PROVIDING NEWS AND INFORMATION TO MASSAGE THERAPY PROFESSIONALS IN NEW ZEALAND

MNZ MAGAZINE

massage new zealand

ISSUE 3 2021

Men's Health

- MEN'S PELVIC HEALTH: IS THERE A PLACE FOR IT IN MASSAGE THERAPY?
- ERECTIONS: GUILTY UNLESS PROVEN INNOCENT
- SEEING MALE CLIENTS FOR WHO THEY ARE AND NOT WHAT THEY ARE
- MEN AND THERAPY: IT CAN AND DOES WORK WELL
- MALE MASSAGE THERAPISTS AND GENDER-BASED DISCRIMINATION

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EDITORIAL

Kia ora koutou katoa

Another year is nearly over and what a year it has been again! Our thoughts are with our members in the north, who withstood the worst of the extended lockdown period. Please know that your massage whānau across Aotearoa is with you.

On a happier note, we are excited to finish 2021 with an issue dedicated to the other half of our client base who were not covered in our first issue of the year – men. Men are heavily over-represented in a number of key health measures; their life-expectancy is shorter; the mortality rate from heart disease is far higher than for women; suicide is the leading cause of death in young men. We have a range of articles encompassing aspects of both physical and mental health for male clients, and a piece dedicated to our male members.

We are delighted to feature a new contributor and massage therapist from Canada, Jocelyn Kirton, who has written two excellent pieces. The first focuses on male pelvic health and how we, as massage therapists, might offer support to male clients experiencing pelvic pain. The second piece discusses a topic that can cause alarm in the massage clinic for both client and therapist – erections. Massage college training to deal with erections is usually limited to "just ignore it." Jocelyn explains the physiology of erections and why she believes it is important to acknowledge them.

Mark Gray, bodywork and Hakomi practitioner and massage tutor, proposes that we challenge the biases we may hold when working with male clients. We also highlight the importance of psychological therapy for men with a piece by local psychologist, Mike McKinney. While it is not something within our scope of practice as massage therapists, it is certainly something we should be encouraging male clients to seek out. We are also excited to inform you that St John, trusted provider of First Aid training to MNZ members, now offers a discount to MNZ members on their Mental Health First Aid course. You can find details on this discount on page 18!

Our very own magazine co-editor, Rachel Ah Kit, takes a turn at writing. She delves into gender-based discrimination faced by male massage therapists, whether it is a real issue and why. She explores the literature available, talks with local and international therapists for their experiences, and discusses what MTs can do to change the beliefs that some of the public hold about male MTs.

The MNZ AGM for 2021 was held via Zoom for the second year in a row. We have a full report on the meeting on page 4, along with details of several new Executive Committee members on page 6.

Becky Littlewood, who has cemented herself as the go-to writer for our A&P column, does an excellent job explaining chronic non-bacterial prostatitis and chronic pelvic pain syndrome in detail. This ties in well with our lead article on pelvic pain from Jocelyn Kirton. Regular columnist, Ruth Werner, provides us with yet another insightful commentary. She examines several pieces of research into men's mental health and explains why she is genuinely concerned with what she discovered. We share her concerns, and we strongly encourage you to read what she has to say. Student Jo Boardman talks about the challenges of learning in a COVID setting and her hopes for her future. And as usual we have an interesting selection of books and resources for you to check out, for both your own learning as well as for your male clients'.

As we close off this year, we look forward to 2022 bringing a more settled environment for your work and home lives, with more clarity and less uncertainty. We would also like you to consider contributing to this magazine next year. It is a valuable resource for our members, and we know there are talented writers within our membership, who just need the right opportunity to publish.

Meri Kirihimete!

Odette & Rachel

ARTICLE SUBMISSION AND ADVERTISING SPECIFICATIONS

SUBMISSION DEADLINES

The MNZ Magazine will be published:

Issue 1 2022 – 1st April (deadline 1st Feb)
Issue 2 2022 – 1st August (deadline 1st June)
Issue 3 2022 – 1st December (deadline 1st October)

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

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

ADVERTISING RATES AND PAYMENT

MNZ Magazine now ONLINE only.

For current advertising opportunities and pricing please see:

https://www.massagenewzealand.org.nz/Site/about/advertise/advertising-opportunities.aspx

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ARTICLE SUBMISSION GUIDELINES

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

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

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

Co-editors – Rachel Ah Kit, Odette Wood

magazine@massagenewzealand.org.nz

coeditor@massagenewzealand.org.nz

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CO-CHAIR REPORT

A lot has happened since our last report. We've had our AGM and there is a new Executive Committee. It is fantastic to see such a great response to the implementation of our new structure with several new members joining the team. The new Executive Committee can be seen in the AGM report provided by Nici Stirrup, Executive Administrator later in this section.

There have been extra meetings happening with the unfolding events due to COVID-19. In October we sent out an email to members outlining the new Ministry of Health guidelines for therapists to work at Level 3. Later in the month the Ministry of Health deemed that all Allied Health regulated under the HPCA Act should be mandated to be vaccinated with other Allied Health members strongly encouraged to be so.

The Government then announced its new "traffic light system" which mandated that all businesses that work in "close proximity" with customers/ clients would require vaccine certificates to be shown, and then on 26 October announced that staff of all businesses that require vaccine certificates would themselves have to be vaccinated.

This is an evolving and fluid situation which the Executive Committee are responding to as required – this does take up time to make sure we impart accurate and timely information to our members and this means that we sometimes need to shift our priorities.

By the time you read this we will have had an all-day strategic planning meeting and we will be fully engaged in moving MNZ forward as intended.

MNZ Co-chairs

Helen Smith & Bernie Withington

ADMIN REPORT

MASSAGE NEW ZEALAND INC. - ANNUAL GENERAL MEETING 2021

The MNZ Annual General Meeting (AGM) this year took place on Zoom. We had every hope that a physical meeting in Wellington would have been possible and initially that is what we planned for. Unfortunately, due to COVID-19 lockdowns and restrictions we once again had to run the meeting virtually. We had just over 70 members registering for the meeting this year and 53 members attending on the day which fulfilled quorum. This was an improvement on last year's attendance. Thank you to all who joined us and to those who sent their apologies. It is great to see the membership taking an interest in the progress of the organisation and our professional industry.

