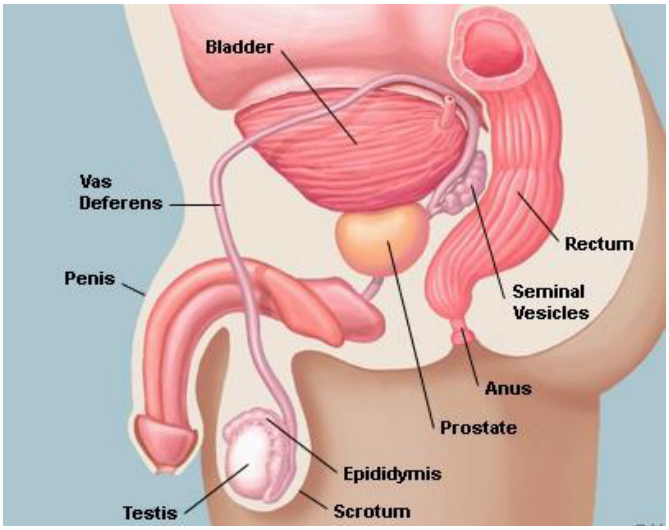

Fig 1. Position of prostate gland between bladder and penis Retrieved from https://urology.ucsf.edu/patient-care/cancer/prostate-cancer

Enlarged Prostate

This may be a non-cancerous (benign) increase in the size of the cells or the number of the cells of the prostate. This increase puts pressure on the urethra and makes it difficult to urinate. A non-cancerous growth does not spread to other parts of the body, but tends to grow locally.

Prostate Cancer

A cancerous growth (malignant) may spread to lymph nodes and other parts of the body. Prostate cancer is the second most frequently diagnosed cancer in males worldwide (Rawla, 2019) with 3500 per year diagnosed in New Zealand (Ministry of Health, 2018).

AETIOLOGY AND RISK FACTORS

The aetiology (causes) of prostate cancer are unknown compared to other common cancers, but in several studies the risk factors that may contribute are:

Age

an increasing number of men over 50 years of age are being diagnosed. This is most likely due to increase in screening and increase in life expectancy (Bray, 2018).

Genetic Disposition

It is estimated that approximately 20% of diagnosed prostate cancers have a family history (Sridhar, 2010). Although data on sexual orientation are not typically collated, resulting in scarce information about cancer in sexual minorities (Blosnich et al., 2014).

Diet

There have been many studies looking into possible links between prostate cancer and red meat, dairy products, soy products, tomatoes, selenium, Vitamin D, alcohol and coffee to name a few. Rawla (2019) found that there were no studies that sufficiently demonstrated a direct correlation between particular diets and nutrition patterns with risk or prevention of prostate cancer development. More research is required to look at the link between eating behaviours and prostate cancer to determine any connections.

Obesity and Physical Exercise

Obesity particularly when combined with inactivity was shown to lead to an increase in blood levels of insulin (Kaaks & Stattin, 2010). Higher levels of insulin in the blood have been found to promote growth and proliferation of cancers.

Keogh & MacLeod (2012) found that prostate cancer patients who commit to exercise had lower prostate-specific antigen (PSA) levels compared with those less active. This meant those who were active had a lower risk of high-grade disease, as well as having a greater quality of life and less fatigue. Exercise may be one of the easily modifiable risk factors to assist in prevention of prostate cancer.

Cigarette Smoking

There is a 2-3 times higher risk in smokers of more than a pack a day compared with non-smokers, to develop prostate cancer (Rawla, 2019).

Chronic Inflammation of the prostate

Prostatitis (inflammation of the prostate gland) is hard to diagnose because it is often asymptomatic. Rawla (2019) concludes that chronic inflammation is associated with increased risk of prostate cancer, independently of whether the source was pathogens or environmental factors (such as infections, chemical trauma, physical trauma and diet). Irritations, no matter the source, may cause abnormal flow of urine from the bladder and up to the ureters. It seems this may cause chronic inflammation in the prostate.

Bisphenol A (BPA)

Tse et al (2017) published evidence that cumulative exposure to BPA was associated with an excess risk of prostate cancer in the Chinese population. BPA leaching from containers may contaminate food and beverage, which is then ingested.

Ejaculatory frequency

In 2017 Papa et al. sampled a smaller group of men (2,141) from age 20 to 50 and found no relationship for ejaculatory frequency in the third to fifth decades of life.

EPIDEMIOLOGY

Prostate cancer incidence increases with age. The incidence rate is nearly 60% in men over the age of 65 years. Prostate cancer incidence rates are highly variable worldwide. The worldwide variations in prostate cancer incidence might be attributed to PSA testing as this has increased in the last 15-20 years. In Europe, prostate cancer is the most frequently diagnosed cancer among men, accounting for 24% of all new cancers in 2018 (Rawla, 2019).

PATHOPHYSIOLOGY

There are two kinds of tumours: noncancerous (benign) and cancerous (malignant). Benign tumours do not spread to other parts of the body and are not life threatening (except in very rare situations).

Cancerous tumours can attack nearby cells and destroy them. Cancer cells can also get into body fluids and spread to other parts of the body. This is called a secondary cancer or metastasis. Blood and lymph fluid may transport cancer cells to other parts of the body.

SYMPTOMS

Most men who have problems urinating have an enlarged prostate but do not have cancer. However, prostate cancer may have the following symptoms, according to the Mayo Clinic (2021):

- dribbling, leaking or trouble with the flow of urine
- urgently needing to go to the toilet, but stream of urine is weak
- blood in urine or semen
- erectile dysfunction
- bone pain
- losing weight without trying

DIAGNOSIS AND SIGNS

Blood test

This is a non-routine test to check for Prostate Specific Antigen (PSA) protein. A high amount of PSA may be a sign of prostate cancer.

Physical examination

This involves a doctor's gloved finger in the anus to check the prostate through the wall of the rectum (as in very close proximity).

Biopsy

A sample of cells is taken from the prostate (Fig 2) to check if they are cancerous. This may mean blood is seen in the urine or semen for a few days after the biopsy. This is normal.

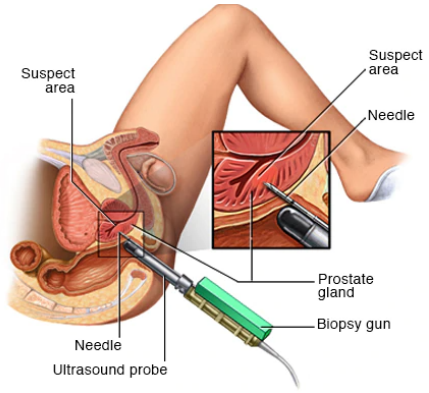

Fig 2. Prostate Biopsy. Retrieved from https://www.mayoclinic.org/tests-procedures/prostate-biopsy/about/pac-20384734

Ultrasound

An ultrasound probe is inserted into the rectum to make measurements of the prostate, using sound waves.

Bone scan

A radioactive dye is injected via the arm and then the body is scanned. Abnormal cells may show up in the bones, as these cells will absorb the radioactive dye.

CT (computerised tomography)/MRI (magnetic resonance imaging)/PET (positron emission tomography)

These are all scans which take a detailed 3D picture of the inside of the body, to check the size of the prostate gland and whether the cancer may have spread to other areas.

Not every person would have every test. The oncology team will discuss each case and create an individual plan (Cancer Society of NZ, 2021).

MEDICAL TREATMENT OPTIONS

Active checking

Blood tests to measure and record PSA levels every 3-6 months.

Surgery

Used when the prostate shows no spread to lymph nodes and the prostate can be fully removed.

Radiation treatment

Three types of radiation treatment for prostate cancer are:

- External beam radiotherapy The most common radiation treatment for prostate cancer, where a beam of radiation is aimed at the prostate (very specifically) to break down the cancer cells.
- Low dose rate brachytherapy Permanent low dose radioactive seeds are permanently placed in the prostate gland to deliver internal radiation treatment. It is used when the cancer is low-risk and found only within the prostate gland.
- High dose rate brachytherapy Temporary implant using radioactive needles which are temporarily placed into the prostate. Usually used in combination with external beam radiotherapy to treat higher-risk prostate cancer. It may also be used alone to treat low-risk prostate cancer also. A patient receiving this treatment will be in a hospital room alone for the duration of a few days.

Hormone therapy

Prostate cancer cells need the male hormone testosterone to grow. Specific hormone therapy is used to lower the amount of testosterone in the body.

Chemotherapy

Drugs are used to destroy cancer cells while doing the least possible damage to normal cells. The chemical therapy is given either orally or via intravenous drip into the body. This may be recommended when the cancer has spread outside the prostate or when hormone therapies are no longer working. May be on analgesics for pain management.

Immunotherapy/Biologic therapy

Used to sensitise white blood cells (WBC) and enable the WBCs to mount an attack on the specific cancer cells (Cancer Society of NZ, 2021).

MASSAGE THERAPY IMPLICATIONS

As a massage therapist dealing with clients who are actively pursuing particular treatment options for prostate cancer, it is possible that other issues related to the diagnosis may be addressed. Werner (2016) suggests "bodywork can improve the quality of life for people who face this challenge". Areas that may be improved are: sleep, anxiety, depression, management of pain to name a few, as long as appropriate adjustments are made.

