

Introduction, With a Response to AMMA

By James "Doc" Clay, MMH, NCTMB

O body swayed to music, O brightening glance, How can we know the dancer from the dance?

- *W.B. Yeats*

Clinical massage therapy has been around a comparatively long time.

(Ben Benjamin has certainly been practicing it quite a while.) The various schools of myofascial release are clinical in intent. Bonnie Prudden, after being treated by Dr. Janet Travell, published a number of books and established her system of myotherapy. The Rolfers, Hellerworkers, and CORE myofascial therapists, with their approaches to structural alignment, practice what has to be considered a type of clinical bodywork.

Clinical massage therapy/bodywork is the product of a number of converging streams. The psychiatrist and psychoanalyst Wilhelm Reich, who began as a disciple of Freud, postulated the expression of character in body structure, and was certainly one of the first to develop an approach to treating mind and body together. Dr. Reich's system lives on in bioenergetics, an approach developed by his student, Alexander Lowen. Ida Rolf pioneered the manual treatment of the fascia to restructure the body. Traditional massage therapy began to expand to address specific pain problems. Travell and Simons explored myofascial trigger points and pain. Osteopaths such as Leon Chaitow contributed many procedures and techniques from the osteopathic tradition. We are heirs to all these ideas and practices that came before us, and are putting them together in a "bodywork synthesis" called clinical massage therapy.

But the perceptions of the public in general, and the medical profession in particular, have been limited largely to relaxation massage. I recently talked with Dr. Kathi Kemper, a pediatrician and the author of *The Holistic Pediatrician*, about massage therapy and pediatrics. She's quite interested in the topic, and thoroughly familiar with the work of Dr. Tiffany Field at the Touch Research Institute of the University of Miami Medical Center, but I found it nearly impossible to interest her in the effects of clinical massage

therapy in the treatment of specific problems of myofascial pain and dysfunction (I haven't stopped trying!). Neonatologists know how effective massage is for helping premature babies gain weight, but pediatricians in general are utterly ignorant of the effectiveness of clinical massage therapy for treating headaches, earaches, and other childhood problems with myofascial components.

There are signs that the situation is changing. Recent articles have reported favorably on the effectiveness of clinical massage therapy for such problems as low back pain and neck pain, one even appearing in *Reader's Digest*. (I strongly recommend that anyone interested in keeping up with such studies subscribe to the newsletters from WebMD.com - they report such items on a regular basis.) Perhaps we needed some time for the public to become comfortable with massage therapy in general, before they were ready to accept clinical massage therapy as an option for pain treatment.

The purpose of this column is not to deal with clinical issues themselves - that's what we have Ben Benjamin for - but to address the variety of issues confronting clinical massage therapy as it develops and evolves. I want to do this in an interactive way, by soliciting your input. What do you think the issues are? What are your opinions about various aspects of the discipline we will have to deal with as therapists? How does clinical massage therapy differ from traditional relaxation massage in such areas as:

- ethics and priorities; positioning and draping;
- trademarked proprietary approaches vs. free exchange of information;
- "clinical" vs. "medical" massage therapy;
- clinical massage therapy in pediatrics;
- education;
- licensure and certification;
- professional organizations;
- insurance and managed care; and
- relations with the medical and other health professions.

My decision to write a column on clinical massage therapy was well-timed, as it followed the publication of the American Medical/Manual Massage Association's (AMMA) guidelines for a medical massage curriculum in the September 2002 issue of *Massage Today*. This first column is an ideal place to reflect on that article. I find much in it to agree with, such as the recommendation for more thorough training in anatomy, physiology, and pathology, more intensive clinical exposure during training, internships in clinical

settings, and a greater emphasis on problem-oriented therapy. However, I also found a number of points to take issue with.

1) I've heard the term "medical massage" used for several years, and have never been quite comfortable with it, for a variety of reasons. In *Basic Clinical Massage Therapy: Integrating Anatomy and Treatment*, I wrote:

The term clinical massage therapy is more accurate than medical massage therapy because clinical massage therapists view the body from a different perspective from that of the physician. We do not treat conditions according to medical diagnostic criteria, but according to clinical massage therapy assessment criteria.