We completed the usual proceedings of ratifying last year's AGM minutes and 2021 financial reports. Please note the YE 2021 Financial Reports are not required to be audited this year. Minutes, annual executive reports, and financial reports are available to view on the website here:

https://www.massagenewzealand.org.nz/Site/members/news/annual-reports-agm.aspx

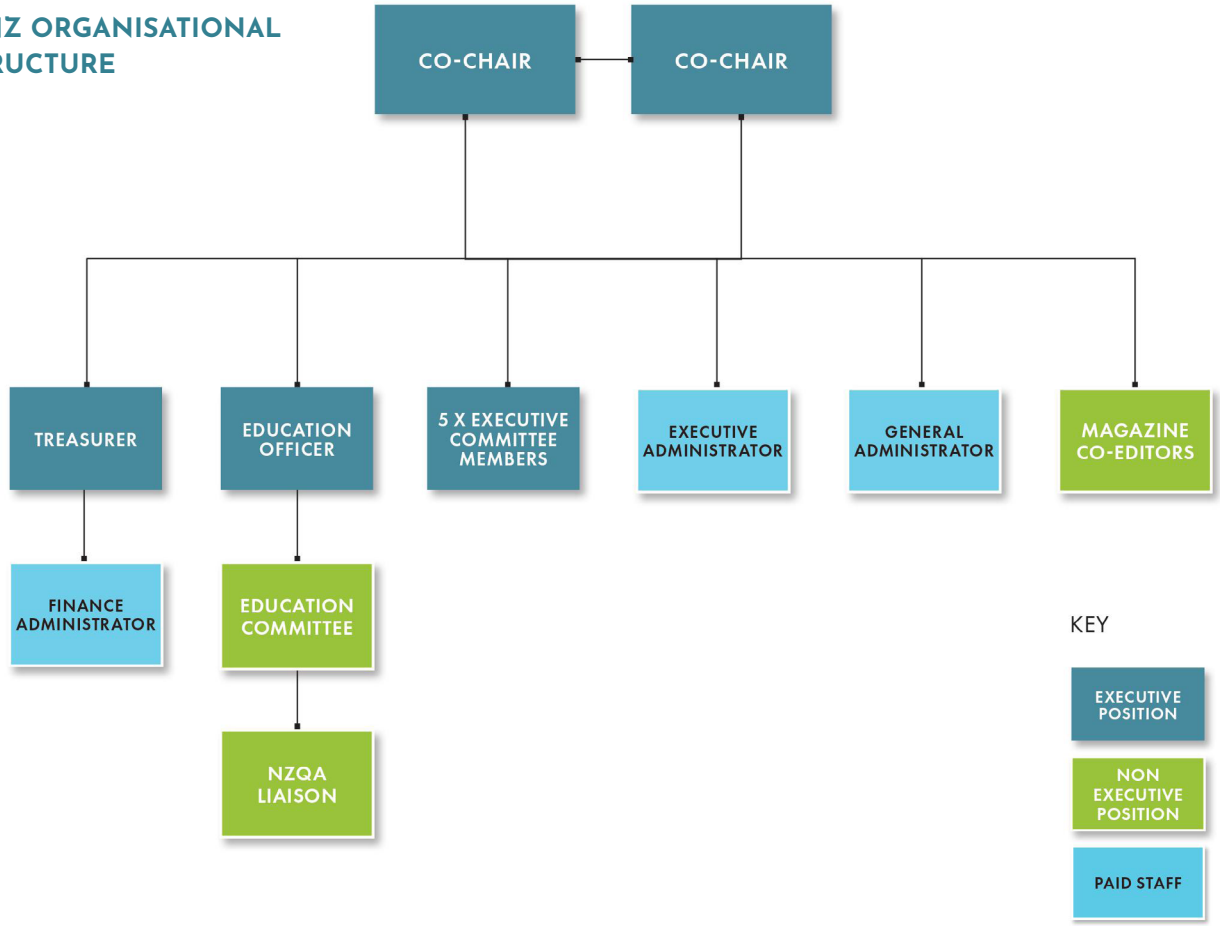
We entered one remit to the MNZ Constitution this year for clause 5.2 regarding financial reporting. This was to clarify the process and remove ambiguous wording. The MNZ Rules were also amended due to the recent restructure of the MNZ Executive Committee at a Special General Meeting on 1st August. The mention of previous executive and non-executive roles have been removed from the document. Clauses 10 and 12 regarding the complaint procedure were adjusted, as well as clause 14 regarding Top Student Award. Members also had discussions on several other areas that will need to be amended for next AGM, such as the statements on minimum qualification requirement, supervised clinical hours for students and potentially the rules on life membership. The current documents are available to view on the website here:

https://www.massagenewzealand.org.nz/Site/about/constitution.aspx

Thank you to everyone who accepted nomination into various Executive and Non-Executive roles. It was exciting to see many volunteers all keen to take part in developing so many areas of the organisation. Please welcome the following members to the team who were voted in at the meeting:

Helen Smith	Co-chair
Bernie Withington	Co-chair (with Complaints portfolio)
Vicki Scott	Treasurer
Doug Maynard	Education Officer, NZQA Liaison
Ali Sullivan	Executive Committee member

MNZ ORGANISATIONAL STRUCTURE



Iselde de Boam	Executive Committee member (AHANZ/Affiliate portfolio)
Shelley Moana Hiha	Executive Committee member
Felicity Molloy	Executive Committee Member (co-opted in November)
Odette Wood	Magazine Co-editor
Rachel Ah Kit	Magazine Co-editor
Pip Charlton	Education Committee
Dawn Burke	Education Committee
Joanna Tennent	Education Committee
Mark Gray	Education Committee

If you are interested in finding out more about joining the Executive Committee, then we welcome you to bring your skills and experience to the team. To view role descriptions please email admin@massagenewzealand.org.nz and contact our MNZ Co-chairs if you are interested in a role – co-chair@massagenewzealand.org.nz.

Congratulations to Mark Fewtrell for receiving the Bill Wareham award for 2021. We presented in a nutshell, Mark's multiple contributions to MNZ and members over the years and congratulate him as he steps into his 25th year of providing massage therapy in Auckland. Enjoy the award Mark, you've earned it!

Mark Fewtrell, Bill Wareham award recipient 2021

Gifts and thanks were presented to the following members, for their contributions to MNZ over the past year:

MNZ Education Committee – Pip Charlton, Dawn Burke, Joanna Tennent, Mark Gray and Shelley Moana Hiha who have all been key players in supporting Doug as he continues his journey as Education Officer and have all been instrumental in the NZQA Qualifications Review of Level 5 and 6 Diplomas and further developing RPL and CPD processes.

Tania Kahika-Foote who has stepped down as Treasurer after having consecutively completed one term in this role and one term previously as Regional Liaison Coordinator. Tania has been involved in multiple key projects and discussions over the years and has done a fantastic job in supporting the Executive team, the organisation, and its members. We hope to see Tania coming back to us in the future to continue her journey.