Werner (2016) notes the following red flags and contraindications:

- Surgery – constipation is a common post-surgery complaint, but abdominal massage is inappropriate. Lymph nodes may also have been removed and post-surgical infection is a possibility. It is important to check in with the client's surgical specialist.
- Radiotherapy – Often the skin at the entry and exit sites of the external beam therapy may become red and irritated. Diarrhoea and bladder irritations are most likely symptoms after prostate treatments. If implants were used, the patient will not be in contact with anyone until these are removed. It is suggested to wait until 6 weeks after the final treatment before abdominal/pelvic massage is considered and in discussion with oncologist.
- Chemotherapy – may lead to anaemia, elevated risk of infection and clotting issues. It may show as coldness and fatigue. Be aware of these symptoms with your client.
- Other therapies – communicate with the health care team of the client and if in doubt refer to a specialist therapist in this area.

RESOURCES

https://prostate.org.nz/

https://kupe.net.nz/

Ministry of Health launched a new website to help men check for prostate cancer

https://nz.movember.com/about/foundation

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AUTHOR BIO

Carol Wilson was a tutor of Anatomy & Physiology and Pathophysiology at the New Zealand College of Massage for almost 20 years and served as MNZ Magazine editor/co-editor for 10 years, retiring from that role at the end of 2020. Carol is currently assisting MNZ with the AHANZ working group and developing other massage options.

ANATOMY & PHYSIOLOGY

LYMPHATIC SYSTEM

By Becky Littlewood, RMT

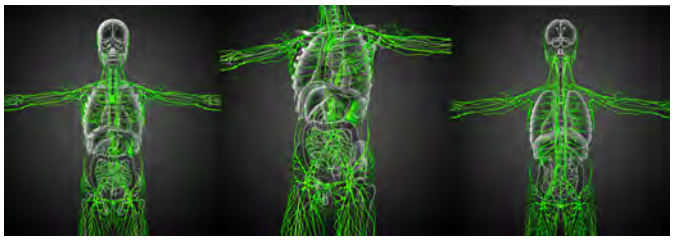

Fig 1. Lymphatic System

Hippocrates described it as 'white blood', 17th Century physician, Gasparo Asellius described the vessels as 'milk veins', and in the 18th Century, three physicians, William Hunter, William Hewson and William Cruikshank dubbed lymphatic vessels 'vasa absorbantia' (absorbent vessels) (Rovenská & Rovenský, 2011). Vital for good health and an important part of our wellbeing and homeostasis, what exactly is the lymphatic system?

Made up of lymphatic fluid, vessels, nodes and organs, the lymphatic system supports both the cardiovascular system and the immune system. The two main objectives for the lymphatic system are to return fluids to the bloodstream to increase blood volume and to support the immune system through filtering and cleansing lymph fluid before it is returned to the cardiovascular system.

Lymphatic capillaries entwine around blood vessels in the capillary bed for easy collection of fluids sitting in the interstitial space (see figure 2). Interstitial fluid is made up of fluids that are left behind as blood is forced out of, and reabsorbed back into, our capillary vessels (Marieb & Hoehn, 2014). Once interstitial fluid enters the lymphatic vessels it becomes known as lymph fluid and goes through a well-connected system that moves fluid back up the body and into the bloodstream. Special lymphatic capillaries sitting in the intestines, known as lacteals, 'milk' fat from the small intestine. Known as 'chyle' this fat laced lymph is transported back into the bloodstream via the lymphatic system (Marieb & Hoehn, 2014). Between 8-12 litres of lymph fluid is returned to the cardiovascular system daily (Scallan et al. 2016).

So, how does lymph fluid make this epic journey from our capillary beds back into our bloodstream?

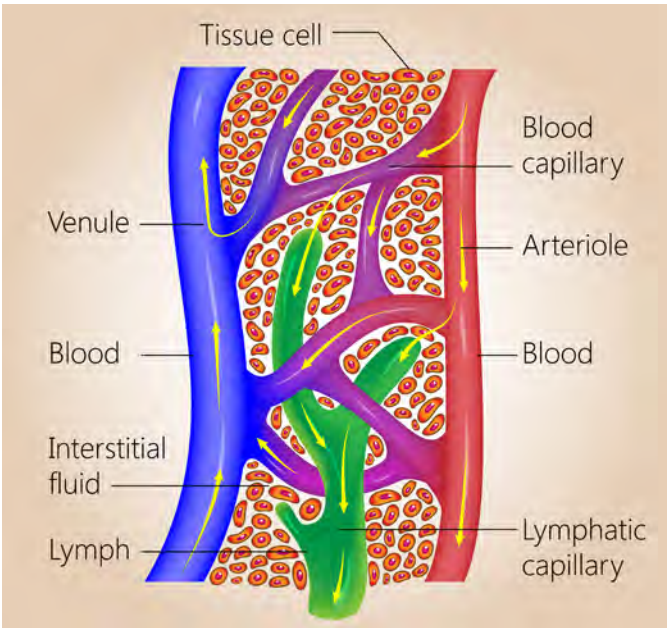

Fig 2. Capillary bed showing the lymphatic capillary (green) entwined with arterioles and venules

LYMPHATIC CAPILLARIES

As stated, interstitial fluid is picked up by lymphatic capillaries, and these have a unique structure. The ends of the capillaries are closed and the endothelial cells that make up the vessel walls are loosely structured and overlap, much like the tiles of a roof. They have filaments that attach onto nearby tissues and as the interstitial fluid between cells increases, pressure against the lymph vessels forces a gap between these loose endothelial cells. In this way, the vessel walls open and allow fluid to enter. Pressure from inside the lymphatic capillaries forces the flaps to shut and prevents lymph fluid from leaking back into the interstitial space.

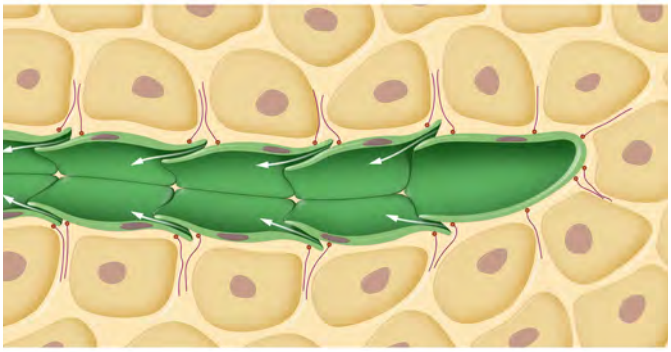

Fig 3. Lymphatic capillary

The loose structure of lymphatic capillaries allows for uptake of proteins, pathogens, cell debris and cancer cells (Marieb & Hoehn, 2014), all of which are cleansed or destroyed by immune system activity in the lymph nodes.

LYMPHATIC COLLECTING VESSELS

Lymph fluid moves from lymphatic capillaries to lymphatic collecting vessels. These vessels are larger than capillaries, have thicker walls (Marieb & Hoehn, 2014), and form more pathways for lymph flow into lymph trunks. Once lymph fluid is in lymphatic collecting vessels, a system of one-way valves prevents the backflow of lymph (Null & Agarwal 2021).

LYMPHATIC TRUNKS

As the lymphatic collecting vessels merge, they form lymphatic trunks which receive lymph fluid from specific parts of the body (see below) (Marieb & Hoehn, 2014).

Lower body lymph is drained into the **left and right lumbar trunks**, meeting at the cisterna chyli (keye-lie), which then drains into the thoracic duct.

The left and right bronchomediastinal trunks are situated in the thoracic region, and drain lymph collected from the lungs, heart, trachea, mediastinal and mammary glands. The left bronchomediastinal trunk drains into the thoracic duct and the right drains into the right lymphatic duct.

Subclavian trunks collect lymph fluid from the apical lymph nodes, situated in the armpit, which have collected fluid from the upper limbs. The right subclavian trunk drains into the right lymphatic duct, and the left drains into the thoracic duct.

Jugular trunks drain lymph from the cervical lymph nodes of the neck, with the left draining into the thoracic duct and the right draining into the right lymphatic duct.

The intestinal trunk is singular and collects chyle containing lymph from the small intestines.

LYMPHATIC DUCTS

Lymph fluid collected from capillaries, collecting vessels, and trunks, is drained into two lymphatic ducts: the right lymphatic duct and the thoracic duct. Each of these ducts receives lymph fluid from specific parts of the body; the right lymphatic duct collects lymph from the upper right side of the body, from just above the cisterna chyli to the top of the right side of the head and the right arm. The thoracic duct is larger in size and collects lymph from the rest of the body, including the lower limbs, left arm, left thorax, and left side of the head. Both ducts drain into the junction between the subclavian veins and the internal jugular veins.

LYMPHATIC CIRCULATION

Once lymph fluid is in the lymphatic capillaries, it is moved towards the ducts via a number of different mechanisms.

Lymphatic vessels are wrapped within the same pockets of connective tissue as blood vessels, bringing them into close proximity and enabling the pulsing arterial stream of nearby arteries to gently move the lymph fluid superiorly (Marieb & Hoehn, 2014). Alongside assisting venous return, movement of the skeletal muscles also creates pressure against the walls of the lymphatic vessels, moving lymph upwards towards the ducts (Moore & Bertram, 2018; Breslin, 2018). Finally, the walls of the lymphatic vessels themselves contain smooth muscle. Governed by the autonomic nervous system, contraction of smooth muscle fibres encourages lymph movement towards the ducts (Webb, 2003). The presence of valves within lymph vessels supports lymph circulation by preventing the backflow of fluid.

