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RECOMMENDED REFLECTIVE READING

Communicate Effectively with Clients

Establishing the Guidelines for Treatment

THERAPIST AND CLIENT BOUNDARIES

Extracted from Clinical Massage Therapy Fiona Rattray & Linda Ludwig 2000
AMMI Training files 2001
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Abstract: The authors systematically examine the concept of boundaries and boundary violations in clinical practice

Boundaries in the context of therapeutic massage refer to the limits established by the therapist in relation to the client, before, during and after the treatment. They can be very concrete such as timing guidelines or more abstract such as the intention of touch. They can be very clear such as the decision not to treat a parent but murky around issues such as the effects of bartering massage for car repairs or a teacher assessing an injured student.

Boundaries are, in part, defined by the concept of the therapeutic relationship: the client arrives for treatment expecting a professional therapeutic process. The therapist has the responsibility to ensure that this trust is not broken. It is also the therapist's responsibility to make any adjustments necessary during the course of a treatment to safeguard proper client-therapist boundaries and professionalism, including referring the client to another therapist for treatment *(Pavia,* 1995). Boundaries are also governed by legislation for the profession about appropriate behaviour

Establishing boundaries requires that a person be conscious of her thoughts and actions and the motivation behind the actions, and be able to analyze situations for possible harmful effects on the client or herself. This keeps the therapist from projecting her own. beliefs or prejudices on the client. Preconceptions about race, gender, age, sexual orientation, body size, disease processes or people who get diseases can interfere not only with the therapeutic relationship but with the success of the treatment.

Good boundaries prevent the therapist from being triggered by clients, or over-identifying with them. For some therapists this can be especially difficult when treating clients who are terminally ill or elderly.

The client's sense of the healing process must be respected. For example, suggestions for self -care may not be carried out and the client's dysfunction is maintained. The therapist should try to be supportive, but also to explain the limitations in improvement that can be expected.

Some other boundary issues relate to the therapist's confidence in her skills and knowledge versus the client's requests. As a health care professional, the therapist should carry out treatments with confidence in the skill of techniques used, the effects of pressure and knowledge about tissue. For example, the therapist works with the tissue as it presents, using appropriate techniques and pressure, but the client wants ever -increasing pressure (the "no pain, no gain" mentality). If the pressure requested seems too deep or unsafe, the therapist must have the confidence to explain her sense of the tissue's limits and continue to massage at an appropriate depth. The client is then free to return for further treatment or choose another therapist.

Sometimes the client requests massage to an area that seems unsafe to the therapist. For example, massage to the calf is requested to address painful calf cramping. The therapist performs an assessment which might indicate a potentially dangerous condition such as deep vein thrombosis. The client should be informed why calf massage is inappropriate without alarming him. Appropriate treatment plan modifications are made. A referral to a physician is also recommended.

Occasionally, the client's request for increased pressure is from a distorted sense of the meaning of touch. For example, someone with an abuse history may request deeper pressure, causing pain, since the experience of touch is equated with pain. For the therapist to continue to use uncomfortable amounts of pressure just reinforces the abusive nature of touch for this person. If the therapist respects her own sense of appropriate depth, this scenario could be avoided.

The most effective work is done by the therapist who works neutrally - that is, without her own emotions, personal agenda or ego becoming engaged in the treatment. The therapist may think of it as leaving any personal agenda and her ego outside the treatment room. The client is, after all, coming to the therapist for treatment, not the other way around. In addition, the therapist's words and actions should reflect respect for the client and an awareness of the power differential inherent in the therapeutic relationship, both during and outside the treatment.

There is another important boundary concept which is sometimes overlooked. Massage therapists are thoroughly trained to create a respectful and safe environment for the client. The reciprocal side of this concept - in other words, the importance for the therapist to feel safe and to be treated in a respectful manner by the client - should not be forgotten. A student or therapist who feels unsafe during a treatment has the right to terminate the therapeutic relationship.

Timing

One area that is often overlooked in establishing boundaries is the time allotted to do a treatment, also referred to as *timing.* The therapist and the client agree upon a treatment duration - for example, one hour. A portion of that hour, perhaps 15 minutes, may be spent on assessing the client's condition, with the remaining 45 minutes spent on the massage itself. The entire treatment, including the assessment and massage, is, therefore, performed within the agreed-upon treatment duration. The therapist also needs a few minutes at the end of the treatment, before the next client arrives, to keep the first client's ongoing health history form up to date. It is the therapist's responsibility to create a treatment plan for each visit that stays within the agreed-upon time frame. This involves budgeting the time spent on anyone area of the client's body so the entire treatment can be completed.

Of course, it is possible for the therapist and client to renegotiate the treatment duration if appropriate. If the half -hour treatment to relieve the effects of a fibrositic headache has not been sufficient, the therapist and client may choose to renegotiate an additional 15 minutes. However, the therapist must take into consideration her schedule for the rest of the day's massage appointments and the client's own schedule for that day.

It is important for the therapist not to go over time on a treatment because this can distort boundaries between the therapist and the client. If the client books a half -hour appointment and the therapist goes over time and performs a 40-minute treatment, the client may now have the expectation that the treatment duration is flexible. He may begin to expect an extra 10 minutes for the cost of a 30-minute treatment. In effect, the therapist is giving her time away at a reduced rate. The client may not necessarily appreciate the lack of boundaries and precision in the treatment duration, especially if he has a daily schedule to follow. If the client goes to a new therapist, he may have a distorted idea of treatment -duration boundaries and may bring these expectations to the new therapeutic relationship

Emotions and Massage

Massage engages the entire person, physically and emotionally. When a client arrives for an appointment, he is often seeking relief from a physical complaint or stress. He may not even be aware of his emotional state or how the massage might affect this. Emotional releases may occur during a treatment. Several factors contribute to this. The therapist is providing a private space and creating a safe, respectful environment. The power of touch cannot be denied. There is also a phenomenon known as *tissue memory (Up/edger; Vredevoogd,* 1983; *Barral, Mercier;* 1988) which can trigger an emotional response in the client.

Tissue memory is thought to be the remembrance of physical or emotional trauma that is stored in the tissues of the body, especially connective tissue. The fascia may somehow store the kinetic energy of the original injuring force. As the therapist works closer to the lesion site, the client may recall the pain and thoughts that were experienced when the injury first occurred; a release of emotions may result. It is not unusual for the rate of respiration to increase as the person goes into a sympathetic nervous system response.

Some clients seek the sanctuary of the treatment room to release tears and emotional stress they feel building up. For example, a client is aware of holding tension in his neck and shoulders after his house was damaged by fire. He seeks massage to reduce both his muscular and emotional tension. Others may not specifically seek massage for this, but during the treatment feel safe enough to let their emotions out. For example, a person has just experienced a death in the family; he is coping well but being away from everyone in the quiet space of the treatment room, he is able to relax and talk about the death, then begins to cry.

In all cases, it is essential that the therapist be supportive and make the experience safe for the client. The client should not be left alone. The therapist should stop the treatment and stand near the client. It is important that the therapist's own emotions do not become engaged or triggered. A therapist who does not consciously understand her own reactions to emotions is likely unable to put these emotions aside in the therapeutic setting. If, for example, the therapist habitually becomes withdrawn and uncomfortable when somebody cries, she may respond this way when a client cries during treatment. The client may perceive this as not only unsupportive but judgemental *(Haldane,*1984). The client should be reassured that his emotions are accepted and that emotional release during massage is not uncommon. If it seems appropriate, the therapist can maintain some gentle physical contact. For example, the therapist can gently place her hands on the client's shoulders. When the client is calm, the therapist should determine whether or not the client would like to continue the treatment.

If the therapist feels it necessary, she may inquire if the client has a support system or people he can talk to about personal issues. If not, a referral to a counsellor may be offered. It is beyond the scope of practice of massage therapists to counsel clients.

Confidentiality must be maintained by the therapist; this applies to anything said by the client during the course of the treatment. Being reminded of this fact can sometimes reassure a client who has revealed personal information during the treatment.

Dual Relationships

A dual relationship is one in which the therapist's professional relationship with the client is merged or blended with another form of relationship *(Pavia,* 1995). It is essential that the therapist maintains the therapeutic relationship and preserves the integrity of the profession by not entering into a dual relationship with a client.

Such relationships create situations where it becomes increasingly difficult to maintain clear boundaries and the therapeutic process becomes distorted. There is a risk of harm for both parties.

While some dual relationships are clearly defined in legislation, in many cases there are no specific guidelines for dealing with them. The therapist must carefully weigh the benefits against the risks to herself and the client, if a particular relationship is entered into.

One difficult situation is the therapist who lives in a small town; treating acquaintances is unavoidable if a massage practice is to be maintained. The therapist in these circumstances must be ever vigilant of maintaining clear boundaries and setting clear expectations for treatments with clients.

Categorising Dual Relationships

- Dual relationships can be categorized as low, moderate or high risk situations. An example of a low risk dual relationship is socializing with a client. Either the client or the therapist may develop minor expectations of the other when the person is seen outside the therapeutic relationship.
- Moderate risk situations include the therapist who treats a close friend or an immediate family member. The blurring of the therapeutic boundary may, for example, lead to the therapist feeling guilty if the client's health does not rapidly improve, or the client and therapist may emotionally trigger each other.

Another example of a moderate risk situation is when a massage therapy instructor treats a student enrolled in her course. This example does not include a student volunteering to be the client in a classroom demonstration of techniques, but rather when the student books a series of appointments in the instructor's clinic. In some cases, it may be appropriate for a student to experience a single treatment from an instructor, so the student may directly learn from the instructor's methods. However, an ongoing therapeutic relationship crosses and distorts numerous boundaries including confidentiality, objectivity in grading (whether actual or perceived by other students), expectations for classroom interactions and financial issues.

- An example of a **high risk** situation is a sexual relationship between the therapist and the client, regardless of who initiates it. This situation is covered in detail in the following section on massage and sexuality. Sexualizing the therapeutic process or having a sexual relationship is prohibited due to the potential harm to the client. There are severe penalties for the therapist in Victoria. (Sex industry workers are required to be registered with the State – See Professional Associations Code of Ethics, Code of Practice and Scope of Practice for guidelines and disciplinary processes).