Sarah Rule and Allison Anderson amongst many other volunteers, have done an amazing job this year supporting Iselde as AHANZ representative and took part in completing the NZIER report, "Hidden in plain sight: Optimising the allied health professions for better, more sustainable integrated care". This features a 2-page article titled "Hidden in plain sight: Optimising the role of remedial massage therapy in the future health and disability system". A wonderful achievement! The full report can be accessed here:

https://www.massagenewzealand.org.nz/Site/news/articles/nzier-media-release.aspx

A big thanks to Odette Wood and Rachel Ah Kit for their immense efforts and outstanding work on the magazine and for continuing their roles as Magazine Co-Editors. We really appreciate the many hours that you devote to producing outstanding reading material for us all.

The next AGM date has not yet been set. We are hoping to hold a conference next year as well, potentially in Auckland. The details at this stage have not been confirmed. We are investigating availability, and as soon as we have dates confirmed for AGM and conference, we will share this with membership so you can save the date. If you are interested in assisting with organising conference, then feel free to contact the MNZ Executive Committee. We would love to hear from you.

We look forward to seeing you next year!

Nici Stirrup

MNZ Executive Administrator

admin@massagenewzealand.org.nz

NEW EXECUTIVE COMMITTEE MEMBERS

BERNIE WITHINGTON – CO-CHAIR AND COMPLAINTS PORTFOLIO HOLDER

2020 Bachelor of Health Studies (NMT), NZCM Wellington

2020 Decongestive Lymphatic Therapy, Casley-Smith Australia

2018 Oncology Massage, OML Australia

I began my massage career about four years ago, by renting a room at an Osteopath clinic in Wellington CBD. After our first COVID lockdown I threw caution to the wind and started Waiora Collective, a Complementary Therapies & Holistic Health studio in Porirua.

As a fledgling in our industry, it may seem odd that I have agreed to be thrown in the deep end as Co-chair and hold the Complaints portfolio for our association. I often said while studying at NZCM that I would participate and contribute to our governing body. So, here I am.

Massage New Zealand Incorporated is ready for progression. Our deficit of matauranga and Te Tiriti o Waitangi in our documentation and policies, highlights the necessity to implement our kawanatanga in a more inclusive environment.

Working collaboratively with fellow Co-chair, Helen Smith will have many advantages, and I am looking forward to learning from her and establishing a solid foundation to develop our future whakawhanaungatanga of massage therapy, allied health, and primary health care.

So, if you want to be part of this exciting progression, please contact us, as there are plenty of work groups where your participation will be valued.

Nga mihi nui,

Bernie Withington

VICKI SCOTT

Degree in Applied Science (completed 2nd year)

BCom – Accounting

ALA Accredited Lymphoedema Practitioner

Diploma in Reflexology

Certificate in Oncology Massage - OM1 & OM2

I commenced my journey into bodywork only 6 years ago, starting with a Relaxation & Rejuvenation Massage course at the Lotus College here in Dunedin. I found I loved working with the feet so I completed a Diploma in Reflexology.

While attending a workshop on Reflexology Lymphatic Drainage (RLD) I discovered the lymphatic system, and it became one of my passions.

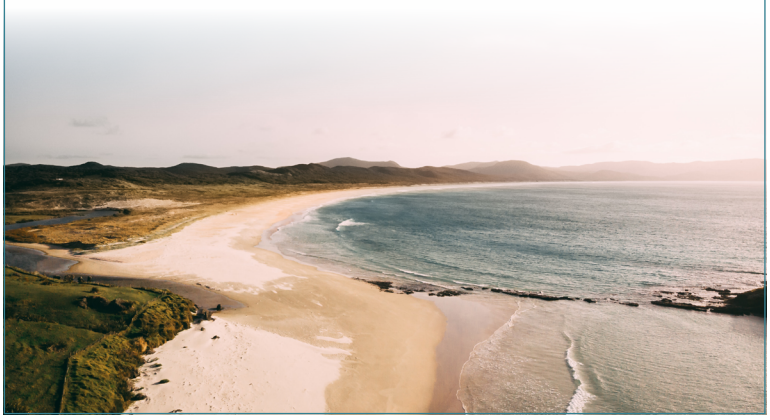
I attended many workshops over the next couple of years, and in 2019 I went back to Otago Polytech to complete the second year of the Degree in Applied Science. In early 2020 I completed my Decongestive Therapist training and am now a certified therapist. I have also completed training in Oncology Massage and Scar therapy. I love what I do and am continually learning.

Alongside training for my new massage career, I have been working in my other career as a Management Accountant for a local business. Previously, I was the Treasurer for both my children's school BOT and Reflexology New Zealand. On both committees I was involved with policy, strategic planning, and HR. I feel these skills will help, as we progress to increase our recognition as a respected professional body.

The lovely people on the MNZ Executive Committee, their enthusiasm and passion are what inspired me to put my name forward and I look forward to being part of the team.

All MNZ Executive Committee members, Volunteer and Administration Staff would like to take this opportunity to thank all of our members, stakeholders and advertisers for your continued support and wish you and your families a very restorative and safe Christmas and New Year. What ever you do over this festive period – be well.

Ngā mihi nui ki a koe.



MEMBERSHIP UPDATE

As of the 1st of October 2021, we have a total of 463 members. This sees similar overall numbers to this time last year, although this year we have more RMT members than last year and less student members. The reduction in student numbers may be influenced by the closure of the New Zealand College of Massage campuses across the three main centres at the end of 2020. MNZ has been actively promoting MNZ and student membership to some of the other colleges and hopefully this will lead to increased student numbers in 2022.

Oct 2020	Oct 2021
RMT: 386	RMT: 412
SMT: 62	SMT: 38
AFF: 14	AFF: 14
Total: 462	Total: 463