Breathing also plays a valuable role in lymphatic transport. Movement of the diaphragm creates a lymphatic pump, moving lymph fluid through the many lymph nodes located under the diaphragm (Kocjan et al. 2017). Kocjan et al. state that diaphragmatic breathing exerts a negative pressure responsible for pulling lymph into the cisterna chyli (2017), which then drains into the thoracic duct. The cisterna chyli is located at the T12 to L2 vertebra and is located lateral to the right crus of the diaphragm (the vertical fibres that attach the diaphragm to the vertebra) (Kiyonaga et al., 2012).

LYMPH NODES

As fluid is moved from the capillary beds to the ducts, it travels through a series of nodes, small 2.5 cm long organs that form part of the lymph organ network of the body.

Nodes filter pathogens and cell debris from lymph fluid, cleansing it for return to the cardiovascular system. Lymphocytes that mature into T-cells (T lymphocytes) and B-cells (B lymphocytes), macrophages, dendritic cells, and reticular cells make up this remarkable system of protection. Reticular connective tissue is lymphoid tissue that provides a structure for lymphoid cells to sit within. As pathogens are detected, T-cells and B-cells are activated, attacking, and destroying infected cells (the role of T-cells), or marking antigens (pathogens) with antibodies (the role of B-cells), identifying them for destruction by macrophages.

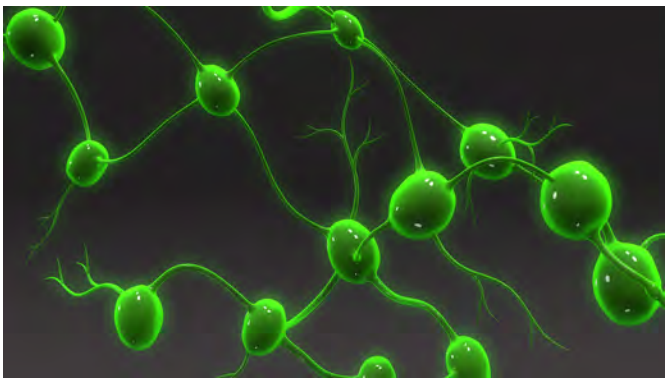

Fig 4. Lymph nodes

Nodes are plentiful throughout the body and proliferate in the armpit, groin and neck, the sites where lymphatic collecting vessels form trunks. Node anatomy is complex, with afferent lymphatic vessels transporting lymph fluid into the node through the B-cell containing superficial cortex and the Tcell containing deeper cortex. Dendritic cells move into lymph nodes when they detect infection or inflammation in nearby tissues and activate naïve (immature) T-cells (Hampton & Chtanova 2019; Ozdowski 2021). Afferent vessels outnumber efferent vessels in a lymph node, allowing lymph fluid to stay in the node long enough for it to be thoroughly cleansed and filtered. Lymph fluid travels through several nodes for cleansing and filtering, and in this way, there are numerous opportunities for pathogens to be destroyed before lymph fluid is returned to the cardiovascular system.

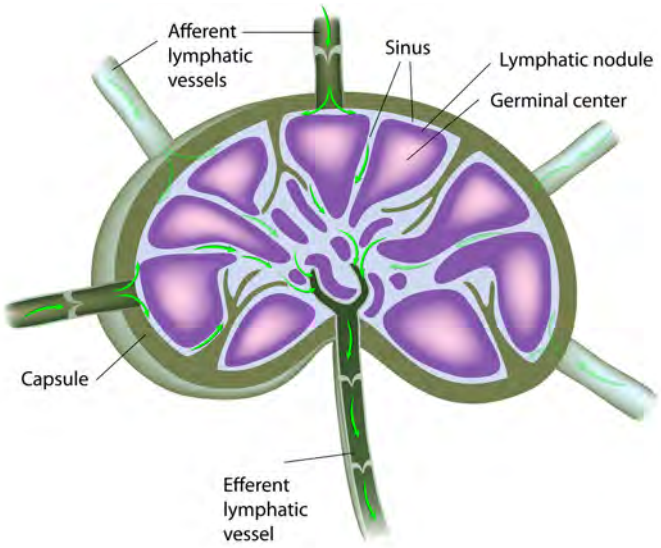

Fig 5. Anatomy of a lymph node

LYMPHOID ORGANS

We are all familiar with the effects of inflamed tonsils or a burst appendix. The thymus, spleen and 'Peyer's patches', join the tonsils and appendix to make up the lymphoid organs. What role do they play in the lymphatic system?

These organs differ from the lymphatic nodes due to their lack of ability to filter lymph fluid. They contain efferent lymphatic vessels that drain lymph fluid, but they lack the afferent lymphatic vessels supplying them with fluid.

The spleen is the largest lymphoid organ, is located between the stomach and the diaphragm on the left side of the body, and is highly vascularised (Chaudhry et al., 2020). Its role is to provide lymphocyte 'proliferation and immune surveillance and response' (Marieb & Hoehn, 2014, p. 817), as well as functioning as a blood-cleanser. Spleen tissue contains red and white pulp. White pulp spleen tissue helps to produce and mature white blood cells (WBCs) – lymphocytes and macrophages - whereas red pulp, amongst other activities, stores WBCs, which are then released to injury sites for healing and to aid in the inflammatory process (Chaudhry et al., 2020).

The thymus, located in the neck, is the primary site of T-cell production in childhood through to adolescence. It is most active through the early years of life and begins to decline post-puberty, though it retains an ability to produce immune cells throughout a person's life (Marieb & Hoehn, 2014). Importantly, this organ tightly protects immature T-cells from exposure to bloodborne pathogens to prevent them from being activated too soon (Marieb & Hoehn, 2014).

Peyer's patches, tonsils and appendix are our mucosa-associated lymphoid tissues (MALT). These tissues are situated in mucous membranes in the body (Marieb & Hoehn, 2014). Lymphoid tissues can also be found in the mucous membranes of our genitourinary and respiratory organs ((Marieb & Hoehn, 2014), but the Peyer's patches, tonsils and appendix are the largest of the MALTs.

Peyer's patches are found in the small intestines, the tonsils in the throat and the appendix in the large intestines. The role of these tissues is to guard the body against pathogens in these areas of high activity. Pathogens in the air, our food and, naturally, our intestines are destroyed by the lymphoid tissues in these organs.

Many believe that the appendix has no value and whilst we can survive without this organ, its position at the end of the ascending colon (at the base of the cecum) is postulated to be useful as a potential 'safe house' for beneficial bacteria (Smith, et al., 2017, p. 40; Kooij et al., 2016, p. 1). Its unique location and anatomy enable it to keep beneficial bacteria out of the main flow of the large intestinal content stream (Smith, et al., 2017), allowing it to remain untouched and ready to repopulate the gut with good bacteria after an intestinal infection (Smith, et al., 2017). Its role as a lymphoid tissue-containing organ helps to destroy intestinal pathogens via natural killer T-cells within its mucosa (Kooij et al., 2016).

The lymphatic system is an extraordinary and complex system, essential to maintaining homeostasis and immune function within our bodies. When it malfunctions, we are at risk of developing lymphedema (swelling in the tissues). Ranging from mild to severe, lymphedema can be a painful and limiting condition. Manual lymphatic drainage (MLD), conducted by a qualified MLD massage therapist, is an effective and powerful treatment for this condition.

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AUTHOR BIO

Becky is a Level 7 massage therapist. She is the owner of Rejuvenate Therapy: Massage & Bodywork, an evidence-informed practice, serving those with needs arising from a myriad of causes. Becky loves her work and loves continuing to improve her knowledge and practice.

WHO'S WHERE

Prime Massage Therapy opened its doors in May this year and is located on the main shopping street in Onehunga, Auckland. This quiet and serene clinic sits up on the first floor well away from the hustle and bustle of the street below.

Nici Stirrup completed the Bachelor of Health Studies (Massage and Neuromuscular Therapy) at NZCM in 2017. She is a level 7 RMT and an Easy-Claim Provider with Southern Cross.

Nici provides Neuromuscular Massage Therapy to assist with chronic and acute pain, stress, injury recovery, pathologies/co-morbidities. She focuses on restoring pelvic alignment, encouraging good foot biomechanics and cranio-sacral balance including TMJ treatment. Nici has experience also in providing clients with exercise rehabilitation and stability training.

https://www.primemassage.co.nz/

CLINIC ADDRESS:

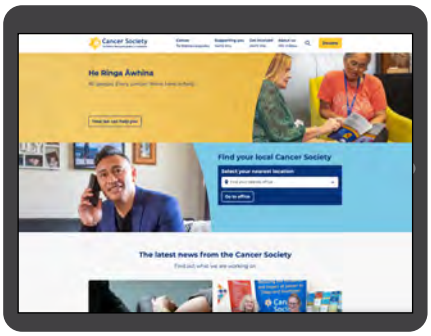
212b Onehunga Mall Road,
Onehunga, Auckland

USEFUL SITES AND ONLINE RESOURCES

Cancer Society NZ

https://www.cancer.org.nz

The Cancer Society of New Zealand is currently the leading non-government organisation dedicated to reducing the incidence and impact of cancer and ensuring cancer care for everyone in New Zealand. Their website has information on support available for people with a cancer diagnosis. There is also a section of stories of people who have survived cancer as well as those who have lost someone they love.