Massage and Sexuality

The therapist and client each have their own ideas about the meaning of touch and its relationship to sexuality. These ideas are influenced by cultural concepts about the body and by personal experiences. For many Australians, the intimacy of touching is often seen primarily as sexual, a concept which is reinforced through the media. In response to this concept, the standards on this continent for secure draping and designation of appropriate areas to massage are well established. People from other cultures, such as many Europeans, are surprised when receiving massage in Australia, because the draping covers so much of the body and breast massage is avoided.

While massage therapy itself is not, nor should it be, sexual, the environment may occasionally be challenging, because anywhere from 30 minutes to 90 minutes are spent in direct contact with the client. While both the client and the therapist are capable of creating sexual energy, it is the *therapist* who is responsible for maintaining appropriate professional boundaries and leaving sexual energy outside the treatment room.

During a therapeutic or remedial massage, the therapist and client are together often in a private environment. To avoid any obvious misconceptions, the treatment environment should be professional (this does not preclude an interesting decor), the lighting should be adequate (for example, candles can send a mixed message and are not appropriate), the therapist should dress professionally and interactions with the client are friendly but not overly familiar.

Therapist Feels Attracted to the Client

During the treatment, if the therapist feels sexual attraction to the client, as soon as the therapist is conscious of it, the therapist must shift this energy because that intent will be present in how she touches the client.

Control falls to the therapist regarding the intention behind the touch. The expectation of the massage is that the therapist's touch is not focused on sexual arousal, but on treatment of the client's presenting symptoms. It is an enormous breach of trust and a violation of the client on many levels for the therapist to introduce sexual energy or contact into a treatment.

To redirect the energy, the therapist breaks direct contact with the client and takes a few breaths. She focuses on something else. For example, she reviews the treatment plan agreed upon with the client. This refocusing is called *bracketing* a *thought.* The therapist then performs a new massage technique, so she refocuses her attention. Now refocused, the therapist completes the treatment.

Under no circumstances should a sexual intention be acted upon. It is not only unethical and poses a great risk for potential harm to the client but it is also illegal. For example, in Australia, sexualisation of the therapeutic relationship by the therapist is defined as sexual abuse and prohibited under the *Codes of Ethics, codes of conduct and Scope of Practice of Professional Massage Associations.* Sexual abuse of a client includes behavior, remarks and touching of a sexual nature as well as physical sexual relations. It is *always* the therapist's responsibility to ensure that this abuse does not happen.

When the massage is finished the therapist must do some serious thinking about what occurred and why. Counseling should be sought if necessary. If the client rebooks, the therapist must determine for herself if she can maintain appropriate boundaries and intent. If this is not possible, the client should be referred to another therapist with a brief explanation of why. If the attraction is mutual, the therapeutic relationship must be terminated and the client should seek massage from another therapist.

Client Sexualises Massage

A client can unconsciously or consciously sexualize a massage. Sexual arousal is a function of the parasympathetic nervous system response. Therefore, there is the potential for massage to create feelings of sexual arousal in the client any time sympathetic nervous system firing is decreased. Sexual arousal, however, is not purely physical: it also depends on tactile and psychological responses or intent *(Vander* et *al.,* 1994). There is a variety of ways to deal with the situation, depending on the therapist's sense of whether it is unintentional or intentional.

Unintentional

As the client relaxes, perhaps drifting in and out of sleep, the therapist perceives that sexual energy is present for the client as a product of relaxation. The therapist may choose to *redirect* the energy. The therapist should stop whatever technique is being performed and break contact with the client. A different technique is then used. It may be one that affects the sympathetic nervous system, such as brisk tapotement, or one that uses more focused pressure to a particular area, such as treating a trigger point. A stretch may be performed to create a different stimulus.

The *client's* focus is redirected to the treatment plan as the therapist begins to talk about the purpose of the techniques used and their effect on the tissue, or asks for feedback about the tenderness or tension in the area being worked on. Providing that the energy has shifted, the treatment is continued following the treatment plan.

Intentional

A client arriving for massage with the conscious intent to be aroused is not always obvious about it. Once treatment is underway, this intent may be indicated in a number of ways, such as rubbing the genitalia into the table. A male client may have an erection, genitalia may be exposed, a female client may move the draping to expose her breasts, inappropriate sexual comments may be made or stories may be related.

This is also a breach of the therapeutic relationship and a potentially harmful situation for the therapist, making her feel victimized or ashamed. In this situation the therapist must do more than shift the energy. There are different strategies for dealing with this.

The therapist can clearly state what she feels is happening in what is called an "I statement"; for example, "I feel that you are generating sexual energy". The therapist should let the client know that sexual energy is not appropriate in the context of therapeutic massage. Potentially, this allows the client to respond and clarify what is happening.

For some therapists it is difficult to state, "I feel you are generating sexual energy" or some similar statement. It may be more comfortable to say, "I think that the type of massage I do is not the kind of massage that you're looking for." This also allows the client to respond. If the client denies this is the case, the therapist needs to make a decision as to whether she feels safe about continuing the treatment. If the treatment continues, the strategies for redirecting energy are used. If the therapist does not feel safe, the treatment should be terminated. As with all treatments, the incident is objectively documented on the client's file.

Such situations are very difficult for the therapist, especially students and new therapists. Too often there is so much emphasis on the client's needs, that a therapist is reluctant to terminate both the massage and the client-therapist relationship, even when the therapeutic relationship is breached and the therapist's own boundaries are crossed. Termination of treatment should not be treated lightly but must be considered an option.

COMMUNICATION BETWEEN THERAPIST AND CLIENT

Background to Clear Communication
One of the strengths of massage therapy lies in the fact that massage therapists spend more time\with the client than do most other health care practitioners. This abundance of clinical time allows the massage therapist to gather information from the client that is necessary to create an appropriate treatment. The therapist can explain to the client about her condition, what will happen during the massage treatment and what the client can do after the treatment to encourage the healing process. It is not uncommon for a therapist to hear a client say, "Oh, now I understand why I should put cold on an acute injury. No one has ever explained it to me before."

Gathering information and educating the client require clear communication.

Communication involves both the information the therapist exchanges with the client and the manner in which this information is conveyed. Some components of clear communication include using an appropriate tone of voice, being non-judgmental, using accessible vocabulary and having good listening skills.

During all communications with the client a neutral voice is used. While communication can never be entirely objective and clear, using a neutral voice means asking a question or phrasing a statement in words that are as neutral as possible in tone, content and meaning. Care is taken not to lead the client or make assumptions about her symptoms. Generally, open-ended questions are used; these are questions that require more than a yes or no answer. The therapist should not be overbearing, especially if the client is uncertain about having some aspect of the massage performed. Likewise, an overly solicitous manner may seem condescending or diminishing to the client. A calm, confident tone of voice is especially important when working with a first-time client, who likely has no idea of what therapeutic massage entails and has questions about what will happen during the treatment.

The concept of initial neutrality is also important when responding to a client's health history information. For example, a client reports that she is pregnant and the therapist replies, "That's great! Congratulations!" However, for whatever reasons, this may not be great for the client. The therapist's statement, no matter how sincere, is not initially neutral and the client may think that the therapist is not really going to listen to her concerns. The client is more likely to say what is true for her if the therapist responds instead with the neutral, "How do you feel about that?"

It is important for the therapist to choose language that does not convey negative stereotypes or have double meanings. For example, describing a limb as "uninjured" or "injured" avoids the judgmental terms" good side" and "bad side". When describing areas of the client's body that will be uncovered by the top sheet during the treatment, "uncover your leg" has less potential for misunderstanding than" expose your leg".

Avoiding language with negative stereotypes is also important with people who have physical or other disabilities. labels such as "an epileptic" or "a hemiplegic" focus on the condition or disability, not on the person as a whole. The intention is to describe the person first rather than the disability. Examples of this type of respectful wording are "the person with epilepsy" and "the person with hemiplegia". Similarly, the phrase "uses a wheelchair" replaces "wheelchair-bound" and the phrase "person who experienced" replaces "victim of". The therapist can also listen to the language the client uses to describe herself and ask how the client prefers to be described. For more information see the communication skills chapter under conditions of the central nervous system.

Therapists are taught to understand and use anatomical and medical terminology. They are also expected to communicate with other therapists and health care professionals using proper vocabulary.

The client, however, may not be familiar with this terminology. Instructions such as "extend your knee", "turn supine" or "I'd like to treat your pectorals" may not be clearly understood. One method of communicating clearly is to use lay terms or common words to describe things. The examples above then become "straighten your knee", "turn onto your back" and "I'd like to treat the muscles of your upper chest". Another method is to combine both the lay and medical terms, which may help to educate a client in medical wording. The last example above then becomes "1' d like to treat the muscles of your upper chest, or the pectoral muscles". The therapist may wish to point to these muscles on himself An advantage of this method is that it does not assume the client is unfamiliar with medical vocabulary. It also allows for education in terminology if the client is unfamiliar with these words. Flip charts, diagrams and anatomical models can also be used to help the client visualize a particular structure.

Gathering information from the client about her health history before the treatment involves some additional skills. Some clients do not say much because they do not understand the relevance of their past health history to massage therapy or are impatient to start the massage. Other clients are very forthcoming about their health histories, sometimes giving an overabundance of details related (or unrelated) to their condition. The therapist may either have to coax information from the client, or redirect the client's flow of information. The therapist should acknowledge the client's needs: "You seem in a hurry to get the massage started" or "That's a great story. How about we finish this assessment and you can tell me the rest once you're on the table". This is followed by a brief explanation of why a complete assessment is necessary: "So that I can develop a safe and effective treatment plan for you".

Especially with a first-time client, the therapist should explain that all information given is confidential, unless the client gives specific written permission to share it with another health care practitioner or third party. Confidentiality is intended to prevent a client from feeling vulnerable about disclosing her health history. This confidentiality of the client's written records and verbal information is protected by law. Treating the client's health history information confidentially and respectfully also means refilling the paperwork after a treatment, instead of leaving the health history document lying about.