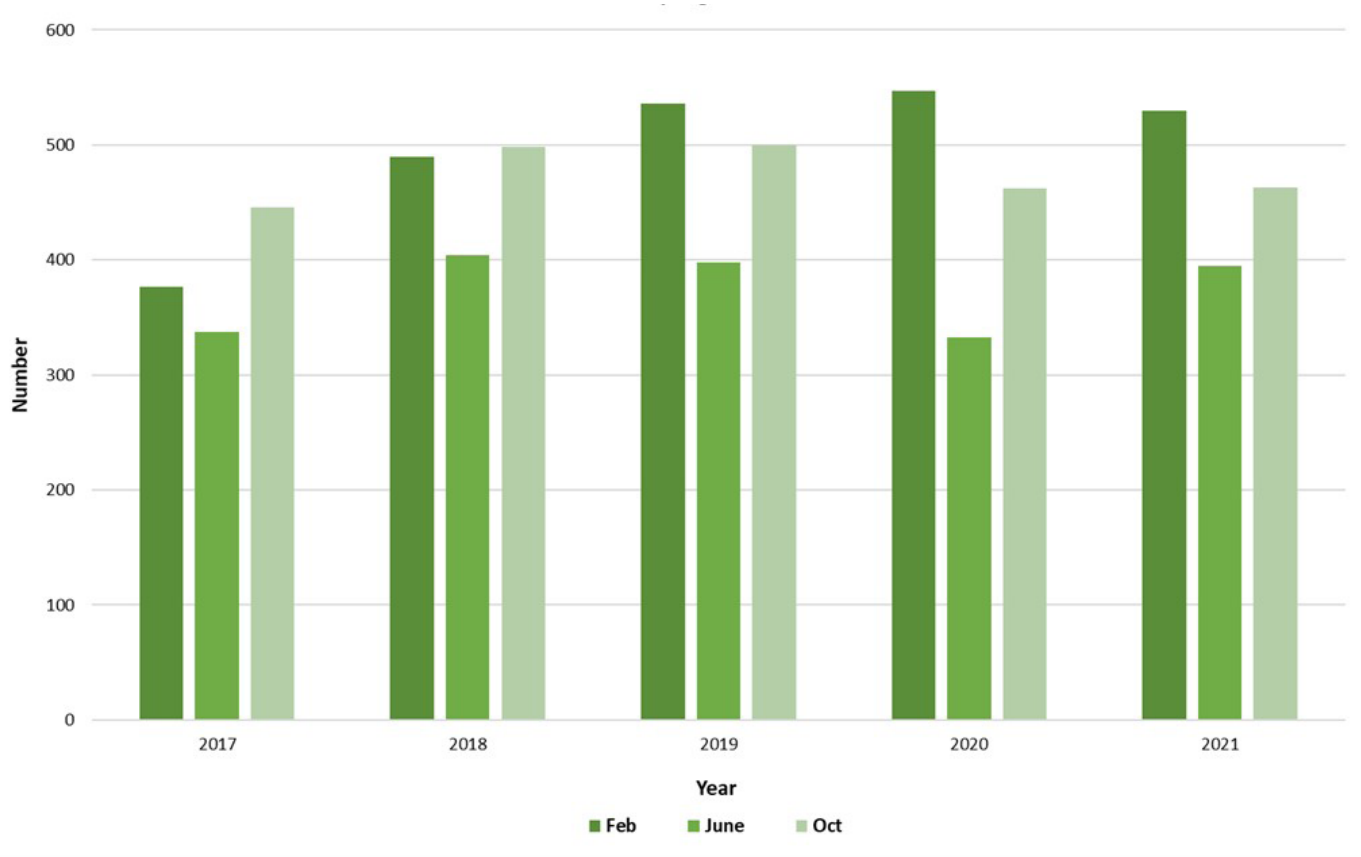
Since June we have seen an even flow of new members and late renewals with an increase of 59 RMTs. We have also received an increase in the number of queries coming from Australian and other overseas therapists looking to move to NZ.

Please do encourage any students to get in touch and apply for their free student membership. Esther is your go-to person for this.

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

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

MNZ MEMBERSHIP FIGURES 2017 - 2021



MEN'S PELVIC HEALTH: IS THERE A PLACE FOR IT IN MASSAGE THERAPY?

By Jocelyn Kirton, RMT

Imagine experiencing pain in the most intimate of areas. The narrow variety of treatment options available are not only invasive but yield frustratingly limited results or perhaps they are not successful at all. Now imagine being stigmatized for trying to seek health care for those concerns. This is an all too familiar trend in practice from the men seeking help for their pelvic pain.

Topics in this article may challenge perspectives massage therapists hold. It is encouraged that the profession honours its capacity as individual clinicians with this information, while also challenging its comfort levels. It is important health care providers grow in their understanding and reasoning.

Men have pelvises, and by extension, a pelvic floor too. They may need to discuss their concerns about bladder, bowel, and sexual health with a health care provider. Incontinence, overactive bladder/bladder pain syndrome, erectile difficulties, premature or changes in ejaculation, chronic constipation, testicular or anal/rectal pain and prostatitis (or chronic pelvic pain syndrome) are a few examples of conditions men may need to speak to their health care provider about.

Unfortunately, bringing it to the attention of a health care provider can be stressful and embarrassing. Men often will wait to see if symptoms will resolve on their own (Aschka et al., 2001; Kannan & Veazie, 2014).

Persistent pelvic pain can wear a lot of disguises, particularly, prostatitis. Simply defined, prostatitis is an inflammation of the prostate gland.

For those who are not familiar, prostatitis has four categories: (Nickel, 2000)

1. Acute Bacterial prostatitis
2. Chronic Bacterial prostatitis
3. Chronic non-bacterial prostatitis (NBP) or Chronic Pelvic Pain Syndrome (CPPS)
   a. Inflammatory
   b. Non inflammatory
4. Asymptomatic inflammatory prostatitis

Although its definition is simple, prostatitis is complicated in its treatment and management. One may assume management is straight forward if a bacterial infection is present. Perhaps a cycle of antibiotics and the problem will resolve. Unfortunately, bacterial-related prostatitis cases only make up 5-10% of all prostatitis diagnosis. 90-95% of all prostatitis cases are type 3 prostatitis; the non-bacterial type, also referred to as chronic pelvic pain syndrome (CPPS) (Anothaisintawee et al., 2011; Doiron et al., 2019). Currently antibiotic therapy is recommended for initial treatment intervention (Bowen et al., 2015). The role of antibiotics in the management of non-bacterial prostatitis has been questioned in research, although it has been reported that even in the absence of a bacterial infection, antibiotics provided symptomatic relief (Rees et al., 2015).

Little is known about what causes chronic pelvic pain syndrome (NBP) and even less about how to manage it (Rees et al., 2015). Some studies suggest that age, surgeries, stress, and lifestyle can be contributors, but risk factors remain unclear (Wang et al., 2016).

Symptoms are not localized to the prostate, which can be embarrassing information to share (Kannan & Veazie, 2014). Symptoms can present as pain in the perineum, penis, anorectal region, lower back, abdomen, hip and groin. It can also present with erectile difficulties, pain with ejaculation and/or urination and IBS symptoms (Rees et al., 2015). With multiple symptoms

comes a large amount of testing, imaging, and interventions. This has been described in my practice by men as a chaotic process that leaves them anxious about receiving a scary diagnosis like cancer or an untreatable sexually transmitted infection. Then they endure a wait time of up to six weeks only to discover all tests come back negative. One study reported the more interventions someone has for their pelvic pain, the worse their reported outcomes on pain and quality of life were (Schaeffer et al., 2002). Prostatitis as a collective does not discriminate as it effects 34-50% of men in their lifetime (Rees et al., 2015).

Prostatitis is not only biological or tissue driven. Anxiety, depression, insomnia, and relationship strain are a few of the psychological and social consequences of persistent pelvic pain in men (Brünahl et al., 2017). In one study, 95.2% of men living with persistent pelvic pain fulfilled diagnostic criteria for at least one mental health disorder. The highest scored categories were somatization, depressive and anxiety disorders (Brünahl et al., 2017). It is crucial clinicians take a wide lens or biopsychosocial approach with this population as pelvic pain is multifaceted (Brandt, 2021).