The following websites are all New Zealand based foundations and organizations providing support for specific types of cancer. We have listed several of the most common types of cancer:

Bowel Cancer New Zealand: https://bowelcancernz.org.nz

Breast Cancer Foundation NZ: https://www.breastcancerfoundation.org.nz

Leukaemia & Blood Cancer New Zealand: https://www.leukaemia.org.nz

Melanoma New Zealand: https://www.melanoma.org.nz

New Zealand Gynaecological Cancer Foundation https://nzgcf.org.nz

Prostate Cancer Foundation NZ: https://prostate.org.nz

Sweet Louise Support for Incurable Breast Cancer: https://sweetlouise.co.nz

Health Navigator

https://www.healthnavigator.org.nz/health-a-z/c/cancer

The Health Navigator website provides one place for New Zealanders to find reliable and trustworthy health information and self-care resources. This section contains a wealth of information on types of cancer and the different treatments, as well as ways to manage cancer pain and live with cancer.

PINC & STEEL

https://www.pincandsteel.com

NZ based resource for physiotherapy for cancer rehabilitation, PINC & STEEL provide training programmes across NZ and the world. For massage therapists, there is a useful directory of NZ physiotherapists trained in cancer rehabilitation for referring clients to, or to align with to receive referrals from them.

Skylight Trust

https://www.skylight.org.nz/resources/illness-and-disability/cancer

Ways to support someone with a cancer diagnosis.

Psychology Today

https://www.psychologytoday.com/nz/blog/cancer-is-teacher/201502/why-is-it-difficult-get-massage-when-you-have-cancer

This post discusses the difficulties patients face when massage therapists refuse to massage them because they believe cancer to be a contraindication.

Mayo Clinic

https://www.mayoclinic.org/diseases-conditions/cancer/symptoms-causes/syc-20370588

Easy to understand health information, this section describes the symptoms, causes, diagnosis and treatment of cancer.

Society for Oncology Massage

https://www.s4om.org

The Society for Oncology Massage (S4OM) exists to support and educate massage therapists, consumers, and health professionals about the value and specific considerations and applications of oncology massage. It is a US based not-for-profit, and their website has several useful resources for current OM therapists or those interested in becoming one, as well as for clients and their families.

Tracey Walton & Associates FAQs

http://www.tracywalton.com/faqs/index.html

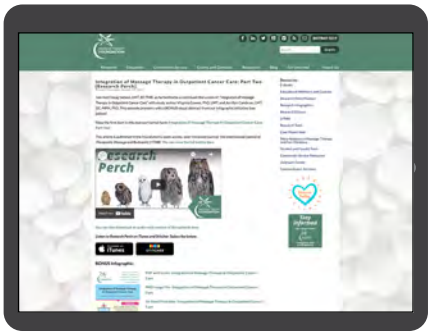
Tracy Walton is a researcher, writer, award-winning educator, and specialist in massage therapy and cancer care. Her website contains a wealth of resources related to oncology massage, including online courses she offers, research and useful links.

The Massage Therapy Foundation

http://massagetherapyfoundation.org/integration-of-massage-therapy-in-outpatient-cancer-care-research-perch

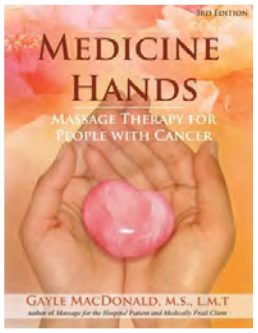
http://massagetherapyfoundation.org/integration-of-massage-therapy-in-outpatient-cancer-care-part-two-research-perch

These two episodes of the Research Perch podcast discuss a study by Virginia Cowen on the integration of massage in outpatient cancer care.



BOOK REVIEWS

MEDICINE HANDS: MASSAGE THERAPY FOR PEOPLE WITH CANCER



By Gayle MacDonald

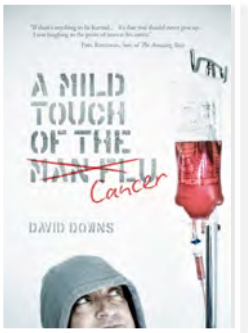
https://www.bookdepository.com/Medicine-Hands-Gayle-MacDonald/9781844096398

The field of oncology massage is maturing into a discipline with a deeper and deeper body of knowledge. The 3rd edition of Medicine Hands reflects this maturation. Every chapter contains updated information and insights into massaging people affected by cancer. New chapters have been added to cover each stage of the cancer experience: treatment, recovery, survivorship, side effects from the disease, and end of life. These new chapters and organizational structure will make it easier for the reader to find the information needed to plan the massage session for a given client.

This book is an excellent textbook for any therapist learning oncology massage.

This is a great book for therapists to understand the patient perspective, and to lend to clients who are living or supporting someone with cancer.

A MILD TOUCH OF THE CANCER



By David Downs

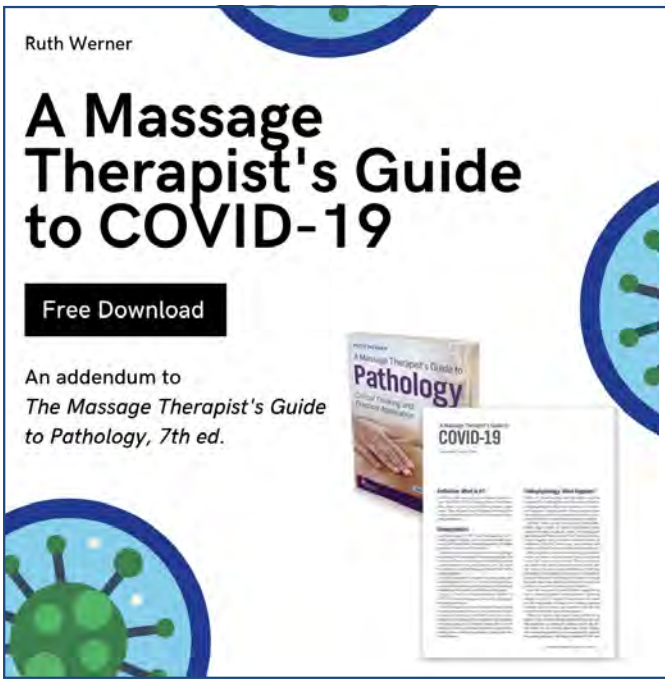
https://www.mildtouch.nz/orders (Physical book)

https://www.audible.com/pd/A-Mild-Touch-of-the-Cancer-Audiobook/B07WBW477T (Audiobook narrated by the author)

"I'll start in the middle, where the cancer has started, right in the guts..." And so begins businessman, comedian, author – and cancer survivor - David Downs' remarkable book A Mild Touch of the Cancer.

Contrary to the book's title, David had lymphoma and it was terminal. But A Mild Touch of the Cancer isn't your standard 'how I survived' compendium. It is a hilarious tale, written while battling one of life's greatest challenges. It's a book about living with optimism and positivity, by a self-proclaimed Genetically Modified Organism.

David's book documents a year of gruelling treatment, which at one point nearly made him sell his house to raise the necessary $1M for trial CAR-T cell treatment in Boston, US. It was this treatment that saved his life. An unexpected pioneer in genetic engineering, David is now instrumental in assisting Wellington's Malaghan Institute to begin trials of CAR-T cell therapy in New Zealand.



Ruth Werner – News Flash

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

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

Get it and share it here:

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

MASSAGE THERAPY AND CHEMOTHERAPY GOOD RESEARCH AND... NOT SO GREAT

Greetings, MNZ Readers!

I recently had the honor of working with my friend Dr. Niki Munk to present a class at the Oncology Massage Summit, hosted by the Society for Oncology Massage (S4OM). Dr. Munk began her professional career as a massage therapist, and she became deeply interested in massage therapy research. She went on to get a doctorate in gerontology, and now she is an Associate Professor of Health Sciences at Indiana University, where she guides other massage therapists through the process of obtaining advanced degrees. She also conducts her own research on a variety of massage therapy-related topics, especially pain and emotional well-being.

Our job for the S4OM meeting was to present some recent research about massage therapy and cancer, and since we did a really thorough job of dissecting a couple of seemingly-similar reports that are relevant to this issue of Massage New Zealand, I thought I would take advantage of that work and share them with you.

This column will provide examples for why reading an abstract doesn't yield enough information to rely on specific findings. It will also elucidate why it's useful to peruse the charts and tables in research articles closely—this is something that doesn't come easily to me, so I have been very grateful for Dr. Munk's expertise with this skill.

The first paper I will present to you comes from Puducherry, India, and it is available free-full-text. It describes a simple but clearly conceived clinical trial looking at the role of massage therapy to address nausea, vomiting, and retching in the context of chemotherapy.

ASHA, C., MANJINI, K. J. AND DUBASHI, B. (2020) 'EFFECT OF FOOT MASSAGE ON PATIENTS WITH CHEMOTHERAPY INDUCED NAUSEA AND VOMITING: A RANDOMIZED CLINICAL TRIAL', JOURNAL OF CARING SCIENCES, 9(3), PP. 120–124. DOI: 10.34172/JCS.2020.018.

Abstract (edited for form and length)

Introduction: Cancer is a global problem, and it is a leading cause of death worldwide. Nausea, vomiting, and retching are one of the common side effects that are seen among the majority of the patients undergoing chemotherapy. Foot massage is a complementary therapy that reduces chemotherapy-induced nausea and vomiting (CINV) and improves the quality of life among cancer patients undergoing chemotherapy. This study aims to measure the effectiveness of foot massage in reduction of nausea, vomiting & retching on patients undergoing chemotherapy treatment.

Methods: A randomized clinical trial study was used to assess the effect of foot massage on patients with chemotherapy-induced nausea and vomiting among patients undergoing highly emetogenic chemotherapy. Simple random sampling by the lottery method was used to select newly diagnosed cancer patients who underwent highly emetogenic chemotherapy (N= 82). The Rhodes index of nausea, vomiting and retching (RINVR) questionnaire was used for data collection.