During the treatment, communication also involves information from the client to the therapist about sensation, such as pain, that the client may be experiencing. Some people

are able to describe what they are feeling easily, especially if they have had massage before. Others may need to be offered examples and a possible vocabulary. In this case, the therapist might say, "When I'm working on these muscles in your neck, you may feel sensations in another part of your body; for example, discomfort or tingling into your arm." However, it takes a certain amount of skill to offer possibilities without leading the client to conclusions that are not what the client is really feeling.

It is important for the client and therapist to communicate during the treatment. The amount of talking should be directed by the client; some clients say very little during a massage, while others are more comfortable talking. However, continuous conversation can move the therapist's focus from the treatment, making the work less effective. It may also distract the client from feeling the massage. For people who like to talk, it is often comfortable to chat during part of the massage; and then the therapist directs the client to focus on her breathing or a specific area being treated. A comfortable balance for both the client and the therapist between complete silence and too much conversation is ideal for the effectiveness of the massage.

Presenting the Treatment Plan

The process of creating and presenting a treatment plan begins when a prospective client phones to book an appointment; it is important to inform the client of the cost of the treatment and to request that she arrive a few minutes early to fill out a health history form. Cost and duration of treatment are part of the information the client needs to make a choice about the massage.

However, just because a client books an appointment does not mean she has automatically consented to massage; she may be gathering information about massage and may decide it is not for her.

After the client has arrived for the treatment and completed the paperwork, client and therapist proceed to the treatment room. The therapist refrains from asking personal health questions until in the privacy of the treatment room.

The therapist informs the client that all information is confidential and explains that gathering this information is necessary to create an effective and safe treatment. After taking a few moments to read over the client's health information, the therapist reviews the form with the client to be sure all the information is complete. For example, if a client has left the part on the health form that has to do with medication use blank, it may indicate several things. The client may indeed not be taking any medication; or she may be taking over-the-counter medication such as Aspirin and not interpret this as medication use; or she may be taking a herbal preparation and also not consider this medication use.

. Both the Aspirin and the herbal remedy could have an impact on certain techniques the therapist chooses, contraindicating their use. These are important pieces of information for the therapist to have in the creation of a safe, effective treatment plan.

At this time, the therapist may ask more questions to clarify and complete the information on the health history form and he may review why the client is there for treatment.

Consent to the Treatment Plan

Why Use a Treatment Plan?

A verbal treatment plan is simply an outline of what the therapist proposes to do in the treatment session, including the pre-treatment assessment, cost and the duration of the treatment, described in language that the client can understand. Consent to the treatment plan, often called *consent to treat* or *informed consent,* means that the client understands and agrees to what the therapist is suggesting.

Informed consent applies to other health care professions as well as massage therapy. Whether required by law or not, the purpose of the treatment description is to demystify health care procedures and to create informed health care consumers who, perhaps for the first time, are able to make choices on their method of treatment.

The importance of this concept can be illustrated if the reader remembers a personal situation where a health care provider either did not describe a particular procedure ahead of time or did not describe what the reader would experience during or after a procedure. While some people may not wish to know all the details, having enough information about the potential risks and benefits of a procedure gives the person a sense of control and choice in the situation.

Consent to Assess

Usually some form of assessment is required before the treatment plan can be determined. An assessment gives the therapist an idea of which soft tissue condition the client is most likely to be experiencing and which specific structures are involved. Even if the client's focus is relaxation with no specific condition to be treated, the therapist should at least assess the client's breathing patterns.

Assessment includes the verbal health history information already obtained, as well as observations, palpation and testing done by the therapist; these involve looking closely at the client and touching or moving the client.

In order to perform the rest of the assessment, the therapist needs to obtain consent to assess.

Consent to assess is a subcategory of consent to treat; it is used to inform the client of the assessment process and what the client may experience.

For example, if the therapist thinks that a postural assessment is necessary, the client is told that she will need to stand upright while the therapist observes how the client's body is aligned. It is often easier if the client wears shorts and a T-shirt for this, so she will need to know this also.

If palpation of a specific structure is needed - for example, to assess whether heat, tenderness or swelling is present - the therapist discusses why palpation is necessary and asks the client to let him know if the structure is tender. If testing is required, the therapist briefly describes the test position and movements, explains that testing may temporarily exacerbate the client's symptoms and asks the client to report any symptoms experienced.

The therapist asks the client if she has any questions (and answers them). He then gets the client's agreement to assess.

Consent to Assess Includes

- .. Confidentiality of information
- .. Why assessment is necessary
- .. A brief description of what will happen
- .. What the client will wear if different from street clothes
- .. The areas to be observed, touched or moved
- .. That assessment may temporarily exacerbate symptoms
- .. That the client should describe any symptoms experienced during assessment
- .. Does the client have any questions?
- .. Does the client agree to the assessment?

Example of Consent to Assess Statement

"From your confidential health history information, I see that you have been experiencing low back pain.

In order for me to figure out what structures are involved, and what I should treat, I'd like to perform some assessment.

You can take your shoes off and sit on the table. I'll be asking you to move into certain positions, then placing you into certain positions.
During the tests, your symptoms may temporarily return; please tell me if they do, at which point we'll stop the tests.

Do you have any questions?

Do you agree to the assessment?"

Consent to Treat

Now that the therapist has an idea of the client's health history, which structures need to be treated and what techniques are appropriate; the actual treatment plan is formulated.

There are several components of the plan; these can be assembled in an order that suits the therapist.
The therapist lets the client know the goals of that day's treatment, such as reducing pain or increasing the range of motion of a particular joint.

Before the treatment begins, the client needs to know what position she will be in: prone, supine, side lying or seated.

If a face cradle is used, the client is instructed on how to position her head. If pillows are used, their position is described so the client knows where they go.

The therapist lists the areas of the client's body that will be treated in the proposed plan. A rationale may be needed to explain why certain areas are treated. For example, a client

may not understand why the therapist wants to work on the client's abdomen to treat the back pain she is experiencing unless the therapist mentions that iliopsoas, a muscle palpated deep in the abdomen, can refer pain into the back.

If a client is uncomfortable having a particular area worked on, the description of areas to be treated allows her to ask that this area be omitted from today's treatment.

For example, a person may have numbness and tingling around an old scar and be initially uncomfortable with it being touched. While lists can be made up of areas that some clients may find sensitive, such as the throat, abdomen and adductors, it is impossible to know what area a client will feel uncomfortable having treated, if in fact she feels this way at all. It is non-judgmental to just list the areas in the proposed plan and let the client choose. The only exceptions to this are nipples and genitalia which are never appropriate for massage therapy treatment and are outside the scope of practice for massage therapists.

Many first-time clients are worried about how much clothing to take off and whether they will be totally uncovered while they are on the table. The next part of the treatment plan addresses this concern.

Depending on the areas that the therapist will be treating, the client is asked to take off as much clothing as is comfortable. She is instructed to get between the sheets or towels and cover herself with the top sheet or towel (this prevents the therapist (if he/she has left the room) from returning to the treatment room and discovering that the client is laying on top of both the sheets).

She is told that she will be covered, or draped, by the sheets or towels, during the treatment and that only the areas of the client's body that are being treated will be uncovered while the therapist is working on them.

Clients may worry that massage may be painful or uncomfortable. The client is informed that, during the treatment, the pressure can be adjusted so the client is comfortable. For some treatments, temporarily uncomfortable techniques, such as frictions, are useful to reduce symptoms, but ultimately techniques are used within the client's pain tolerance and may be stopped any time the client wishes.

It is also possible that after the treatment the client may experience discomfort; the client is advised as to the self-care she can use to alleviate this possibility.

Pain during or after treatment is an example of a risk of treatment.

What about the benefits or positive effects of massage? The client is informed of these, as, for example, when treatment may decrease pain and swelling around an injured joint.

If the therapist wants to use heat, cold or remedial exercise such as a stretch in the treatment, the client is informed of this also.

Once the client has a picture of the treatment, she is asked if she needs any assistance in getting on the table.
The therapist lets her know that this plan can be changed or stopped at any time, even

during the treatment. She is given a chance to ask any other questions she may have before she agrees to the proposed treatment plan.

If the client hesitates over a *particular aspect of* a *treatment plan, the therapist should not pressure the client* to agree *against her will, even if he perceives it as* a *key element* to *the success of the overall treatment.* For example, the assessment reveals that the client's back pain is related to her flat feet and the therapist includes foot massage in the treatment plan. If the client says, “I'm a little uncomfortable having my feet massaged because they're ticklish”, the therapist respects this limitation. He simply reviews the rationale for the approach and has the client consider it for next time, or offers some self -care that may also help with the foot concern.

Occasionally the health history information or the results of the testing will indicate contraindications or modifications to the treatment plan; or even that the client should be referred to another health care provider instead of having massage. In such a case, it is important to explain either the contraindications or modifications to the plan, or that massage is not appropriate that day, and refers the client appropriately.

Consent to *Treat Includes*

... Goal of treatment
... Position of client
... That the client will be covered (or draped) except for area worked on
... That the client will be between sheets
... Pillow position
... Areas of body treated and rationale for this
... That the client will remove clothes according to client comfort
... That the amount of pressure used can be adjusted
... Risks of treatment
... Potential benefits of treatment
... Alternatives to plan (if needed)
... Hydrotherapy, stretching
... Contraindications (if present)
... Cost and duration
... Does the client need assistance getting on the table?
... Does the client have any questions?
... Does client consent to the plan?

Successfully Communicating the Treatment Plan

If unfamiliar with the concept of a treatment plan, the reader by now may be wondering how all this can be said in less than three minutes, let alone remembered by the client.

The goal of the treatment plan is to inform the client so she feels more relaxed and has a sense of what will happen.

It takes a bit of practice for the therapist to choose wording that makes the consent statement informative and concise, while using terms that are clear to the non-medically oriented client.

The information does not have to *be in a particular order; indeed, some of the treatment*

plan components are said before the client is in the therapist's office; and consent to *assess happens before the treatment plan.*

Once the therapist practices a few times, the wording will be familiar and the tone more casual.

The therapist can also keep in mind how he felt the first time he had a massage and the questions he had about what would happen during the treatment; this should help in how to convey the information.

Example of Consent to Treat Statement

The example below is one way to state a treatment plan once the client has been assessed.