RELEVANCE TO MASSAGE THERAPISTS

In a recent social media post of mine, I shared some observational statistics made over the last three years of treating men with pelvic pain. Out of 302 men seen for their pelvic pain, 184 had seen or regularly see a massage therapist for treatment related to their pelvic health concerns, without disclosing them to their massage therapist. This is relevant to massage practice because the chances are highly likely that at some point in a massage therapist's career, they will have treated someone with an underlying pelvic health concern and not been aware.

How many men with pain in their low back, pelvic girdle, groin, or abdomen have received treatment from a massage therapist? Treating lower back pain is a frequent occurrence in practice (Smith et al., 2011). Pelvic pain can wear other, orthopedic-type disguises. A reason for this is because "Pelvic organs' afferent innervations converge at spinal segments with neurons from somatic structures such as the skin and muscles of the back and buttocks, abdomen, thighs and perineum. Thus, there is an enormous potential for referred pain, secondary muscular and viscero-visceral hyperalgesia." (Curran, 2008, p25). In less scientific terms, there's similar spots in the spinal segments that the pelvic organs and somatic structures communicate to the spinal cord/central nervous system and because of this, there's potential for other structures to get involved and sensitized.

A common analogy for this occurrence might be having one think of police action in their neighbourhood. One may be on high alert for threatening or potentially threatening activity in the area. When there is a threat or even perceived threat, all the neighbours in the area (muscles, other connective tissue, and even other organs) might become overactive or hypervigilant to prevent harm or further harm. This may lead to over activity of the pelvic floor musculature (PFM), overactive bladder, IBS symptoms and sexual dysfunction (Curran, 2008). These are the peripheral or bottom-up influences. Also consider the top down or centralized pain influences such as anxiety, depression, stress, and social contexts. This offers another layer of potential pain system sensitization and may even contribute to the chronicity of pelvic pain (Brünahl et al., 2017; Dybowski et al., 2018).

Would the massage therapy profession feel equipped to navigate a treatment with someone who disclosed their pelvic health concerns? Would massage therapists feel comfortable talking about bladder, bowel, and sexual health concerns? How would you feel talking about pelvic health with a male client? There is gap in massage therapy education when it comes to this topic. Even the basics such as erections, sexual health, therapeutic alliance, and clinician safety are not taught competently in school. Moreover, men need another entry point to receive care for their pelvic health concerns. Massage therapists have plenty to offer this population from pain relief, help with sleep, anxiety, and depression (Moyer et al., 2004), and creating safe spaces to talk about their pelvic concerns. The current way these sensitive topics are taught, or not taught, in school leaves the profession ignorant which does not serve the profession or, more importantly, the public.

I stated earlier in my practice, 184 men actively sought care from a registered massage therapist (RMT) for treatment related to their pelvic health concerns without disclosing to the RMT they have pelvic health concerns. Of the 184, 76% of this group reported the biggest barrier to disclosing a pelvic health concern was their RMT would stop treating them. Most men valued their relationship with their RMT over wanting to disclose a pelvic health concern and risk making the RMT feel uncomfortable.

In my practice, it is quite common that men report their fear of disclosing a pelvic health concern to an RMT they receive regular treatment from. The fear being the RMT perceives them as sexualizing the treatment environment. In the case of 13 men who did feel comfortable enough to disclose a pelvic health concern to their RMT, they reported the RMT:

1. Suddenly became too busy to treat them anymore
2. Abruptly cut them off and strongly suggested talking to their doctor
3. Ended the treatment because the RMT did not feel comfortable treating them anymore.

When I first started documenting all these occurrences, the immediate concern for these men came to mind. The way they had been treated by their RMT continues the cycle of

stigmatization these men face and may further solidify their beliefs to suffer in silence. However, it also presented a unique opportunity. Massage therapists may be the first point of contact to educate, dismantle the stigma and make a meaningful referral if management is out of that individual massage therapist's scope of practice. My observations would suggest men heavily value their therapeutic relationship with their massage therapist. If massage therapists are striving towards being recognized as health care professionals, they must embrace navigating uncertainty in their practices.

Massage culture perpetuates those treatments are most appropriate if this is a female pelvis, or someone who has a pelvis with a uterus, vulva, and cervix, and/or if this is a pregnant or postpartum pelvis. The women I have served in my practice have disclosed to me never being asked about their sexual health concerns, even when reason for treatment directly indicated a sexual health screen. The definition of sexual health by the World Health Organization is: "... a state of physical, emotional, mental and social well-being in relation to sexuality; ... [It's] fundamental to the overall health and well-being of individuals, couples and families...Sexual health, when viewed affirmatively, requires positive and respectful approach to sexuality...as well as the possibility of having pleasurable and safe sexual experiences" (WHO, 2006).

Notice how this definition not only states how it is fundamental, but sexual health is not defined only by its absence of disease or dysfunction. Massage therapists need to stop viewing the pelvis as a dystopia of dysfunction or potential dysfunction. Pelvises are very robust and are capable of a coordinating a broad range of complex functions. From pregnancy and delivery, erections, orgasms, urination, and bowel elimination. It is a storage center, that is also equipped for pleasure and allows people to experience physical intimacy with themselves or one another. Anatomically speaking, the urogenital system is very intimately connected in the male pelvis. The prostate and bladder share the urethra (and penis) for urination and ejaculation. It is almost impossible to compartmentalize the urination functions from the sexual functions because of shared structures. The biases and views massage culture hold are creating barriers to care, especially in men's pelvic health. I understand I am standing on the shoulders of giants. The profession in Canada, especially in British Columbia, has come a long way from being viewed as a part of the sex industry to now being recognized as health care. I thank those voices who came before me in their avocation to desexualize massage therapy as I would not be able to practice the way I am today. With that said, the profession will always progress onward, and now it is time to carve out a novel path for the profession.

FINAL REMARKS:

Massage therapy provides a safe space for people to discuss and receive care for their concerns. As a population that is often stigmatized for their pelvic health concerns, men would severely benefit from this. Massage therapy is non-invasive, provides pain relief and influences anxiety and depression, all of which, men living with persistent pelvic pain would benefit from. However, the profession needs to conquer their apprehension and hesitation around managing the entirety of pelvic health, including sexual health and men's health. Further education for RMTs is needed around navigating uncertainty in their practices. Finally, if massage therapists can provide care that suspends judgement and allows for greater inclusiveness and collaboration with people, they will be recognized for the important role they contribute. Massage therapy is set up for serving men living with persistent pelvic pain, but it is now up to the profession to enact it's potential.