Result: Nausea, vomiting, and retching were significantly reduced in the experimental group compared to the control group after the intervention. There was a significant difference between pre-intervention and post-intervention scores within the group.

Conclusion: The findings of the study revealed that the foot massage therapy is effective in reducing chemotherapy-induced nausea and vomiting among patients undergone highly emetogenic chemotherapy. The study helped to conclude that foot massage can be considered effective intervention in chemotherapy patients.

From this abstract, we can see that the researchers had 82 subjects with various forms of cancer who were randomized into two groups. The experimental group received foot massage, and the other group didn't. They all began "emetogenic" chemotherapy: that means chemo likely to induce vomiting. And the results were clear: after the intervention the experimental group experienced less nausea, vomiting, and retching (NVR) than the control group, so the team concludes that, "foot massage can be considered effective intervention in chemotherapy patients."

But wait, not so fast.

There were some significant limitations in this study that are not described in the abstract, and these caveats are important. Let's take a closer look.

1. Who was included? The participants were men and women between 18 and 70 who were beginning chemotherapy treatment for cancer. Specific exclusion criteria were described (specifically age, foot and leg problems, and cancers of the GI tract). Many of the original study volunteers were excluded, but the reasons were not reported; this would have been helpful to other researchers to see.
2. How and when for massage? Both groups established some baseline measures for NVR before their chemo treatments started. Then the massage group got three treatments of 20 minutes each—all on the same day. Their first massage was in the hospital shortly before their chemo infusion began, their second massage was during their infusion, and their third massage was shortly after the conclusion of their chemo treatment. All we know is that the massage was applied to the feet and lower legs; no other details were provided. So, all the results were in response to a single day of treatment; this intervention did not apply over a longer period of time. This is convenient for researchers, who, by making participation extremely convenient, are less likely to lose study subjects. But it is not a reflection of how massage therapy is practiced in general, which is a limit on external validity.
3. Reported results? Results from the experimental and control groups were taken by a telephone interview 48 hours after the chemotherapy appointment. The experimental (massage) group had more people with no NVR, the same number of people with mild NVR, and fewer people with moderate NVR as compared to the control group. The conclusion is that massage may help with the side effects of NVR for people undergoing their first session of chemotherapy. Here's one problem: the person who collected the data is not identified. If it was the massage therapist, this can be problematic, as people are often reluctant to give negative information to their massage therapist (this is called collector bias). But an even bigger issue is that chemotherapy side effects often don't arise or peak until later in the treatment cycle, so this result doesn't speak to that challenge at all.
4. What did they use as a measuring tool? The research team used a survey called the Rhodes Index of Nausea, Vomiting, and Retching (RINVR) to collect data on the severity of symptoms related to chemo side effects. But the citation for the validity of the RINVR tool was not accurate. Dr. Munk and I looked more deeply into this and found that the RINVR tool has been validated for NVR as a post-operative problem, but it doesn't have a deep history in the context of chemo-induced NVR. It may be fine, but the fact that the authors didn't pursue this further is a weakness.

In conclusion, this study showed that foot and lower leg massage appears to improve NVR-related side effects for this group of patients undergoing their first chemotherapy treatment, as reported 48 hours later. This is not the same as, "foot massage therapy is effective in reducing chemotherapy-induced nausea and vomiting among patients undergone highly emetogenic chemotherapy."

Can we see why going beyond the abstract is important? Foot and leg massage might be great for people having nausea, vomiting, and retching that arise from chemotherapy, but this study only supports that finding for one dose of chemo in relation to three massage sessions. To say anything broader would require more research. The findings of this study may not be generalizable, and massage therapists could be led to rely on this article to make a case for massage that would not withstand scrutiny.

Our second paper also looks at massage therapy in the context of chemotherapy side effects. This article addresses CIPN, or chemo-induced peripheral neuropathy. It comes from Ankara, Turkey. When Dr. Munk and I were first choosing papers, this was available without payment. Unfortunately, it has now been put behind a paywall. If this paper interests you, you may be able to get access through a medical library, since it was published in a popular medical journal.

IZGU, N. ET AL. (2019) 'PREVENTION OF CHEMOTHERAPY-INDUCED PERIPHERAL NEUROPATHY WITH CLASSICAL MASSAGE IN BREAST CANCER PATIENTS RECEIVING PACLITAXEL: AN ASSESSOR-BLINDED RANDOMIZED CONTROLLED TRIAL', EUROPEAN JOURNAL OF ONCOLOGY NURSING: THE OFFICIAL JOURNAL OF EUROPEAN ONCOLOGY NURSING SOCIETY, 40, PP. 36–43. DOI: 10.1016/J.EJON.2019.03.002.

Abstract (edited for form and length)

Purpose: This assessor-blinded, prospective, randomized controlled clinical trial aimed at investigating the effect of classical massage on chemotherapy induced peripheral neuropathy and the quality of life (QOL) in breast cancer patients receiving adjuvant paclitaxel.

Methods: A total of 40 female breast cancer patients were randomly allocated to the classical massage group (CMG) or the control group (CG). Classical massage was applied to the patients in the CMG before each paclitaxel infusion. The CG received only usual care. Presence of peripheral neuropathic pain and QOL were assessed at baseline and weeks 4, 8, 12, and 16. Nerve conduction studies (NCS) findings were also recorded at baseline and week 12.

Results: The peripheral neuropathic pain was lower in the CMG compared to the CG at week 12 ($p < 0.05$). The sensory and motor sub-scale scores of the QOL measure showed statistically significant differences over time in favor of the CMG ($p < 0.05$). Sensory action potential amplitude of the median nerve was significantly higher and the tibial nerve latency was significantly shorter in the CMG compared to the CG at week 12.

Conclusions: This study suggested that classical massage successfully prevented chemotherapy-induced peripheral neuropathic pain, improved the QOL, and showed beneficial effects on the NCS findings.

This abstract, in my opinion, veers toward overstating findings. The word "prevention" is tricky under the best of circumstances, and for a single clinical trial of 40 people, no matter how carefully conducted, to claim that massage "successfully prevented chemotherapy-induced peripheral neuropathic pain" is perhaps hyperbolic. All they needed to do was to add "for these subjects" to the end of the sentence to make this much more usable.

That said, this study demonstrated that the massage group did not experience worsening CIPN between baseline and measures taken at 12 weeks, while the control group on the same medication definitely did. So if massage is the only variable, it is fair to say that it could have contributed to this outcome at least among these subjects.

This study was much more complex and multifaceted than the Asha paper. While its number of subjects was 40 (compared to Asha's 80), it sought data on a variety of subjective and objective scales that revealed a lot of information about what massage therapy might and might not do for people with breast cancer undergoing chemo treatment with paclitaxel.

Paclitaxel, trade name Taxol, is a drug derived from the Pacific yew that interferes with cell division. It is used for many types of cancer. CIPN is a common side effect of Taxol, and CIPN is notoriously difficult to treat. This damage to motor, sensory, and autonomic nerves can be severe enough to interfere with patients' activities of daily living, or even to require that they interrupt their treatment to recover—and of course this may lead to poorer outcomes.

The article makes a compelling case that massage therapy, employed before CIPN develops, may improve patients' quality of life (on subjective scales), and nerve conduction study results (on objective scales).

The methods section of the abstract gives a full picture of the project: baseline measurements of all the subjects were established before treatment began. Then the experimental group (CMG for "classical massage group)" received massage treatments before each of their 12 chemotherapy doses. The massage treatments (unlike in the Asha paper) are carefully and thoroughly described. Any massage therapist would be able to recreate these sessions.

Data on quality of life and neuropathic pain were gathered at weeks 4, 8, 12, and 16. Nerve conduction studies were taken at baseline and week 12.

The surveys used for pain and quality of life are well-validated measurement tools. They demonstrated that randomization was successful, because between-group key measures were similar at baseline.

Lastly, and importantly, all the data were processed by a blinded assessor who didn't know if they were looking at information from the experimental group or the control group.

The way the results of the study were reported, in my opinion, made them difficult to interpret. I was so grateful to have Dr. Munk lead me through the tables that, to my word-loving eyes, were incomprehensible. But in summary, the research team found that neuropathic pain did not increase among the massage group, and it did increase among the control group. That is a big finding! In addition, the nerve conduction studies found that while both groups had some loss of

function in the median nerve, the loss was less severe in the massage group. And—although this was buried in the table and not discussed by the researchers, the nerve conduction study showed that function in the sural nerve of the massage group improved. The improvement did not reach the level of statistical significance, but it was a surprise, nonetheless.

Does all this rise to the level of the claim that massage therapy "prevents" CIPN for people taking Taxol for breast cancer? We can't say that based on a study involving 40 subjects. But for these subjects the data shows that reported CIPN symptoms did not increase over the course of the study among the experimental group.

While it was very strong, this study was not without limitations. One of the most important is that among the massage group subjects, two people started the study with some symptoms of peripheral neuropathy. In the best of all possible worlds, these subjects should have been excluded, but that's not how it worked out for this study to meet its enrollment for power analysis.

In addition, it would have been a stronger project if the nerve conduction studies had been conducted more frequently, especially at week 8, when CIPN symptoms seemed to peak for the control group, and quality of life reports were at their lowest.

Lastly, I was surprised that the team didn't comment on the improvement in sural nerve function that was shown in the nerve conduction studies of the massage group. This improvement, minor as it was, may be related to the fact that the lower body got twice the amount of massage as the upper body. Conceivably this dosing variable might have impacted nerve function more than anyone predicted. I would love to see someone pick up this thread to see where it leads.