The therapist should check local regulations, if any, concerning the specific contents of a *treatment plan.*

"The results of the tests show that the muscles in the front of your hip and thigh are tight, which could be causing your low back pain by tipping your pelvis forward. Lengthening these muscles may help to reduce the back pain that you are experiencing.

“I'd like to start the treatment with you lying between the sheets face up on the massage table. This pillow goes under your knees. You will be covered at all times by a sheet, except for the part of your body I'm working on.”

“In this half -hour treatment, I'd like to first work on the front of your thighs and then on a muscle called iliopsoas, which is deep in your abdomen and runs across the front of your pelvis. It can refer pain into your low back.” (The therapist can point to the area on himself or on a muscle chart).

“Once these muscles are relaxed and stretched, I'd like you to turn over so that I can work on your low back and the muscles around your hip, which also seem to be tight.”

“Let me know if the pressure I'm using is too light or too heavy and I'll adjust my pressure according to your tolerance. Also, if I press on an area and it gives you the same pain or sensation that you've been experiencing, or if it refers elsewhere in your body, please let me know. This tight point in the muscle, called a trigger point, may be contributing to your pain.”

“You might feel a little bit sore tomorrow in areas that I've been working on; to help reduce this, you can take a hot bath at home and I’ll show you some stretches after the treatment.”

“If at any time you feel uncomfortable during the treatment and want me to stop or adjust it in any way please let me know and I will do so. Is there anything you would like me to leave out? Do you have any questions? Do you agree to this treatment plan?” The therapist waits for the client’s responses.

At present, the client’s verbal consent to a treatment plan is sufficient. After the treatment, the therapist may wish to have the client initial the health history form beside that day’s treatment notes, indicating that consent to the plan was given.

Changing the Plan

In massage therapy, the treatment plan is something that is developed by the therapist with some input from the client so her needs are met.

- The *client* can modify or change the plan either before or during the treatment. The therapist may then suggest alternatives to the treatment plan, which are accepted or rejected by the client. For example, after hearing the proposed plan which includes a head, neck and shoulder massage, and the client says, “Please don't massage my head, I'm going out after this and don't want my hair messed up”. The therapist then adjusts the plan appropriately to avoid the head. In another example, the client does not agree to direct work on shortened adductor muscles. The therapist can propose alternatives, such as working through the sheets, a post-isometric stretching technique or self-care hydrotherapy and stretching to effect the changes needed; the client then consents to the plan that is comfortable for her.

- The *therapist* can also propose to change a treatment plan part way through a massage. For example, the client has consented to a one-hour full-body relaxation massage. During the treatment of the client's back, the increased tone in these muscles makes the therapist think that the focus needs to be on the upper body, not the legs. The client must consent to the proposed change to the plan, otherwise the original plan is followed.

During and After the Treatment

There are a few elements that are added either during testing, during the massage or at the end of the treatment, otherwise the treatment plan becomes too long and complicated or the client will likely forget what she is being asked to agree with.

These elements are specific information about extremes of pressure, remedial exercises, instructions about getting off the table and specific after-treatment self-care information.

These are described just before the therapist is about to use the specific technique or just before the client is asked to perform a certain action.

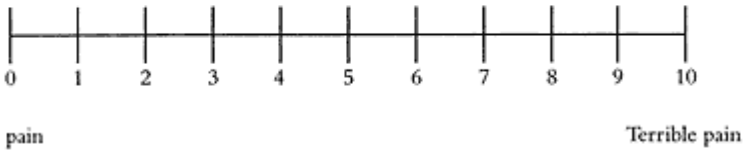
- Extremes of pressure may be either deep or light. To establish a client's tolerance of deep pressure and pain prior to using a particular technique, a "one-to-l0 pain scale" can be useful.

On this scale, one equals no pain, seven equals the client's pain tolerance and 10 equals extreme pain. The scale allows for differences in people's pain perception. One person's pain tolerance may be quite different from another's; a person's pain tolerance may vary from one day to the next; but a seven, whatever the actual amount of pressure used, is always the client's maximum *tolerance.*

The therapist should not use pressures above a six for general treatment. The client is instructed to tell the therapist if the pain begins to approach a seven; at no point should the pressure cause pain to exceed this number. If the client indicates this level of pain has been reached, the therapist decreases the pressure until the client reports that it is comfortable. The pain scale is useful when treating trigger points or doing deeper fascial work.

English

Please point to the number that best describes your pain.



A client may need information on techniques that use lighter pressure, as some people have a mistaken perception that only deep work is effective. For example, the therapist can explain that lymphatic drainage techniques to reduce swelling must be light to be effective; too much pressure will actually collapse the vessels that move the fluid, making drainage techniques ineffective.

- Specific instructions for remedial exercise during the treatment are given as the therapist is ready to use them; care is taken to use clear, accessible language.

- At the end of the treatment, the client may feel momentarily dizzy if she sits up quickly. The therapist instructs the client to take her time getting up to prevent this dizziness.

- If needed, specific post-treatment exercises may be demonstrated once the client is up off the table and dressed. At this point the client is able to watch the therapist demonstrate the exercise, then try the exercise herself while the therapist makes sure she is doing it correctly.

Consent with Repeat Clients

With repeat clients, a treatment plan can educate about massage to a different part of the body than she is used to, or about a new technique.

When treating a repeat client, the therapist reviews the client's health history with her to make sure there have been no changes in the client's health status or personal information since the last appointment.

- In terms of the treatment plan statement, the therapist may summarize the initial plan.

He simply asks the client's response to the previous treatment and if the previous treatment approach is still acceptable; then he adds the details of any changes necessary for that day's treatment plan.

The Concept of Boundaries in Clinical Practice: Theoretical and Risk-Management Dimensions

Thomas G. Gutheil & Glen 0. Gabbard

Abstract: The authors systematically examine the concept of boundaries and boundary violations in clinical practice, particularly as they relate to recent sexual misconduct litigation. They selectively review the literature on the subject and identify critical areas that require explication in terms of harmful versus nonharmful boundary issues short of sexual misconduct. These areas include role; time; place and space; money; gifts, services, and related matters; clothing; language; self-disclosure and related matters; and physical contact. While broad guidelines are helpful, the specific impact of a particular boundary crossing can only be assessed by careful attention to the clinical context. Heightened awareness of the concepts of *boundaries*, *boundary crossings*, and *boundary violations* will both improve patient care and contribute to effective risk management.

"Role boundaries may be crisp or flexible or fuzzy, depending on the role under consideration and on the cultural climate."
-Ingram (1)

REFERENCES

1. Ingram DH: Intimacy in the psychoanalytic relationship: a preliminary sketch. Am J Psychoanal 1991; 51:403-411

2. Gutheil TG: Borderline personality disorder, boundary violations, and patient-therapist sex: medicolegal pitfalls. Am J Psychiatry 1989; 146:597-602

3. Stone MH: Boundary violations between therapist and patient. Psychiatr Annals I 976; 6:670-677

4. Gabbard GO (ed): Sexual Exploitation in Professional Relationships. Washington, DC, American Psychiatric Press, 1989

5. Borys DS, Pope KS: Dual relationships between therapist and client: a national study of psychologists, psychiatrists, and social workers. Professional Psychology: Research and Practice 1989; 20:
280- 293

6. Simon RI: Sexual exploitation of patients: how it begins before it happens. Psychiatr Annals 1989; 19:104-122

7. Jorgenson L: Consultation forum. Psychodynamic Letter 1991; 1(10):7-8

8. Lipton SD: The advantages of Freud's technique as shown in his analysis of the Rat Man. Int J Psychoanal 1977; S8:255-273

9. Grosskurth P: Melanie Klein: Her World and Her Work. New York, Alfred A Knopf, 1986

10. Winnicort DW: Hate in the counter-transference. Int J Psychoanal 1949; 30:69-74

11. Little MI: Psychotic Anxieties and Containment: A Personal Record of an Analysis With Winnicott. Northvale, NJ, Jason Aronson, 1990

12. Eissler KR: The effect of the structure of the ego on psychoanalyric technique. J Am Psychoanal Assoc 1953; 1:104-143

13. Zetzel ER: 1965: Additional notes upon a case of obsessional neurosis: Freud 1909. Int J Psychoanal 1966; 47:123-129

14. Shapiro T: On neutrality. J Am Psychoanal Assoc 1984; 32:269- 282

15. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice. Washington, DC, American Psychiatric Press, 1990

16. Langs R: The Bipersonal Field. New York,Jason Aronson, 1976 1 7. Spruiell V: The rules and frames of the psychoanalytic situation. Psychoanal Q 1983; 52:1-33

18. Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law, 2nd ed. Baltimore, Williams & Wilkins, 1991

19. Viederman M: The real person of the analyst and his role in the process of psychoanalytic cure. J Am Psychoanal Assoc 1991; 39:451-489

20. Novey R: The abstinence of the psychoanalyst. Bull Menninger Clin 1991; 55:344-362

21. Casement PJ: The meeting of needs in psychoanalysis. Psychoanal Inquiry 1990; 10:325-346

22. Greenson RR: The Technique of Psychoanalysis, vol 1 . New York, International Universities Press, 1967

23. Langs R: Psychotherapy: A Basic Text. New York, Jason Aronson, 1982

24. Adler G: Borderline Psychopathology and Its Treatment. New York, Jason Aronson, I 985

25. Adler G, Buie DH Jr: Aloneness and borderline psychopathology: the possible relevance of child development issues. Int J Psychoanal 1979; 60:83-96

26. Kernberg OF: Severe Personality Disorders: Psychotherapeutic Strategies. New Haven, Conn, Yale University Press, 1984

27. Kernberg OF, SeIzer MA, Koenigsberg HW, Carr AC, Appelbaum HA: Psychodynamic Psychotherapy of Borderline Patients. New York, Basic Books, 1989

28. Epstein RS, Simon RI: The exploitation index: an early warning indicator of boundary violations in psychotherapy. Bull Menninger Clin 1990; 54:450-465

29. Krueger DW (ed): The Last Taboo: Money As Symbol and Reality in Psychotherapy and Psychoanalysis. New York, Brunner/ Mazel, 1986

30. Blanton 5: Diary of My Analysis With Sigmund Freud. New York, Hawthorn Books, 1971

31. Fieve R: Moodswing: The Third Revolution in Psychiatry. New York, Bantam Books, 1976

32. Berne E: What Do You Say After You Say Hello? The Psychology of Human Destiny. New York, Grove Press, 1972

33. Gorkin M: The Uses of Countertransference. Northvale, NJ, Jason Aronson, 1987

34. Smith 5: The golden fantasy: a regressive reaction to separation anxiety. IntJ Psychoanal 1977; 58:311-324

NOTE: THOSE WHO WOULD LIKE A REPRINT MAY SEND A REQUEST TO: Thomas G. Gutheil, Professor of Psychiatry, Harvard Medical School, 6 Wellman St., Brookline MA 02446; email: <GutheilTG@cs.com>.