AUTHOR BIO

Jocelyn Kirton has been an RMT since 2013. She has taken a special interest in treating patients with persistent pain, specifically in the abdominal and pelvic regions. Her treatment foundations are built around a neurocentric patient centred clinical reasoning framework. Her educational and practical experiences have given her the unique opportunity to incorporate her knowledge base allowing for a modern and evidence-based approach to persistent abdominal and pelvic pain.

Outside of her practice, Jocelyn wants to impact the Massage Therapy profession by educating RMTs on the positive impact the profession can have for people dealing with abdominal and pelvic pain. She is motivated for other health care professionals to recognize the benefit patients with pelvic pain would receive from seeing an RMT. In her opinion, it's time RMTs get comfortable as a profession in managing patients with abdominal and pelvic pain that is evidence based and safe.

For more information and course listings: https://pelvicrmt.com or @jocelynkirtonrmt on IG

REFERENCES

Anothaisintawee, T. (2011). Management of Chronic Prostatitis/ Chronic Pelvic Pain Syndrome. *JAMA*, 305(1), 78. https://doi.org/10.1001/jama.2010.1913

Aschka, C., Himmel, W., Ittner, E., & Kochen, M. M. (2001). Sexual Problems of Male Patients in Family Practice. *Journal of Family Practice*, 50(9), 773.

Bowen, D. K., Dielubanza, E., & Schaeffer, A. J. (2015). Chronic bacterial prostatitis and chronic pelvic pain syndrome. BMJ clinical evidence, 2015, 1802.

Brandt, C. (2021). Physiotherapy and pelvic floor health within a contemporary biopsychosocial model of care: From research to education and clinical practice. South African Journal of Physiotherapy, 77(1). https://doi.org/10.4102/sajp.v77i1.1538

Brünahl, C., Dybowski, C., Albrecht, R., Riegel, B., Höink, J., Fisch, M., & Löwe, B. (2017). Mental disorders in patients with chronic pelvic pain syndrome (CPPS). Journal of Psychosomatic Research, 98, 19–26. https://doi.org/10.1016/j.jpsychores.2017.04.011

Curran, N. (2008). Chronic Urogenital Pain in Men. Reviews in Pain, 2(2), 25–28. https://doi.org/10.1177/204946370800200207

Doiron, R. C., Shoskes, D. A., & Nickel, J. C. (2019). Male CP/CPPS: where do we stand? World Journal of Urology, 37(6), 1015–1022. https://doi.org/10.1007/s00345-019-02718-6

Dybowski, C., Löwe, B., & Brünahl, C. (2018). Predictors of pain, urinary symptoms and quality of life in patients with chronic pelvic pain syndrome (CPPS): A prospective 12-month follow-up study. Journal of Psychosomatic Research, 112, 99–106. https://doi.org/10.1016/j.jpsychores.2018.06.013

Kannan, V. D., & Veazie, P. J. (2014). Predictors of Avoiding Medical Care and Reasons for Avoidance Behavior. Medical Care, 52(4), 336–345. https://doi.org/10.1097/mlr.0000000000000100

Moyer, C. A., Rounds, J., & Hannum, J. W. (2004). A Meta-Analysis of Massage Therapy Research. Psychological Bulletin, 130(1), 3–18. https://doi.org/10.1037/0033-2909.130.1.3

Nickel J. C. (2000). A new era in prostatitis research begins. Reviews in urology, 2(1), 16–18.

Rees, J., Abrahams, M., Doble, A., & Cooper, A. (2015). Diagnosis and treatment of chronic bacterial prostatitis and chronic prostatitis/chronic pelvic pain syndrome: a consensus guideline. BJU International, 116(4), 509–525. https://doi.org/10.1111/bju.13101

Schaeffer, A. J., Landis, J. R., Knauss, J. S., Propert, K. J., Alexander, R. B., Litwin, M. S., Nickel, J. C., O'leary, M. P., Nadler, R. B., Pontari, M. A., Shoskes, D. A., Zeitlin, S. I., Fowler, J. E., Mazurick, C. A., Kishel, L., Kusek, J. W., & Nyberg, L. M. (2002). Demographic And Clinical Characteristics of Men With Chronic Prostatitis: The National Institutes of Health Chronic Prostatitis Cohort Study. Journal of Urology, 168(2), 593–598. https://doi.org/10.1016/s0022-5347(05)64686-1

Smith, PhD, J. M., Sullivan, PhD, S. J., & Baxter, DPhil, G. D. (2011). A Descriptive Study of the Practice Patterns of Massage New Zealand Massage Therapists. International Journal of Therapeutic Massage & Bodywork: Research, Education, & Practice, 4(1). https://doi.org/10.3822/ijtmb.v4i1.97

Velurajah, R., Brunckhorst, O., Waqar, M., McMullen, I., & Ahmed, K. (2021). Erectile dysfunction in patients with anxiety disorders: a systematic review. International Journal of Impotence Research. Published. https://doi.org/10.1038/s41443-020-00405-4

Wang, Y., Chen, C., Zhu, C., Chen, L., Han, Q., & Ye, H. (2016). Social Determinants of Chronic Prostatitis/Chronic Pelvic Pain Syndrome Related Lifestyle and Behaviors among Urban Men in China: A Case-Control Study. BioMed Research International, 2016, 1–7. https://doi.org/10.1155/2016/1687623

ERECTIONS: GUILTY UNLESS PROVEN INNOCENT

By Jocelyn Kirton, RMT

The topic of erections only came up in first term massage therapy college and was introduced as such: "Erections are a normal part of massage therapy." Then well-intended instructors contrasted that statement by sharing stories of times clients sexualized the treatment environment. This immediately left a poor impression of treating men. From then onward, I was on alert when a male came in for treatment. I would question every shift they made on the table, every deep breath during the treatment and if there was an erection present, I just ignored it and would be on even higher alert, anticipating something sexual to happen. Sound familiar?

A clinician's experiences and biases towards erections can sexualize the treatment environment when someone with a penis comes in for treatment. I was not aware of this until I took a course on sexual biases in health care. My experience with erections up until massage college was only in an intimate sexual setting with a partner. No wonder I would get annoyed or upset that someone had an erection during a treatment. This is a time I am not implying or offering a sexual encounter, and this is not someone who is my partner. The layer of potential threat becomes thicker with the stories those instructors shared or a personal experience of a client sexualizing the treatment environment. The alarms start going off and I would become anxious or uncomfortable. Anxiety is contagious. When anxious vibes get sent into the treatment environment, our clients can pick up on them. Perhaps they shift on the table, adjust their erection, or change their breathing to hide or dissipate it. However, being on high alert, those actions may appear to massage therapists like they are potentially sexualizing the treatment environment. Therefore, communication is so important in these instances. If massage therapists are not comfortable talking about erections, it is likely they will not follow up on client's actions or behaviors if the therapist is perceiving them as sexual. The client might just be trying to dissipate their erection to ease the therapist's obvious anxiety. Therefore, communication is key.