I am always intrigued to read studies that look at the intersections between massage therapy and medication use, especially in the context of cancer. I confess that at the back of my mind I wonder if receiving welcomed, relaxing massage during chemotherapy might not have an influence on the uptake of the drugs, making them possibly more effective with smaller doses. Someday we may be able to conduct a study that asks that important question.

These two studies are promising about how massage therapy can be helpful, although the Igzu study is much more fully reported and reliable than the Asha study. Massage therapists who work with clients who are undergoing cancer treatment will be enriched by what they find here.

AUTHOR BIO

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

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

Ruth can be reached at www.ruthwerner.com or rthwrnr@gmail.com

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relationship. Acute stress may present as restlessness, darting eyes, or twitching feet, and in a health care setting may be complicated by medications, isolation and decreased physical movement. While medications may be given specifically to reduce anxiety, some medications can increase the depth of emotions. However, not all stress presents outwardly: if stress has become chronic, the behaviors are likely to be quite different. Long-term stress may present as fatigue, confusion, anger and/or lethargy.

Assessing for stress level and whether it is acute or chronic can add tremendous advantage in building effective therapeutic relationships with patients who most certainly can benefit from whole-person support. Recognizing and normalizing the stress response without becoming frustrated or reactive is a useful ability to develop.

Holding space

Holding space is the concept of being with a client, fully present but without trying to fix them. Holding space means neither judging nor advising. It is the practice of being attentive. Holding space is being centered on the "spectrum of caring" presented below and in Table 4.1, and is the foundation of authentic communication within therapeutic relationships. The practices of holding space include:

- Deep inhalations which indicate a visceral comprehension of what was shared.
- Attentive silence and stillness.
- A gesture of recognition, such as placing one's hand on one's heart.
- No words are needed.
- Using gentle eye contact which is not too demanding, but is at the ready to listen.

Other than the logistics of charting and interacting with medical staff, the most common concern bodyworkers express about working in medical settings is over what to do in an intensely emotional patient situation. New practitioners in the field often ask: "How can I stay professional and strong when really I feel the need to cry?" Holding space is one strategy for these times.

For example, what should a touch therapist do when a client shares that her very best friend died unexpectedly? Or, how should a therapist respond when a patient at the end of life describes their fear of pain and expected death? Some massage practitioners will deny or dismiss their client's emotions because it is too uncomfortable and "outside the scope of practice." Some providers will feel the client's suffering so deeply that they offer their own personal experiences and solutions in order to help "fix" a situation that is too hard to bear. Instead, they could just hold space.

Therapeutic active listening

Another fundamental element of authentic communication is therapeutic active listening. According to researchers: "… listening was seen by patients as creating the conditions to promote healing and recovery."[2] In traditional active listening practice often used in psychotherapy, the therapist restates a client's report. An example might be: "I hear you say that your low back has been hurting since being in the hospital on the air mattress." In order to expand this technique to *therapeutic* active listening, the practitioner will include restating and clarifying any emotions or feelings that were shared in addition to the "facts". For example: "I hear you say that you have low back pain now and you suspect that it's from the air mattress. I am also sensing frustration when you say 'it's really hard to sleep here'". Simply being heard and understood can be therapeutic. Also, allowing the patient time to expand on or correct what the clinician repeated will likely improve the quality of the assessment and treatment plan. This is especially important for clients speaking in a second language or when colloquialisms may not be clearly understood between therapist and patient.

Practitioner vulnerability

Another important aspect of authentic communication is responding with a willingness to be vulnerable and honest. If a client's story is particularly moving, an authentic response means acknowledging one's reaction in a controlled way. The practitioner's response should be short

and not fall into over-sharing of personal issues. However, the therapist can and should be human. For example, a patient once shared with a touch practitioner that she is "horrible" at making decisions, and is now faced with what type of treatment to have for advanced cancer. If the touch practitioner personally identifies with, in this case, challenges of decision-making under difficult circumstances, that common experience can be shared. No words are needed, but if the therapist senses it to be appropriate to share their own vulnerability as a means of connecting, the practitioner might briefly disclose part of their own experience. For example, in this case the practitioner might say something like: "I am really bad at making decisions myself. I can imagine with a decision this important, it's very stressful." Being human and allowing one's self to be imperfect, and broken in one's own unique ways, builds a bond and helps both to feel less isolated and closer to the mutually healing experience of being understood. The guideline for personal disclosures in these situations however is always "less is more".

Therapist's journal 4.1
How to touch someone

Before you lay a hand,
you must lay your thoughts aside,
and breathe into yourself,
and gather your intentions –

Why are you here?

Now it's time to pay attention!
to the person sitting here, in front of you,
ready to receive your care.

Who is this person?

You have no idea, and they might not say –
they might not even know,
for what the mind forgets, the body remembers.

This person's body has a history –
perhaps loving, perhaps harsh.
Hands to this person may be
wonders or weapons.

Suppose you have a warrior in front of you,
a survivor,
a child,
a mother,
a lover.

You must be gentle, yet strong.
You must go slow, and flow.

Most importantly, you must breathe –
breathe into your heart, your hands,
your heart-hands.

Remember –
what you feel, he feels,
what you feel, she feels.

Feel the warmth of the space between you.
Only *now* may you begin...
...the laying on of hands.

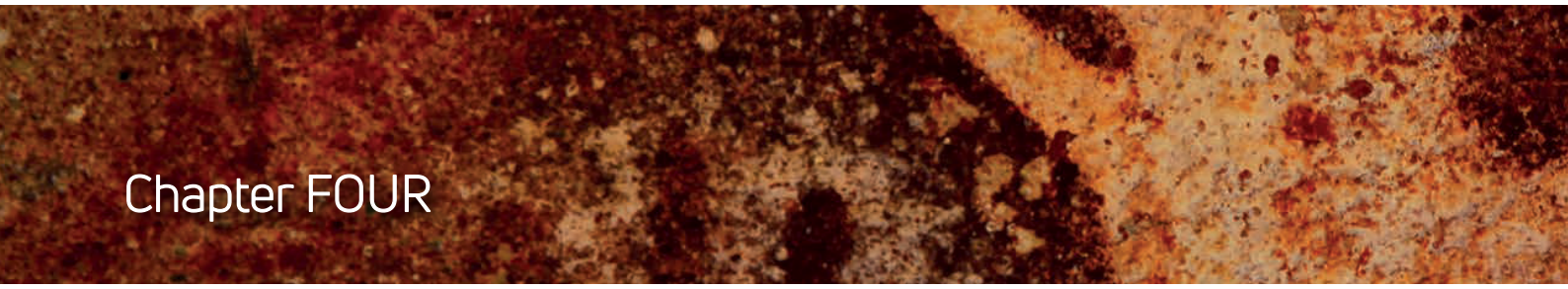
by **Allison Young** CMT

Motivational interviewing

The therapeutic relationship is intended to be patient-centered. However, practitioners often automatically respond by giving advice when patients share something of their situational challenges. A common reply might be: "Maybe you should…", or, "I know another client who had similar issues and they…" These are therapist-centered responses. While they are well-intentioned and might be helpful, these bits of advice could also feel like yet another person imposing unhelpful clutter in an already stressful situation.

Motivational interviewing is a patient-centered strategy used widely in integrative medicine and other health care practices that can empower the client to discover their own answers, motivation and commitment.[4] It engages people in their own health care,[3] and because a provider never has all the answers to life's presenting problems, the burden and risk in finding the answer to the patient's problem is removed from the practitioner.

This strategy is useful on many levels. It can be used when trying to help a patient who is working to improve a symptom, such as anxiety. There are always many options toward a solution – the key is, what motivates the patient and what are they willing to commit to? It is immaterial what the therapist believes they should do.



The bodyworker is there to listen, ask questions when appropriate and help the patient frame a plan that motivates them.

For example, practitioners often struggle with what to say when a patient questions the worth of continuing treatment, or concludes that they are not prepared for dealing with financial crisis due to loss of work. What does one say when the patient has extensive family issues which take priority even over their own health? It is perfectly acceptable, and is actually more appropriate, *not* to provide answers. When conversation is expected, motivational interviewing is a best practice that may help clients identify their own solutions or initiate a transformation. In the above circumstances, the therapist could include motivational interviewing by asking the patient to consider their sources of information. For example, a skillful question might be: "Do you feel comfortable asking a few people on your health care team more about the options you have?" This type of question draws attention to the patient's immediate resources for decision-making, and is open enough to allow for the emotional aspects possibly associated with asking for input, or interacting with medical staff. Affirming the goals of the team for the client's best outcomes is inherent in the question, which also makes it skillful.

Sample motivational interviewing questions

Below are sample motivational interview style questions which may be appropriate for medical settings when patients engage in telling their story. They may be asked during a first appointment or as conversation unfolds at the bedside session. As these are intensely personal questions, complete attention and holding space for an authentic response is crucial. Without genuine interest in the client's answers, the questions could be felt as intrusive or inappropriate. A key component of skillful questions is that they are open-ended – this means there is not a quick yes or no answer and that further conversation is welcomed.

1. What brings you joy? Where do you find happiness? At home, what do you do for fun?
2. Where do you find purpose? What gives you meaning? What are you learning about yourself?
3. What are your goals? What are your goals for when you are back home?