Reflecting on Setting Healthy Boundaries

"Healthy Boundaries allow us to have an equal partnership where responsibility and power are shared....By recognizing the need to set strong limits, you safeguard your self-esteem, maintain self-respect and enjoy healthy relationships."

~ Cindy Ricardo

"Everyone needs to set healthy boundaries. This is a gift to others and you. By allowing people to act in ways that are not appropriate, you actually hurt them too because they are stuck in their unhealthy behavior. Therefore, it is important to learn how to establish boundaries for all involved."

~ Helene Rothschild

"Your personal boundaries protect the inner core of your identity and your right to choices."

~ Gerard Manley Hopkins

"Appropriate boundaries create integrity. Are you accomplishing what you need to accomplish? Boundaries create focus and order."

~ Rae Shagalov

Five Key Tips for Setting Boundaries

Consider Total-life Objectives: Attend to the life of your dreams and design your ideal Life. You will energize, through attention, your ideal vision. Continually visualize and implement new plans for your life. Back your plans with action, and if an action doesn't fit into your design, say "no" to that action.

Practice Mutual Self-Care: In relationships, boundaries should be shared with all relationship partners and accepted as positive agreements that help to maintain and grow the relationship. In this way, boundaries provide mutual self-care and help the relationship to thrive.

Define Your Territory: Identify your boundaries clearly. State exactly what you need in order to feel physically and emotionally safe in all aspects of your life. When communicating with others, be honest about your needs and feelings. Be clear about what *you* will do to protect your wellbeing if your boundaries are violated. Those who respect you authentically will support and accept the boundaries you set for your life.

Enforce Your Boundaries Effectively: Inform others of any behaviour that you find unacceptable. Request politely that the behaviour stop. Explain what you need the person to do instead. If the behaviour does not change, separate yourself from any situation that could harm you emotionally or physically.

Redefine Your Boundaries Periodically: As we grow, both as individuals and in relationships, many of our values, priorities, and goals will change. With these changes, our personal boundaries will also need to change. Re-evaluate your boundaries periodically. Ask yourself at least once a month: *"Do I need to modify, drop, or add any boundary for the most effective life design possible?"*

 To receive more information about setting boundaries or other aspects of life enhancement, contact Steve by visiting www.achieveezine.com/contact/.

The Seven Types of Boundaries

By Lori Radun

Boundaries are designed to protect you and the life that you want to live, and there are seven types of boundaries to consider:

Self-esteem Boundaries
Self-esteem boundaries protect your sense of worth. These boundaries help you feel good about you.

What is the minimum you need to do to maintain self-respect? Perhaps you need to follow through on your promises, or maintain honesty in your life.

What are the limits you need to set with yourself and other people to make sure your self-esteem is not compromised?

Body Boundaries
What do you need to do to protect your body?

What physical limitations might you need to recognize?

What standards need to be in place for you to protect your physical health?

It could be that a certain minimum amount of exercise or a maximum amount of food or drink is required. It might mean you always honour regular health and dental appointments.

Energy Boundaries
Energy boundaries obviously protect the amount of physical and emotional energy you have to operate from.

What energy drains in your life need to be eliminated or minimized?

Which energy refuelers must be present to help you maintain the energy you need for your life?

Time Boundaries
Time is a precious commodity. Without the proper time boundaries, we lose something we can never get back.

What non-negotiable boundaries must be in place to protect your time?

What is the maximum amount of time you will spend on a particular activity, at a specific event, or engaging in work?

Time management is all about having clear boundaries.

Space Boundaries
Our space includes any environment we spend time in. We need to protect our spaces so they nourish us and enable us to live our lives optimally. Pay attention to your needs for organization or beauty in your environments.

How do you know when your ‘housecleaning’ is "good enough"?

What does the minimum and maximum state of your environments need to look like?

Money Boundaries
Just like time, we need money to survive in this life. Your money boundaries protect your finances.

What are the limits you need to set on spending and saving?

What is the minimum salary you are willing to work for?

Consumer debt, for instance, is the result of unidentified or compromised boundaries.

Relationship Boundaries
What boundaries need to be in place to protect your relationships?

Our relationships are truly our greatest gift in life.

How much time do we need to spend to nurture our relationships?

What limits do we need to set on our behaviour in relationships?

Boundaries help ensure our relationships remain healthy.

Boundaries are essential to helping us identify who we are, what's important to us and how we want to live our lives. Without them, other people will decide these things for us.

About the Author Lori Radun is a certified life coach and inspirational speaker for moms. To receive her free newsletter and the special report "155 Things Moms Can Do to Raise Great Children", visit her website at http://www.true2youlifecoaching.com

Following is a collection of articles from *Massage & Bodywork* magazine that serve as reminders of professional conduct.

• "Massage Therapy and Sexual Misconduct: Protecting Our Clients, Ourselves, and Our Profession," by Ben E. Benjamin, PhD, September/October 2017, page 56.

• "Broken Trust: I Was Victimized by My Bodywork Practitioner," by Emma K., September/October 2015, page 76.

• Laura Allen's **Heart of Bodywork** columns also in *Massage & Bodywork* magazine.

- "The Right to Refuse a Client," November/December 2017, page 31
- "Scope of Practice," July/August 2017, page 37
- "What Happens If You're Accused of an Ethics Violation?" May/June 2017, page 35
- "A Red Flag: Bending Our Own Boundaries," March/April 2017, page 35
- "The Nuts and Bolts of Boundaries," January/February 2017, page 33

List of Complaints Websites by State

Victorian Government Health Information

Australian Capital Territory Human Rights Commission

Health Complaints Commissioner, Tasmania

NSW Health Care Complaints Commission

Northern Territory Health and Community Services Complaints Commission

Health and Disability Services Complaints Office, Western Australia

South Australia Health and Community Services Complaints Commission

Office of the Health Ombudsman, Queensland

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9:00am to 4:00pm

MASSAGE ASSOCIATION OF AUSTRALIA
MAA

With you throughout your career

**Your Association.
Your Advantage**

Information contained in this brochure was resourced from the Office of the Health Ombudsman QLD website.

Managing a complaint

(Recommended by the OHO Queensland)

Here are some steps therapists can take to manage complaints quickly and prevent them escalating.

Have a complaint process

- You, or the organisation you work for, should have a process to receive, investigate and attempt to resolve complaints.
- Explain to the client how you will manage their complaint. Responding appropriately can restore trust and prevent a minor grievance from escalating.
- If you feel you can't—or it's not suitable to—manage the complaint, supply the contact details of a person who can (for example, a more senior or experienced staff member or a client liaison officer).
- Outline the complaint management process and how the complaint will be actioned.
- Give a clear timeframe in which the complaint will be addressed.
- Remember, everyone has the right to make a complaint free from harassment or intimidation.

Listen

- Invite the person to talk face-to-face – encourage them to bring along a support person or advocate if they wish.
- Listen carefully and respond sensitively.
- Most clients greatly value the opportunity to talk about what happened and present their view.

Clarify

- Clarify with the client the issues they are concerned about.
- Find out what could resolve their concerns.
- Consider the use of an interpreter.

Understand

- Acknowledge the client's feelings, concerns and experience, even though you might disagree. Acknowledge any distress the client may be feeling.
- Many complaints arise from miscommunication or misunderstood communication. Acknowledge this without dismissing the client's point of view.
- Try to understand the situation from the client's perspective.

Explain

- An open discussion and an explanation of what happened will often resolve concerns.
- Avoid technical language, jargon and clichés, and explain medical terms.
- Try not to be defensive.

Reassure

- Clients are often worried that if they complain, there will be a negative impact on their future care. Reassure them that this won't be the case.
- Offer reassurance the complaint will be kept confidential.

Timeliness

- Respond to the complaint as soon as possible, even if it is just to explain the process and timeframe.
- Stick to the timeframe given.
- Keep the complainant informed.
- Give the reasons for any delay.

Finalise

- Provide a full response so the client can see their complaint has been taken seriously.
- Explain the steps you took.
- Acknowledge areas of disagreement, or varying accounts without dismissing the client's view.
- Outline what happened, any error that occurred, how it happened and any policy or procedure changes you are making to prevent it happening again.
- Be sympathetic. Apologise if appropriate.
- If you and the complainant are unable to resolve the concerns, contact the complaints Ombudsman or Health Commissioner in your state. They are there to help.

It's important if you're approached by a client with a complaint, that you take the time to listen to their concerns and consider how you might be able to address them.

Often people just want a clear explanation of what happened. Some complainants want an acknowledgement that something went wrong, even if the incident was unavoidable or unforeseeable. They may seek an apology, or to see a service improved to prevent the situation occurring again.

Sometimes, complainants may want to see someone held accountable or be seeking compensation.

Experience suggests that people make a complaint because they *genuinely* feel that something was unsatisfactory with the health service provided to them.

As a result, complaints provide an opportunity for you to view your service from the client's perspective and to look for opportunities to improve.