Erections are a normal part of receiving massage, but no one tells massage therapists or massage therapy students why, beyond "It's a normal neurophysiological process."

Massage therapy is known to affect the nervous system in helping facilitate the parasympathetic nervous system (PNS) to take over. When the PNS takes over, this is a good time for rest, digest, and sex. Have you ever had a client's stomach growl during a massage? Of course. Does this mean this person is going to whip out a sandwich and chow down mid treatment? No, because context matters. Their nervous system is getting their digestive system primed for food because the massage has facilitated PNS firing. Same with erections. The massage and the safe environment all play a role in the nervous system priming erectile tissues to get ready for sex. This does not mean someone has sexualized the treatment environment.

Their background processes are getting them ready just in case the opportunity presents itself. However, like the digestion example, it is the decisions and behavior of the person with the erection that determine if they have sexualized the treatment environment. This is a part of something called sexual intelligence; having the ability to understand when sexual advances or communication about sex is appropriate or warranted and when it is not. Therefore, we should not be making judgement calls or condemning a population of people with penises for sexualizing the treatment environment, based solely on the fact an erection is present.

It is important to normalize erections and talk about them before a treatment as part of the informed consent process. The "ignore it" method does not serve the safety of clients and therapists very well. What if the client is really uncomfortable with their erection during a treatment? Or having a difficult time understanding nervous system arousal and sexualization are two different occurrences that walk ***really*** close together. Think about my example above. My experience with erections prior to massage school was only in an intimate sexual encounter. What if that is the same for the individual in front of us? What if this person feels guilty for having an erection during a massage because of their views on sex and relationships? Perhaps they feel during the treatment that massage offers a level of intimacy only reserved for them and their partner. Do they know they can stop the massage if they need to? These are all topics men have brought to my attention of which I was not aware. I never thought about the emotional consequences of someone having an erection they perceive is elicited by someone other than their partner.

Therefore, talking about erections with clients is especially important for everyone's safety and comfortability. I have treated men who disclosed to me their long history of erectile difficulties, only to get an erection during the massage. It can be very confusing and make them appear like they were lying about their struggles and case history. Remember, Moyer et al. (2004) pointed out that massage has a positive effect on anxiety and depression and Velurajah et al. (2021) claimed anxiety and depression in men contribute to erectile difficulties. This is why discussing the physiology of an erection during the initial conversational part of the treatment process is vital in promoting safe spaces for everyone receiving care. Guilt, shame, and embarrassment can play into pelvic health problems. The last thing health care providers need to do is make someone feel guilty about a bodily function that is completely normal. Especially during an intervention that sets up someone's nervous system to have that response.

Here is my little blurb about erections during the informed consent process to clients: "***Erections are a normal physiological response to receiving massage therapy. This occurs because massage therapy helps facilitate your nervous system responsible for rest, digest, and sexual functions. However, just because this response happens does not mean I'm interpreting that as sexual in nature, but I will be checking in to see if you feel safe to continue treatment. If you don't feel comfortable continuing treatment, let me know you would like to stop the massage at any point in time. I'll then re-drape and leave the room.***" I make communicating a withdrawal of consent to treatment easy by giving them the phrasing or wording to opt out. The only time I do not address an erection during treatment is if they are asleep during the massage, which I will clarify with them during the consent process.

Communicating that you will be inquiring about their erection during the treatment also sets you up for safety. If someone has sexualized the treatment environment, I do not want to be in a position where I must wait for someone to behave inappropriately before I stop the treatment. When I ask "I noticed you have an erection. Do you feel safe to continue the massage or would you like to stop?" Their response is going to tell me if I need to stop treatment or not. If they get flustered and apologetic, I typically respond with, "No need to apologize, we discussed at the beginning how erections are a normal neurological response to massage therapy. I want to make sure you feel safe continuing the treatment and if you need a moment to adjust or if you would like to stop the massage." If they have sexualized the treatment environment, they will usually make a lewd comment of some kind, and then I end the treatment and discharge them in a follow up email. No guessing and no analyzing. This puts me in a better position to advocate for my client's safety, and my own.

Erections are a topic in massage therapy requiring more clarity in how to navigate. Normalizing them with education on why they occur during a massage, communicating with clients how erections are a normal part of receiving massage, erection check ins during treatment and the ability to recognize when a client has sexualized the treatment environment, are areas massage therapists need more confidence in. Clear communication around erections is the best way to promote safety within the treatment setting for our clients and for ourselves. Erections are a normal occurrence during massage interventions and need to be taught in a positive and productive manner.

REFERENCES

Moyer, C. A., Rounds, J., & Hannum, J. W. (2004). A meta-analysis of massage therapy research. *Psychological Bulletin*, 130(1), 3–18. https://doi.org/10.1037/0033-2909.130.1.3

Velurajah, R., Bruncкhorst, O., Waqar, M., McMullen, I., & Ahmed, K. (2021). Erectile dysfunction in patients with anxiety disorders: A systematic review. *International Journal of Impotence Research*. https://doi.org/10.1038/s41443-020-00405-4

SEEING MALE CLIENTS FOR WHO THEY ARE AND NOT WHAT THEY ARE

By Mark Gray (MTB, Hakomi Practitioner & Senior Trainer)

Writing a piece about our work with male clients is a challenge. Questions arise: What are the specific issues that so called typical male clients bring? How are these different from female clients? Should there be specific approaches for genders, or should our work be about the individual?

To start, it's important to look at the two people involved, you (therapist) and yes, you guessed it, your client.

Let's start with you—what bias do you bring to your work with male clients? Does being a male or female therapist affect things? This is probably the most important question.

As we grow up, we learn a system of values from the culture around us, which we use to evaluate the world and choose actions (Okumura 2012).

The important thing to understand about Okamura's statement above is that the evaluation and choosing he refers to are not happening at a conscious level, they are implicit beliefs. You are, it seems, a unique and not so unique mix of personal, familial, cultural, and pan-human influences, many of which are more or less hard-wired into your system.

So, can you trust your 'gut' feeling, your intuition? How do you know? What are you basing this on? It's unlikely that intuition comes from somewhere other than past experiences. Take a moment, think back on your life. Who were the key influences and how did you experience them? Are you sure that your perception and the conclusions that come from them are not based on your personal experience of the males in your world? Or indeed the experience of males that the other females in your life had. Yes, it's complicated!

What would happen if you simply let go of your first impressions? What would it take for you to become interested in your client's specific story, without judgment?

I'm not saying there are no "typical" male issues, just saying that it's probably better to meet the individual rather than the gender. Of course, this approach applies to more than gender, it applies to age, culture, ethnicity, religion, etc.