Unfortunately for many chronically ill patients, they can become medicalized and overly identified with their conditions. Asking patients about their joy, meaning, or goals is intended to activate the inner drive and remind them of who they are outside of the medical setting. For example, a newly admitted stroke survivor in a rehabilitation facility requested massage therapy for pain relief. During the first intake, the touch therapist asked: "If you had one goal to accomplish this week, what would it be?" This question opened up the full spectrum of the patient's goals and also helped set expectations that were attainable. The patient responded with: "I need to send my brother a birthday card." The therapist was then able to offer extra focus on the patient's hands and arms and connected that the massage might help "get the hands ready" to write.

The search for meaning can be from moment to moment or the quest of a lifetime. Therapists of any discipline who help patients to recognize their own goals, are mastering therapeutic relationships.

Skillful compassion

People in the various health care disciplines are generally thought to be compassionate by nature. Experience and research show, however, that compassion can also be taught and therefore is a skill that can be improved, regardless of the starting point. Working with seriously ill patients, in environments that are often hectic and stressful, can be very emotionally demanding. Being skillful in expressions of compassion serves patients, their families, staff members and practitioners themselves by allowing for true human emotions without overstepping professional boundaries or scope of practice. The Spectrum of Caring chart (see Table 4.1) was developed specifically for practitioners working with medically complex patients and clients in health care settings. It bears repeating that these skills may inform personal relationships, but the agreements between family and friends are different in important ways. The Spectrum of Caring guidelines below are for the presenting psychosocial needs of a client within a given session of touch therapy.

If authentic communication is the outward behavior that builds therapeutic relationships, skillful compassion

is the internal counterpart. Where is one's heart and mind in any given client interaction? Is there judgment of any kind regarding why the patient is in the hospital? Is the mind busy solving all the person's problems? Skillful compassion is the inner balance of being fully present and not ever assuming one has solutions to another's concerns.

Journaling exercise 4.1
What is helpful to me?

Take a moment to consider a time when you personally have been in a difficult situation, e.g. physically or perhaps in a challenging relationship. What type of support was most helpful to you? Did you appreciate others sharing similar experiences so you could learn from them or perhaps feel less alone? Did you appreciate someone bringing you food, taking care of tasks but otherwise giving you space to be alone? Did you find the best support in a group that shared together over time? Perhaps you felt best supported by an expert, professional provider that took charge of the situation and gave you instructions as to what to do.

In reflecting on your experiences, it is likely obvious that different situations need different and often multiple supports. However, it may also occur to you that you have strong personal preferences for what actually feels supportive to you. If you can do this exercise with a few colleagues and share your responses, you will probably find that different people prefer different types of support. What is helpful to one is not necessarily helpful to another. How does this relate to skillful compassion and healthy therapeutic relationships?

Skillful compassion is offered through listening for and acknowledging the emotional aspects of what a patient shares, and holding space for whatever is expressed without attempting to fix it. For many bodyworkers, this is the appropriate limit to the conversation – holding space is enough. Simply acknowledging the conversation in some way before proceeding to the hands-on work, and again at the close of the session is a good rule of thumb and helps build a therapeutic relationship. For example, a comment such as: "Thank you for sharing some of your story with me," shows gratitude and conveys that the patient was heard.

Internally however, the therapist is wise to stay curious without judgment. Recognize any emotional response is one's own and not the patient's. When patients significantly trigger the practitioner's own emotions, it is best to keep a balance between professional knowledge and heartfelt reaction.

If the ideal outward expressions of healthy therapeutic relationships are excellence in treatment, authentic communications and skillful compassion, the Spectrum of Caring is like a GPS tracking device for the practitioner's internal terrain. Each column in Table 4.1 offers a variation of attitudes and behaviors that fall on the spectrum of caring.

Sympathy

Start with the column labeled "Sympathy." Sympathy here means the provider has an understanding and recognition of the client's difficult situation, and will feel relatively distant from the client.

Empathy

On the opposite end of the spectrum is the response labeled "Empathy." When in empathy, the therapist recognizes and understands the problematic situation but also feels it more deeply. There is an emotional and sometimes visceral experience in the practitioner. For some, there is a kind of meshing or melding with the emotions of the client.

Compassion

While both sympathy and empathy provide a quality of holding space and are certainly expressions of care, there is yet a third, middle way that has the potential to be of better service to the patient and to sustain the clinician. The middle way, to overtly borrow from the Buddhist tradition, is the response of compassion. Definitions and translations can

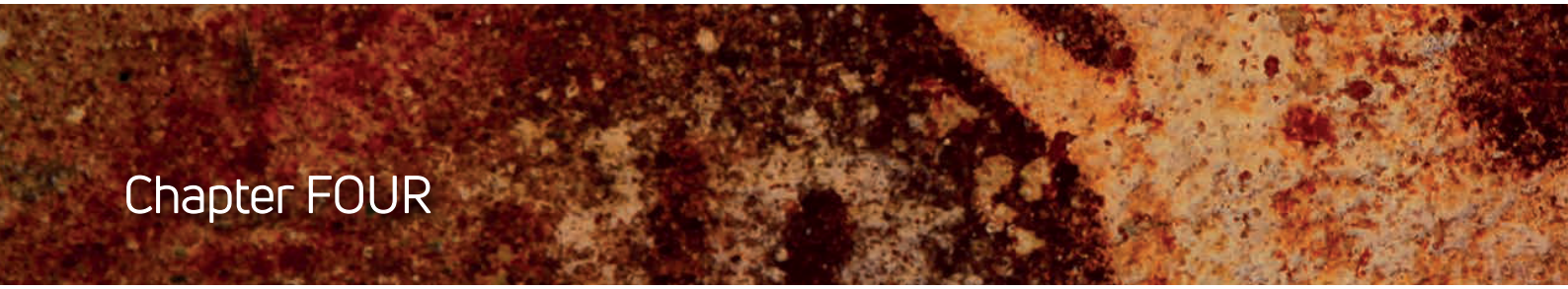


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TABLE 4.1 Spectrum of Caring[9]

Symbol†			
Spectrum	SYMPATHY	COMPASSION	EMPATHY
Location	Brain	Spirit	Heart
	Pity ←	Holding space	→ Overwhelm
Definition	Sameness of feeling; agreement	Sympathetic consciousness of another's distress	Ability to share another's feelings
Description	Perceiving another's situation/ emotions as painful, tragic, horrific, etc. Needing to be fixed, changed, corrected	Meeting another where they are. Being present to all that is. Allowing the emotions and story to be heard/ person to be seen	Being fully connected emotionally to another's emotions or "story". Feeling what you think they feel
Energy (provider's)	Giving away. Pouring out. Can turn into "fixing"	Holding space. Being with. Trust	Melding. Merging. Can turn into "fixing"
Energy (patient receives)	Heavy weight on them	Supportive. Empowering	Melding. Merging. Diverted
Dos	Acknowledge your heart's mind and your mind's heart	Stay present. Don't run away. Help facilitate another's finding their own answers/solutions	Feel what you feel and track what is yours and what is another's
Don'ts	Assume you can fix or solve another's "problems", situations or behaviors	Preach about how it will all work out or that "it's for the best" (passive fixing)	Take on the emotions of another or add your own emotional reactions to another's
Skillful communication	Listen only!	"What do you need?"	"How can I help?" *
Shadow side	Pity. Arrogance. "Fixer"	Disengaged. Philosophic/spiritual righteousness	Boundaryless. Manipulative
Flipside	They/we still show up!	Patients tend to resonate with truth. There is a bigger context to our lives	Burnout. Unable to work. Quit and "go live on a mountain"

†See Question 5 in the Test yourself section at the end of the chapter.
*This is a skillful question for empathy, but not necessarily the best; may lead to breaking boundaries.

confuse the core meaning: here, consider the definition of compassion as the response of understanding, recognizing, and feeling another's difficulties and emotional states. Compassion stays fully present to all that is, without feeling within one's self the need to fix or change the other person. Compassion is a practice of acceptance with an awareness that healing is always a potential. Compassion is neither being on the sidelines nor a superhero. It opens the space to facilitate a client's own discovery of what they need, in any given moment. Compassion allows for feelings of brokenness or rawness but also the sense of freedom in being seen and acknowledged: in a word, accepted. It is a space that understands to the core that transformation, if not cure, is possible no matter the circumstances.

The spectrum of caring: Understanding the therapeutic relationship

As doctor Wayne Jonas says, "healing emerges in the space between people – in the collective mind – and its benefits can go either way".[5]

Examples of skillful compassion in patient–practitioner conversation

- "I can sense the frustration you are experiencing and I can feel that this is a tough situation for you." Eye contact and pausing are helpful here.
- "I can really understand that this is also an emotional time for you. Do you feel like you have the support you need?"
- Have a list of the departments to which you can refer patients. In the hospital, these would include chaplains, social workers, case managers and of course the nurses.

Journaling exercise 4.2
Where are you on the Spectrum of Caring?

Please spend some time journaling your thoughts about the questions below.

The Spectrum of Caring was developed as a guide or framework to help the professional caregiver look inward. *Sustainability* and *resilience* are hot topics in health care as clinician burnout rates and attrition appears to be at an all-time high. While systems and workload demands are prime factors, one's philosophy and world view play a part. What do you believe your role is in health care? How do you define "healing?" Why do you believe people get sick or have pain? One's answers to these questions will give an insight into a therapist's perspectives and presumptions. The suggestions on the Spectrum of Caring guideline are intended to help the therapist navigate closer to center when interacting with patients and clients.