Client Review CPE Form

Date: _____

Member Name_____Member Number: _____

Client name_____

	Yes	No
CLINIC OVERALL • Clinic looks clean and tidy • Music is the right type for massage-- loud or soft or appropriate? • Like our clinic general atmosphere • wait for a masseur for over 10 minutes	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
PRE MASSAGE – did your Masseur: • Take a current medical history or review your progress since the last massage • Discuss your needs and agree on the massage priorities with you • Explain the time and price for your massage • Wash their hands before the massage	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
MASSAGE – did your Masseur: • Drape the areas of your body that were not being worked on with towels or sheets • Ask you for feedback about the pressure being applied • Respond appropriately to your feedback • Answer your questions • Working on your tight/sore area • Ensure that the room was at a comfortable temperature throughout the session • Ensure the massage table looks clean, tidy and have fresh Linen	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐
POST MASSAGE – did your masseur: • Conclude the appointment on time • Provide you with appropriate feedback after the massage • If appropriate, re-booking for the effectiveness of massage	☐ ☐ ☐	☐ ☐ ☐
PROFESSIONAL ATTITUDE – did your therapist: • Dress in an appropriate and professional manner • Allow you to undress / dress in private • Have towels large enough for secure draping • Greeting you and call you name correctly • Have any body odor • Hair tied up if they have long hair	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐
List the best aspects of this treatment session		
Did the treatment meet your needs? What would you change to make the session better?		

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CODE OF CONDUCT

Objective

The objective of the Massage Association of Australia's (MAA) Code of Conduct is to provide its practitioners with a basis for professional and self reflection, and evaluation on ethical conduct. This document defines and identifies acceptable behaviour, promotes high standards of practice, and establishes a framework for professional behaviour and responsibilities.
The MAA is a professional organisation and has an obligation to its members, the general public and the industry as a whole.

The Public Interest

- Members shall ensure that within their chosen fields they have appropriate knowledge and understanding of relevant legislation; Federal, State, Territory and local council laws and regulations; and that they comply with such requirements.
- Members shall in their professional practice have regard to basic human rights, compassion and respect for others and shall avoid any actions that adversely affect such rights.

Duty of Client Care

- Members shall practice within the boundaries of their qualification/s and shall cause no harm to clients either of a physical or emotional nature.
- Members shall carry out treatment with due care and diligence in accordance with the requirements of the client and will treat according to the client's informed consent.
- Where a client is unable to give informed consent for any reason (for example medical condition, psychological state of mind, age), informed consent must be obtained from the client's legal guardian.
- When treating minors (under 16 years of age) the client must be accompanied for treatment by a parent or guardian and have permission for any treatment.
- Uphold client confidentiality.
- Members must maintain accurate clinical records in a secured environment, for the duration necessary to meet legal requirements.
- Members must recognise their professional limitations and be prepared to refer a client to other health service practitioners as appropriate.
- Members shall not engage in services that are sexual in nature with the client.

Duty to the Profession

- Members shall uphold the reputation of the profession and shall seek to improve professional standards through participation in personal development and will avoid any action, which will adversely affect the good standing of the MAA.
- Members shall seek to advance public knowledge and to counter false or misleading statements, which are detrimental to the profession.
- Members shall act with integrity toward fellow therapists/practitioners and to members of other professions with whom they are concerned in a professional capacity.

Professional Competence and Integrity

- Members shall maintain professional skills to represent themselves at a professional standard, seeking to continue or maintain personal and professional development skills.
- Members shall accept professional responsibility for their work.
- Members shall not lay claim to any level of competence which they do not possess, or provide services which are not within their professional competence.

Advertising

- Members must not advertise in a false, misleading or deceptive manner.
- Members must not abuse the trust or exploit the lack of knowledge of consumers.
- Members must not make claims of treatments that cannot be substantiated.
- Members must not encourage excessive or inappropriate use of services.

Privacy

- Members will abide by the requirements of Federal, State and Territory privacy and patient record law.
- Members shall honour the information given by a client in the therapeutic relationship.
- Members shall ensure that there will be no wrongful disclosure, either directly or indirectly, of personal information.
- Records must be securely stored, archived, passed on or disposed of in accordance with Federal, State and Territory record law.
- The client has a right to be adequately informed as to their treatment plan and have access to their information as far as the law permits.

Disciplinary Procedures

This Code sets out certain basic principles that are intended to help members maintain the highest standards of professional conduct. All members must accept professional, legal and ethical responsibilities in order to protect themselves and the public's interest.

Should a case arise where a member is in breach of the Code of Conduct, MAA has the right to cancel a practitioner's membership or take other action in accordance with Section 11 of the Constitution.

Further information can be found in the MAA's Constitution and in the Complaints, Disputes and Disciplinary Procedures.

18 Multi-language Pain Assessment Scales

Pain knows no international boundaries. The Joint Commission on Accreditation of Health Care Organizations now asserts, *"Patients have the right to appropriate assessment and management of pain"*[1] and mandates *that "Pain [be] assessed in all patients."*[1] It's easier to assess pain when the patient can fully understand what is being asked.

Guidelines[2] for teaching patients and families how to "use" a pain rating scale suggest that you:

1. **Show the scale and explain its purpose:** "This is a pain rating scale that many of our patients use to help us understand their pain and to set goals for pain relief. We will ask you regularly about pain, but anytime you have pain you must also let us know. We don't always know when you hurt."

2. **Explain how to use the numbers to rate pain:** "On this pain rating scale, 0 means no pain and 10 means the worst possible pain. The middle of the scale, around 5, is moderate pain. Pain at the 2 or 3 would be mild pain, but a 7 or higher would be severe pain."

If English is not a patient's native tongue, one of the following 18 translations of the 0 to 10 numeric pain rating scale may be useful.

Note: Most of the pain rating scales were translated by volunteers. No back and forth translation has been done, so please be advised that errors may occur. However, these scales have been used extensively by the facilities that submitted them to the *Clinical Manual*.

English

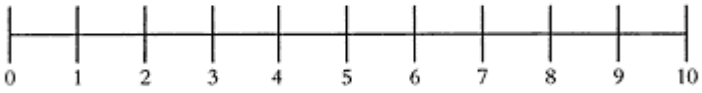
Please point to the number that best describes your pain.

No pain Terrible pain

Chinese *

請指出那個數字反映你痛的程度

Please point to the number that best describes your pain.



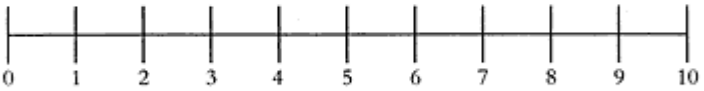
無痛 **劇痛**

No pain Terrible pain

French **

S'il vous plait, indiquez le chiffre qui décrit le mieux votre douleur.

Please point to the number that best describes your pain.



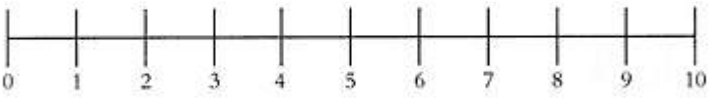
Pas de douleur **Douleur intense**

No pain Terrible pain

German * *

Bitte marhienen sie die nummeru, die ihren schumerz am besher beschraben.

Please point to the number that best describes your pain.



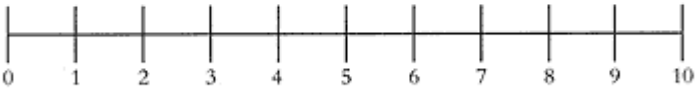
Kein schmerz
No pain

Unertrajlicher schmerz
Terrible pain

Greek * *

Παρακαλώ, δείξετε με το δάκτυλό σας τον αριθμό που δείχνει πόσο πόνο έχετε.

Please point to the number that best describes your pain.



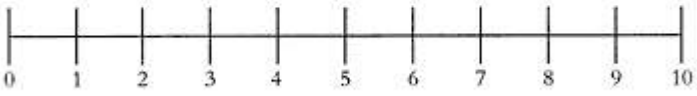
Δεν έχω πόνο
No pain

Έχω πολύ πόνο
Terrible pain

Hawaiian *

E koho a kuhi ʻoe i ka helu pololei ma ke ʻano o ka ʻeha i pili ia ʻoe, ina ʻole (0) ka ʻeha ʻole a ʻumi (10) ka ʻeha palena ʻole.

Please point to the number that best describes your pain.



Ka ʻeha ʻole
No pain

Ka ʻeha palena ʻole
Terrible pain

Hebrew * *

בבקשה תשימו אצבע על המספר מאפס עד עשר:

שמראה לנו כמה חזק הכאב

Please point to the number that best describes your pain.

בלי כאב
No pain

כאב חזק
Terrible pain

Ilocano * (spoken in the Philippines)

Paki tudo ti numero nga mangipakita ti kinasakitna.

Please point to the number that best describes your pain.

Awan sakit na
No pain

Nakasaksakit unay
Terrible pain

Italian * *

Segna il numero che indica il level del dolore.

Please point to the number that best describes your pain.

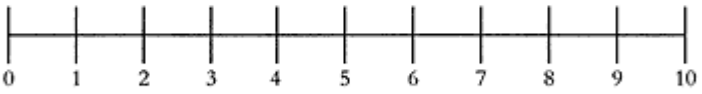
Nessun dolore
No pain

Dolore insuportable
Terrible pain

Japanese * *

痛みの強さの度合を0～10までの階段で示して下さい。

Please point to the number that best describes your pain.



ゼロ　全く痛みがない
No pain

激痛 敢痛
Terrible pain

Korean

현재 통증의 강도를 가장 잘 나타내는 번호에 표시하십시오.

Please point to the number that best describes your pain.

통증이 없음
No pain

통증이 너무 심함 함
Terrible pain

Pakistan * *

برائے مہربانی اپنے درد کی شدت بتانے کے لیے نیچے لکھے ہوئے
نمبروں میں سے کسی ایک کی طرف اپنی انگلی سے اشارہ کریں۔

Please point to the number that best describes your pain.

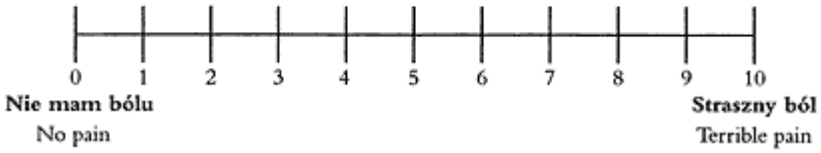
کوئی درد نہیں ہے
No pain

شدید ترین دردہے
Terrible pain

Polish * *

Proszę wskazać numer, który najlepiej określa jak silny jest ten ból.