For example, a physician might diagnose a patient as having tendinitis. This diagnosis implies an inflammation of a tendon, indicating a prescription for anti-inflammatory medication, rest, and application of ice. The same person might be assessed by a clinical massage therapist as having persistently contracted muscle tissue with referred pain from trigger point activity, indicating deep tissue therapy and trigger point compression. The physician and the clinical massage therapist are addressing the same complaint in the same patient from two different perspectives. Neither is wrong, and each perspective may inform the other.

Not only has our field rediscovered and revived a number of therapeutic techniques from the distant past and borrowed many techniques from other disciplines, we have taken advantage of our independence from traditional health care to explore and develop new techniques and new ways of understanding and applying old techniques. I can't help feeling that the use of the word "medical" in designating our profession betrays a desire to enhance our prestige by diving headlong into the medical field. We have seen what has happened to physical therapy as a result of just such a merger: the stifling of creativity and imagination. Although there are many outstanding and creative physical therapists in practice, the vast majority have been inexorably absorbed into the black hole of insurance and managed care, and have succumbed to the pressure to work "by the book." If we are to continue to explore and discover, and increase our effectiveness through creativity, we would do well to maintain our independence from more traditional disciplines.

2) AMMA may have already crossed that line. The article suggests that the training proceed from one body part to the next, learning the anatomy and typical pathology of each area before proceeding to the next area. The examples used are first the hand, then the elbow. Surely the authors are aware that most problems of the wrist and hand are traceable to muscles in the forearm, some of which cross the elbow - not to mention the common possibility of pain in the hand referred from the shoulder or chest! Yet we find the statement, "The medical massage treatment model is, however, neither a 'medical model,' nor is it 'allopathic.' Since it is massage therapy, the medical model is based on a natural and holistic philosophy of care." But the description we are given of a suggested curriculum is entirely reductionistic. Massage is not inherently holistic, and calling something holistic does not make it so. I see no reference anywhere in the article to posture as a causative or aggravating factor in myofascial pain, yet even the most authoritative physicians in the field of myofascial pain and dysfunction, Janet Travell, David Simons, and Robert Gerwin attribute a great deal of responsibility in this area to posture. I believe that most massage therapists are committed to a holistic view of health and the body, but such a view is not apparent in the AMMA statement.

3) The article says that, "Currently, massage education is fixated on 'hours in training,'" and later that "Time in training is not the central factor in developing good medical massage therapists; it is simply one factor." I certainly agree with that concept. However, a quick trip to AMMA's Web site (www.americanmedicalmassage.com), reveals that graduation from a 600-hour program is a requirement for membership in AMMA. Why 600 hours? Most programs I have come across span 500 to 600 hours, and I'm quite certain that most therapists practicing clinically are essentially self-taught, having gained the necessary knowledge and experience after massage school by attending workshops, reading books, watching videos, and working with clients. Among them are probably outstanding clinicians, but they would be ineligible for membership in AMMA.

4) AMMA tells us that, "It is important that the techniques and treatment protocols being taught conform to current and correct applications of medical massage therapy." What are those techniques and protocols? Is the jury already in? Am I to understand that all the research is done, all the exploration finished, our knowledge complete, and we now have a set of "techniques and treatment protocols" that are not only current, but even "correct?" Why wasn't I told? Since I'm just beginning work on my textbook on advanced clinical massage therapy, I hope someone will let me know about this. I'd hate to suggest incorrect approaches.

I find this statement from AMMA frightening. It suggests that we are in a great hurry to become frozen, petrified, closed-minded and institutionalized as a profession. And we should be duly warned that, if "correct" clinical techniques are established beyond question, we are not professionals, but technicians.

5) Finally, I can't overlook the article's reference to a "sore bicep [sic] muscle." Whether on the arm (*biceps brachii*) or the leg (*biceps femoris*), the singular of the word is "biceps" (the plural, in the unlikely event you should ever need it, is "bicipites") - there is no such word as "bicep." Perhaps that seems niggling and pedantic, but words are important, and for a group that emphasizes technical education, it's a point worth making.

It really isn't my intention to start a fight with AMMA. I encourage them, and I wish them well. But it **is** my intention to start (and maintain) an open conversation, because what we are doing is far too important to be left to a single individual or group to dominate or dictate. Having offered my criticisms this month, I will devote my next column to my own thoughts and ideas about **clinical** massage therapy education and standards, and welcome any feedback. Meanwhile, primum non nocere, and keep an open mind.

Click [here](#) for more information about James "Doc" Clay, MMH, NCTMB.



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