Tip 4.2 Patients in trouble

In clinical environments, all staff are required to report if a patient suggests any kind of harm to self or others. Suicide rates for seriously ill people are substantially higher than in the general population. If a patient states, in any terminology, the thought or intention of doing harm to themselves or others, notify the patient's nurse of what you heard directly after the session. Follow all medical center protocols for any additional steps including noting the statement verbatim in the patient's chart.

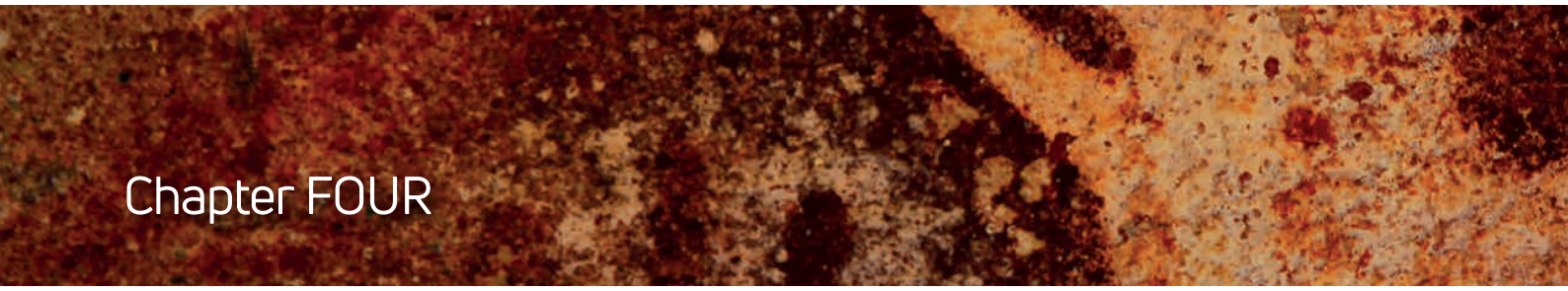
Diversity, equity and inclusion

Health care environments should serve all people in need equally. It is the responsibility of every provider, regardless of discipline, to educate one's self and continually engage in self-reflection around issues of diversity, equity, and inclusion. Aptitude for successfully engaging any and every person who is on the referral list is a core skill in building therapeutic relationships with clients. The beauty of building these skills is that they are often both "good medicine" for the patient, and increase the fulfillment experience of the therapist.

Typically, recognizing the impact of culture on an individual depends very much upon which culture that person identifies with. The daily impacts of a society's culture are a given to those in underrepresented minority groups and are often completely invisible to those in privileged or majority groups. The conversation about bias between groups is not usually easy, but it is imperative for therapeutic relationships.

Dr Linda Clever explains: "Everyone has attitudes. They live in you and tend to persist unchecked unless you take charge… Grounded in emotion, attitudes show up in your body language, words, and behaviors. Attitudes are your outlooks at the same time that they mirror you."[6] It is imperative in the building of therapeutic relationships that practitioners examine their own biases, assumptions, prejudices, and attitudes. Behavior follows thought. Health disparity, with its unfortunate foundation in prejudice and socioeconomic inequities, is a dedicated field of study within public health. Inward examination and reexamination of one's attitudes throughout one's professional career is required for those who seek to build truly therapeutic relationships.

Embedded in any relationship is the reality that people have differences. How differences are welcomed or shunned is a core question in the study of diversity, equity and inclusion. Culture is defined in different ways and changes over time. Around the globe, culture is a cause



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Journaling exercise 4.3
Topics for further research and reflection

Select one or more of these topics to research and journal your thoughts on what you find.

- Implicit bias, automatic reactions. We all have them – take the self-test at: https://implicit.harvard.edu/implicit/iatdetails.html.
- Microaggressions: "Brief, everyday exchanges that send denigrating messages to a target group such as people of color, women, and gays."[7]
- Privileges: Everyone has these too, based on gender, sexual orientation, able-bodiedness, religion, race, nationality, language, age, economic ability, geographic location.
- Being an ally: Recognizing and acting to "call out", or "call in"[8] others' microaggressions or behaviors that foster inequity or exclusion.

for celebration but unfortunately often used as reason for discrimination and unequal treatment. One serious example of the impact of cultural inequity is seen in health care disparities. Among different minority cultural, ethnic, socioeconomic and other demographics, data show significant adverse outcomes in life expectancy, disease rates, and death in childbirth, compared to majority populations. Decidedly, important structural changes are needed to correct these inequities. There is no excuse for waiting, however – each professional provider can do their part to be the change.

Self-care

One important reason to establish self-care practices is to help discharge emotional energy that does not serve the professional caregiver and in turn does not serve those being cared for. What constitutes effective self-care is rarely studied. When asked about self-care practices, many providers talk about what they like to do on their days off. "Time in nature", "playing with kids or pets", "a hot soak" are often on top of the list. These are wonderful

Tip 4.3 Habits for successful therapeutic relationships in health care settings

1. Set appropriate expectations at each session.
2. Hold space: listen and allow silence and stillness.
3. Stay aware of internal reactions and feelings of "need to fix." Hold reactions gently, breathe.
4. Ask skillful questions instead of giving answers.
5. Be human.
6. Be curious about cultural differences and include them in conversation. Accommodate cultural-based needs in delivery of services as appropriate and if possible.
7. Look for assumptions or implicit biases, and consider if they would be any different if the client was from a different demographic, such as ethnic or racial.
8. Give credit to the health care team whenever possible for their thoughtfulness in referrals and support.
9. Track whether emotions are leaning either toward pity or a sense of melding, and consider if a response could be balanced in compassion.
10. Provide closure with each patient. Show gratitude; don't over-promise the future.

options and all highly recommended. For professional caregivers though, daily self-care is a must.

It is relatively easy to incorporate simple activities into a work shift in any medical center setting. Washing hands with intention is one example. Instead of washing hands while thinking of the next tasks, practitioners can use the time to clear the mind with simple breathing exercises. If a session was particularly impactful, the time washing hands could be used to also acknowledge whatever is in one's heart. Naming the emotion and expressing gratitude for the awareness and experience can help close a session internally. Drinking water as a ritual throughout a work day can also be an intentional act of self-care. Perhaps one says a favorite positive word or a mantra before each sip. Perhaps the clinician visualizes a favorite body of water during each hydration. It is not likely that a water bottle can be carried

during sessions, but water bottle "closets" or places where personal belongings can be kept may provide the opportunity to store a special water bottle. Colorful and meaningful stickers could be placed purposefully as self-care reminders. The possibilities are endless, the benefit is crucial.

Summary

While compassion and listening skills are hoped for in all health care professionals, specific skills and behaviors can be developed and improved to promote truly therapeutic relationships with clients. Culturally informed skills of holding space, therapeutic active listening, and motivational interviewing along with the Spectrum of Caring framework may improve the quality of therapeutic relationships. Personal relationships aside, skillful compassion does not attempt to solve problems but engages patients in discovering their own inner wisdom and guidance. The tools of authentic communication, skillful compassion and excellence in discipline-specific care are more effective for client relationships, as well as for increasing the resilience of providers. Appreciating differences, acknowledging individual expression of cultural identities and efforts to include each person and family are embedded practices within successful therapeutic relationships. Self-care is a necessity and is best practiced daily, including through small habits integrated into the work schedule.

Test yourself

Journal your thoughts on the following questions.

1. My philosophy:
   - A What is my philosophy of: Health? Health care? Healing?
   - B What are my perspectives on illness and disease?
2. Reflect on a particularly challenging client interaction.
   - A What was your intention in the communications?
   - B Where did you fall on the Spectrum of Caring?
   - C What behaviors or communications could help "hold space" in a centered, compassionate place for this client?
3. In what ways do you feel included in your work community? In what ways do you feel excluded in your work community?
4. What specific behaviors could you incorporate to help your underserved minority clients feel more included?
5. In the top row of the Spectrum of Caring (Table 4.1) are three blank boxes. Draw a symbol that for you represents each heading of the spectrum: sympathy, compassion and empathy.

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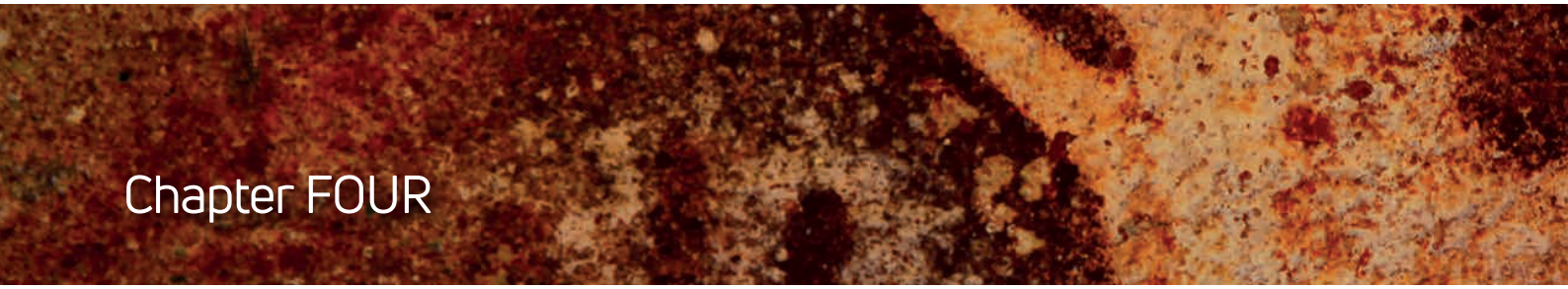

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