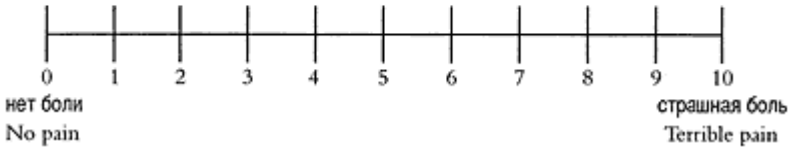
Please point to the number that best describes your pain.



Russian * *

Выбирите число, которое указывает вашу боль по десятибальной системе.

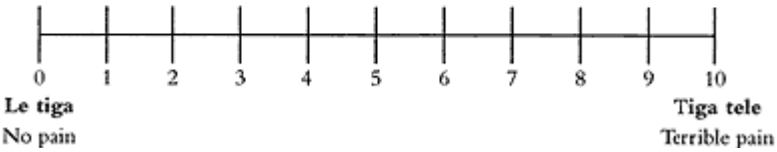
Please point to the number that best describes your pain.



Samoan *

Fa'amolemole ta'u mai le numera e fa'amatala ai le itu-aiga tiga o loo e lagonaina.

Please point to the number that best describes your pain.



Spanish * *

Por favor senale al numero que mejor describe su dolor. (Mas grande el numero mayor su dolor).

Please point to the number that best describes your pain.

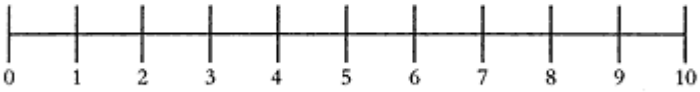
No tiene dolor
No pain

Tiene un terrible dolor
Terrible pain

Tagalog * * (spoken in the Philippines)

Ituro po ninyo ang numerong nagpapaliwanag kung gaano kasakit.

Please point to the number that best describes your pain.



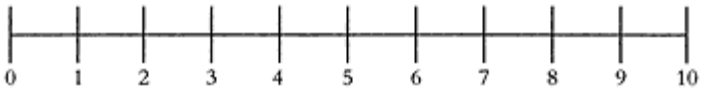
Walang masakit
No pain

Napakasakit
Terrible pain

Tongan * * (spoken in Tonga, an island in the south Pacific)

I he ngaahi fika koena, fakailongai mai ai e tuunga ho falangaaki.

Please point to the number that best describes your pain.



Ikai ha felangaaki
No pain

Ikai matuuaki'e langa
Terrible pain

Vietnamese

Xin chỉ số mô tả đúng nhất sự đau nhức của quý vị

Please point to the number that best describes your pain.

Không đau
No pain

Đau rất nhiều
Terrible pain

References: 1. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH)*. Patient Rights and Organization Ethics chapter. Joint Commission on Accreditation of Health Care Organization website. Available at http://www.jcaho.org. Accessed on September 1, 2000. **2.** McCaffery M, Pasero C. *Pain Clinical Manual*, 1999, Mosby, Inc., New York, New York. Pp. 68-73.

* Courtesy of Pain Management Committee, St. Francis Medical Center, Honolulu, HI. ** Compiled by Josephine Musto, RN, MS, ONC, Nursing Care Manager, Pain Management Service and members of Nursing Department, Saint Vincent's Hospital and Medical Center, New York, NY.

BEHAVIORS POTENTIALLY INDICATIVE OF PAIN

This list is a simple guide to behavioural assessment of pain in patients who are unable or unwilling to provide a self-report of pain. It is not an exhaustive list.

FACIAL EXPRESSIONS	• Frown (wrinkled forehead) • Grimace • Fearful • Sad • Muscle contraction around mouth & eyes
PHYSICAL MOVEMENTS	• Restlessness • Fidgeting • Absence of movement • Slow movements • Cautious movements • Guarding • Rigidity • Generalized tension (not relaxed) • Trying to get attention (beckoning someone)
VOCALIZATIONS (Noises)	• Groaning • Moaning • Crying • Noisy breathing

McCaffery M, Pasero C, Pain: Clinical manual, p. 95.

Complimentary Alternative Medicine (CAM) - Physical Interventions, Cognitive - Behavioral Interventions

PHYSICAL INTERVENTIONS

Acupressure Use of finger and hand pressure over specific points on the body to relieve pain and discomfort and to influence the function of internal organs and body systems. Various approaches are used to release tension and restore the natural flow of energy in the body.

Acupuncture is an ancient method for relieving pain and controlling disease, used in China for thousands of years. Acupuncture is an invasive procedure that involves insertion of needles at various points in the body to relieve pain. It is based on an ancient Chinese theory that two opposing forces, yin and yang, move along meridians in the body. When they are out of balance, pain and illness result. There are about a thousand acupuncture points along these meridians, each of which correspond roughly to hypersensitive areas in muscle and connective tissue. The theory posits that pain is relieved when the correct point is stimulated or prolonged pressure is applied. Acupuncture may also release endorphins and stimulate large nerve fibers to “close the gate” in the spinal cord to pain impulses. It appears to be effective for some patients with chronic pain.

Side effects risks are low and can include:

1. Post-needling pain, bleeding, bruising and local skin reactions.
2. Dizziness or fainting,
3. Rarely, organ damage can occur with deep needling techniques.
4. Infection because of inadequately sterilized needles is a hazard; disposable needles are recommended.
5. Acupuncture is not recommended for patients with serious blood clotting problems.
6. Pregnant women should use acupuncture with caution.

Breath Work/ Deep Breathing for relaxation In this simple technique, the patient uses controlled breathing and focuses his or her attention on the act of breathing only. To begin, breath slowly and diaphragmatically, allowing the abdomen to rise slowly and the chest to expand fully. One can learn to eliminate stress, improve vitality and expand awareness. This may shift attention away from the source(s) of pain.

Comfort measures such as clean, smooth sheets, soft, supportive pillows, warm blankets, and a soothing environment have been used by nurses throughout history to relieve pain and suffering. These measures may be difficult to provide in the noisy, mechanized healthcare facilities of today- they are important to the mental and physical health of clients.

Hydrotherapy is the use of water, ice, steam, and hot and cold temperatures to maintain and restore health. Treatments include full body immersion, steam baths, saunas, colonic irrigation, and the application of hot and/or cold compresses.

Heat Therapy can reduce pain, especially of muscle tendon or spasm. Some patients with other types of pain may benefit. Applications can come in the form of hot packs, hot water bottles, moist compresses, electric heating devices, chemical or gel packs carefully wrapped to prevent burns.

Heat therapy can:

1. Increases the flow of blood to the tissues
2. Dilates blood vessels
3. Increases oxygen and nutrient delivery
4. Decreases joint stiffness /improves muscle elasticity
5. Should be applied for 15-20 minutes
6. Patients may also submerge the effective part in warm water.
7. Avoid heat to radiation therapy skin and tissues.
8. Pregnant women should not utilize methods that subject the fetus to prolonged heat.

Deep heat delivered by short wave or microwave diathermy, or ultrasound can be used in treatment of pain. Deep heat treatments should be used with caution in patients with active cancer and not delivered to an active cancer site.

Cold Therapy: Cold sources should be sealed to prevent dripping, flexible to conform to the body, and adequately wrapped to prevent irritation or damage to the skin. Application can come in the form of ice packs; ice water soaked towels or chemically prepared gel packs.

Cold therapy can:

1. Decreases blood vessels at the surface.
2. Can relieve pain of muscle tension or spasm.
3. Can reduce swelling.
4. Other types of pain may benefit also.
5. Should be applied for 15-20 minutes.

Massage can be a useful addition to a pain management program, especially for patients who are bedridden. Muscles can be stroked, kneaded or rubbed in a circular motion. A lotion can reduce friction on the skin. Massage is not recommended in cases of swollen tissue. It should be used in addition to, and not instead of, exercise by patients who can walk. Muscles can be stroked, kneaded or rubbed in a circular motion. A lotion can reduce friction on the skin. Massage is not recommended in cases of swollen tissue. It should be used in addition to, and not instead of, exercise by patients who can walk.

Massage can:

1. Stimulate blood flow
2. Relax muscles that are tight or in spasm
3. Promote a feeling of well-being

Non-Invasive Stimulatory Approaches- Transcutaneous electrical nerve stimulation (TENS) is a method of applying a gentle electric current to the skin to relieve pain. TENS works by M-2stimulating large nerve fibers to close the “gate” in the spinal cord. It also may stimulate endorphin production. TENS may be used for acute postoperative pain or for chronic conditions, such as low back pain, phantom limb pain, and neuralgia. Studies have shown that it can be effective in certain cases of chronic pain. Patients describe the sensation of TENS as buzzing, tingling or tapping. Pain relief usually lasts beyond the period when current is applied. TENS can become less effective at relieving pain over time. TENS is usually safe and well tolerated, however, it is not recommended on inflamed, infected or otherwise unhealthy skin, over a pregnant uterus (except for obstetric pain relief), or in the presence of a cardiac pacemaker.

Progressive Muscle Relaxation. In this technique, developed in the 1930s, patients contract and then relax, muscles throughout the body, group by group. Progressive muscle relaxation can help patients learn about the tension in their body and the contrast between tense and relaxed muscles. The coach suggests or the client internally thinks to locate an area of muscle tension, contract the muscles in that area and then relax them. As the subject relaxes, pain perception and anxiety diminish. This is at times done systematically, toe to head.

Repositioning Frequent changing the position of the patient and/or the affective limb is essential. Position change and movement are well-known pain-relieving interventions, which relieves muscle spasm and provides a degree of pain relief. Nurses need to offer these important pain-relieving interventions frequently.

Biofeedback Therapy
Biofeedback is a method of treating chronic pain and other stress-related conditions. It uses an electric device to gather information about physical responses and report them back to clients. The information goes to the biofeedback machine by way of electrode sensors placed on the person's skin. It is displayed as visual signals on a monitor. As clients watch these signals, they learn to control their responses.

Biofeedback is a method in which people learn to reduce their body's unproductive responses to stress, and thus decrease their sensitivity to pain. Children are particularly quick to learn from biofeedback. In biofeedback, electrodes are placed on the patient's skin at various points to measure:

1. Muscle Tension- contraction of a muscle causes electrical activity
2. Temperature- blood flow determines temperature of hand and feet
3. Heart Rate
4. Diaphoresis (sweating)

Patients watch the monitor and listen to the tones measuring their stress indicators. They use these as a guide in learning to release tension throughout their body.

ENERGY BASED THERAPIES

Healing Touch is an energy-based therapeutic approach to healing. Touch is used to influence the energy system, affecting physical, emotional, mental and spiritual health and healing. The goal of treatment is to restore harmony and balance, promoting self-healing.

Touch for Health: A science of energy-balancing encompassing aspects of applied kinesiology, acupressure, massage and nutrition to maximize physical and emotional health. Touch for Health emphasizes the uniqueness of the individual, and uses measurement of muscle strength as a biofeedback mechanism to determine the unique needs of the individual.

Reiki: The use of hands and visualization to direct energy to various parts of the body to facilitate healing and relaxation. Reiki can promote mental, emotional, physical, and spiritual balance.

COGNITIVE-BEHAVIORAL INTERVENTIONS

Aromatherapy We have the capability to distinguish 10,000 different smells. Use of essential oils extracted from plants and herbs are used to treat physical imbalances, as well as to achieve psychological and spiritual well-being. Scents are inhaled into the nose and enter through cilia (fine hairs in the nasal lining) into the limbic system (the part of the brain that controls our moods, emotions, memory and learning) Oils can be inhaled, applied externally, or ingested.

Distraction diverts the attention of individuals away from painful stimuli. When people focus on something that gives pleasure, they are less likely to feel acute pain. This phenomenon occurs because the reticular activating system briefly inhibits the awareness of pain. Distraction works best for short acute pain, such as a needle stick. However, it is important to remember that distraction does not work for chronic, long-term pain.

Distraction can be utilized in many forms:

1. Listening to music (either recorded or live), the radio or stories
2. Singing, Reading, Watching TV, Playing hand held video games or puzzles
3. Talking to family or friends at bedside or on the phone

Guided Imagery In this technique, the patient is directed or coached, by another person following a script or imagination, to focus on the pleasant thoughts being offered, for example; the sound of waves gently hitting a sandy beach. In this type of imagery, the senses are used to maximize the experience- such as smelling the flowers, seeing the beautiful blue water, feeling the sand on your feet and hearing the sea gulls. The purpose of the exercise is to provide an experience of relaxation and relief from stress and pain.

Imagery is a technique, in which patients focus on pleasant thoughts, for example waves gently hitting a sandy beach. One variation is to think of an image that represents the pain (such as a hot, blazing concrete sidewalk), then imagine it changing into an image representing a pain-free state (a pretty, snow-covered forest).

Meditation In this technique, practiced routinely in Asia, is a method of relaxing and quieting the mind to relieve muscle tension facilitate inner peace. The aim is to empty his or her mind of thoughts, focusing instead on the sensation of breathing and the rhythms of his or her body. There are numerous forms of meditation.

Relaxation Exercises are useful to reduce anxiety, decrease muscle tension, and lower blood pressure and heart rate. An induced state of altered consciousness gives individuals a sense of control and peace of mind.

Spiritual Support and Belief Systems Spiritual leaders are another potential source of support for patients. Religions are patterns of thought and action that typically include belief systems, devotional rituals, organizational structures, and faith in a mystical power. Belief systems are organized patterns of thought regarding the origin, purpose, and place of humans in the universe. These systems seek to explain the mysteries of life and death, good and evil, health and illness. Typically, belief systems include an ethical code of conduct about how people should relate to the world and its inhabitants. Often, however, people develop their own belief systems, independent of organized religions.

Stress Management Any therapy or educational practice with the objective of decreasing stress and enhancing one's response to the elements of life that cannot be changed. This broad category may include bodywork, energy work, visualization and counselling.

Reframing is a pain/ stress management technique that teaches patients to monitor negative thoughts and images and replace them with positive ones. Patients can learn to have a more positive outlook by recognizing some counterproductive thought patterns, such as:

- Blaming, in which the individual avoids taking responsibility.
- "Should" or "must" statements, which imply that someone has failed to live up to an arbitrary standard.
- Polarized thinking, in which everything is black or white, with no shades of grey.
- Catastrophizing, in which the person imagines the worst possible scenario then acts as if it will surely come true.
- Control fallacy, in which the person sees him or herself as completely controlled by others (or controlling everything).
- Emotional reasoning, in which the individual believes that what he or she feels must be true.
- Filtering, in which people focus on one thing (such as pain) to the exclusion of any other experience or point of view.
- Entitlement fallacy, in which individuals believe they have the right to what they want.

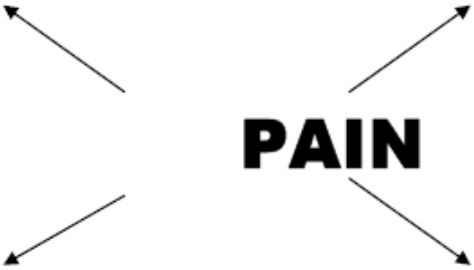
BARRIERS TO THE ASSESSMENT AND TREATMENT OF PAIN

MISCONCEPTION	CORRECTION
1. The best judge of the existence and severity of a patient's pain is the physician or nurse caring for the patient.	The patient is the authority about his or her pain. The patient's self—report is the most reliable indicator of the existence and intensity of pain.
2. Clinicians should use their personal opinions and beliefs about the truthfulness of the patient to determine the patient's true pain status.	Allowing each clinician to act on personal beliefs presents the potential for different pain assessments by different clinicians, leading to different interventions from each clinician. This results in inconsistent and often inadequate pain management. It is essential to establish the patient's self—report of pain as the standard for pain assessment.
3. The clinician must believe what the patient says about pain.	The clinician must accept and respect the patient's report of pain and proceed with appropriate assessment and treatment. The clinician is always entitled to his or her personal opinion, but this cannot be allowed to guide professional practice
4. Comparable noxious stimuli produce comparable pain in different people. The pain threshold is uniform.	Findings from numerous studies have failed to support the notion of a uniform pain threshold. Comparable stimuli do not result in the same pain in different people. After similar injuries, one person may suffer moderate pain and the other severe pain.
5. Patients with a low pain tolerance should make a greater effort to cope with pain and should not receive as much analgesia as they desire.	A stoic response to pain is valued in this society and many others. Research shows that clinicians often do not like patients with a low pain tolerance. However, imposing these values on the patient and withholding analgesics is inappropriate.
6. There is no reason for patients to hurt when no physical cause for pain can be found.	Pain is a new science, and it would be foolish of us to think that we will be able to determine the cause of all the pains that patients report.
7. Patients should not receive analgesics until the cause of pain is diagnosed.	Pain is no longer the clinician's primary diagnostic tool. Symptomatic relief of pain should be provided while the investigation of cause proceeds. Early use of analgesics is now advocated for patients with acute abdominal pain.
8. Visible signs, either physiologic or behavioral, accompany pain and can be used to vert its existence and severity.	Even with severe pain, periods of physiologic and behavioral adaptation occur, leading to periods of minimal or no signs of pain. Lack of pain expression does not necessarily mean lack of pain.
9. Anxiety makes pain worse.	Anxiety is often associated with pain, but the cause and effect relationship has not been established. Pain often causes anxiety but it is not clear that anxiety necessarily makes pain more intense.
10. Patients who are knowledgeable about opioid analgesics and who make regular efforts to obtain them are "drug seeking" (addicted).	Patients with pain should be knowledgeable about their medications, and regular use of opioids for pain relief is not addiction. When a patient is accused of "drug seeking," it may be helpful to ask, "What else could this behavior mean? Might this patient be in pain?"
11. When the patient reports pain relief after a placebo, this means that the patient is a malingerer or that the pain is psychogenic.	About one third of patients who have obvious physical stimuli for pain (e.g., surgery) report pain relief after a placebo injection. Therefore placebos cannot be used to diagnose malingering, psychogenic pain, or any psychologic problem. Sometimes placebos relieve pain, but why this happens remains unknown.
12. The pain rating scale preferred for use in daily clinical practice is the VAS.	For patients who are verbal and can count from 0 to 10, the NRS pain rating scale is preferred. It is easy to explain, measure, and record, and it provides numbers for setting pain-management goals.
13. Cognitively impaired elderly patients are unable to use pain rating scales.	When an appropriate pain rating scale (e.g., 0-5) is used and the patient is given sufficient time to process information and respond, many cognitively impaired elderly can use a pain rating scale

REASONS FOR GOOD PAIN CONTROL

- Pain increases the risk for infection since it depresses the immune response.
- Pain decreases gastrointestinal motility.
- Pain can cause atelectasis and hypoxemia.
- Pain inhibits rehabilitation.
- Pain can lengthen hospital stay.
- And pain decreases patient satisfaction – increases anxiety and irritability.

PAIN IMPACT ON THE DIMENSIONS OF QUALITY OF LIFE
(Ferrell, Rhiner, Cohen & Grant, 1991)

PHYSICAL WELL-BEING AND SYMPTOMS	PSYCHOLOGICAL WELL-BEING
8. Functional Ability Strength/Fatigue Sleep/Rest Nausea Appetite Constipation	Anxiety Depression Enjoyment/Leisure Pain Distress Happiness Fear Cognition/Attention
	
SOCIAL CONCERNS	SPIRITUAL WELL-BEING
Caregiver Burden Roles & Responsibilities Affection/Sexual Function Appearance	Suffering Meaning of Pain Religion

SEARCH MEDICAL RESOURCES:

Medlineplus http://www.nlm.nih.gov/medlineplus/
A service of the U.S. Library of Medicine and the National Institutes of Health, MEDLINEplus offers extensive information from the NIH and other sources on over 600 diseases and conditions, as well as a medical dictionary and encyclopedia.

ClinicalTrials.gov http://clinicaltrials.gov/
Provides regularly updated information about federally and privately supported clinical research in human volunteers. ClinicalTrials.gov gives you information about a trial's purpose, who may participate, locations, and phone numbers for more details.

PubMed
http://www.ncbi.nlm.nih.gov/PubMed/
A service of the National Library of Medicine, PubMed provides access to over 12 million MEDLINE citations from medical and scientific journals dating back to the mid-1960's.