The therapeutic relationship is a two-way interaction. Your client will also have implicit (and possibly explicit) beliefs/ideas about you! How do you respond to his response to you?

So, a good question to ask yourself is how do you want to be seen? What are your strengths? What do you need to work on? All this is in relation to meeting this specific client for who they are.

It is also critical to realise that it is around these implicit beliefs that we organise our experience and that these beliefs/values are revealed through the way we express ourselves—our body language, the way we talk, facial expressions etc. The consequence of this for us as therapists is that the unintended expression of these beliefs may create a less than optimal therapeutic relationship and subsequently affect the outcome. Or their expression might create an optimal therapeutic relationship, one that deepens with each session.

At the end of the day, I prefer to see my clients for who they are and not what they are. I hope that I can see myself as a therapist beyond my own gender (while still accepting that I am operating from that place).

AUTHOR BIO

My bodywork journey started in 1991, with a 7-day introduction to Structural Integration at the Mana Retreat Centre in the Coromandel. I finished the 18 month Structural Integration training in 1993 and then headed off to Europe for a 6 month OE, I stayed for 22 years!

Based in London, I had a bodywork practice, got a Masters in Therapeutic Bodywork, became a certified Hakomi practitioner and trainer, and worked for 12 years at the University of Westminster's School of Life Sciences in London where I was the Programme Leader and Principal Lecturer on a BSc(Hons) in Neuromuscular Therapy.

In 2015 I returned to New Zealand and began teaching at the New Zealand College of Massage on their Level 6 and Level 7 programmes.

REFERENCES

Okumura, S. (2012). *Living By Vow: A Practical Introduction to Eight Essential Zen Chants and Texts.* Somerville MA: Wisdom Publications.

RECOMMENDED READING IF YOU WANT TO EXPLORE MORE

Duncan, B. L., Miller, S.D., Wampold, B.E. & Hubble, M.A. (Ed.). (2010). ***The Heart & Soul of Change: Delivering What Works in Therapy*** (Second ed.). Washington, DC: American Psychological Association.

Hubble, M. A., Duncan, B.L., & Miller S.D. (Ed.). (1999). ***The Heart & Soul of Change: What Works in Therapy.*** Washington, DC: American Psychological Association.

Kurtz, R., Martin, Donna., & Sparks, Flint. (2013). ***Loving Presence: A Practice for Life*** [e-book]. Retrieved from http://www.donnamartin.net/books

Rogers, C. R. (1961). ***On Becoming a Person: A Psychotherapists View of Psychotherapy.*** Houghton Mifflin.

Siegel, D. J. (2010). ***The Mindful Therapist: A Clinician's Guide to Mindsight and Neural Integration.*** London: W.W. Norton & Company Ltd.

EDITORS' NOTE: According to the Ministry of Health, the suicide rate for men in New Zealand is more than three times that for women. Suicide is now the leading cause of death for young men. One in eight men will experience depression. And men are far less likely to seek help, or even talk about how they are feeling. But sometimes, while lying on a massage table, when they are more relaxed, they might open up a little. As a massage therapist, providing counselling is out of your scope, but this article could help you understand how referring a client out for counselling or psychological help will benefit them.

MEN AND THERAPY: IT CAN AND DOES WORK WELL

By Mike McKinney, Clinical Psychologist

Let's be honest, one of the biggest challenges for guys and "doing therapy" is making the decision to go in the first place. Many men are sceptical that "talking about stuff" can be of benefit. In part, this is due to learning experiences that may have promoted the message that men cope and just get on with things. This can make it hard to consider that psychological health is relevant and that very idea may bring up a clash with some of the masculinity scripts identified with here in New Zealand. These include the belief that men are meant to tough things out, not seek help and never show that they are struggling – for these are surely signs of "weakness".

There is some truth that women have an advantage over men in terms of their comfort with verbal communication and that they are more practised at talking about personal stuff. However, this just means that the genders may enter the therapeutic setting on a different footing. There is no evidence to show that they will leave therapy with different outcomes and that only women will benefit. The issue isn't that men can't talk about challenges and problems; it's just that they aren't so used to it, i.e. it's more of a familiarity issue rather than being about ability. Similarly, clinical experience shows that, if the therapist uses mutually understandable language and terms, men can communicate confidently and knowledgably about personal issues.

It can be helpful to understand that talking issues over with a therapist is not about handing over power or control. Good therapy is about working together to make sense of challenges and then generating options for addressing these. Sometimes it is an unfounded worry about being embarrassed or not being in control that can be the barrier to making contact. There can also be concerns around issues of status and fears about not being viewed as good enough. For example, being in a managerial position may come with some pressures (real or imagined) to always be in control and

able to deal with situations. It is important to realise that mental health issues/challenges and life problems are not limited to one "type" of man. There are plenty of top sportsmen that work regularly with psychologists to enhance their understanding of themselves and how they can better respond to challenging situations. Additionally, there are men in senior positions in large companies that have experienced anxiety, depression, challenges with stress or difficulties with burnout. I can assure you that none of these guys got to the top by being incapable, weak or unable to cope.

One of the realities of men and psychological help-seeking is that they often make contact as a result of external factors/forces. This may be due to the fact things are falling apart at work and the boss suggests seeking some help, or it (more usually) is due to partners encouraging their menfolk to get "some help". This fits with the general male approach to health and wellbeing – keep going till the wheels fall off. Perhaps adopting more of a preventive maintenance approach may be of greater help? Just as a regular tune up or oil change for the car or motorbike helps performance and promotes long-term reliability, the same may be true for men. By adopting this preventive maintenance approach, they may be able to identify ways to address problems and challenges before they become overwhelming and have a negative impact on more areas of their life.

It's not just the talking bit that brings about change. It's about working collaboratively with another (objective) person to figure out why the issues are happening and then what the options are to bring about a positive change. By being open to this, men will find that they can have more meaningful engagement and levels of achievement in important areas of their life. This can be around learning how to maximise your performance on the sporting field or in the work place. It can be about learning how to deal with issues such as depression and anxiety or working through challenges within relationships. All of these areas have the potential to enhance one's sense of personal control, help to achieve aims and also enhance quality of life. Not bad outcomes from taking the risk of talking to someone huh?

AUTHOR BIO

Mike McKinney is a Registered Clinical Psychologist with 28 years' experience. Over this time, he has worked in mental health and physical health settings in both the public and private domains. He has worked with a wide range of clients over the years presenting with issues including: depression, anxiety, adjustment issues, persistent pain, chronic health conditions, stress management, problem solving, as well as challenges within their career/work setting. Mike is the author of "All or Nothing: Bringing balance to the achievement-oriented personality" (Exisle Publishing) and he has recently submitted his second book for publication, on learning to manage uncertainty. Mike runs PsycInsight, a private psychology practice in Christchurch, https://www.psycinsight.co.nz/

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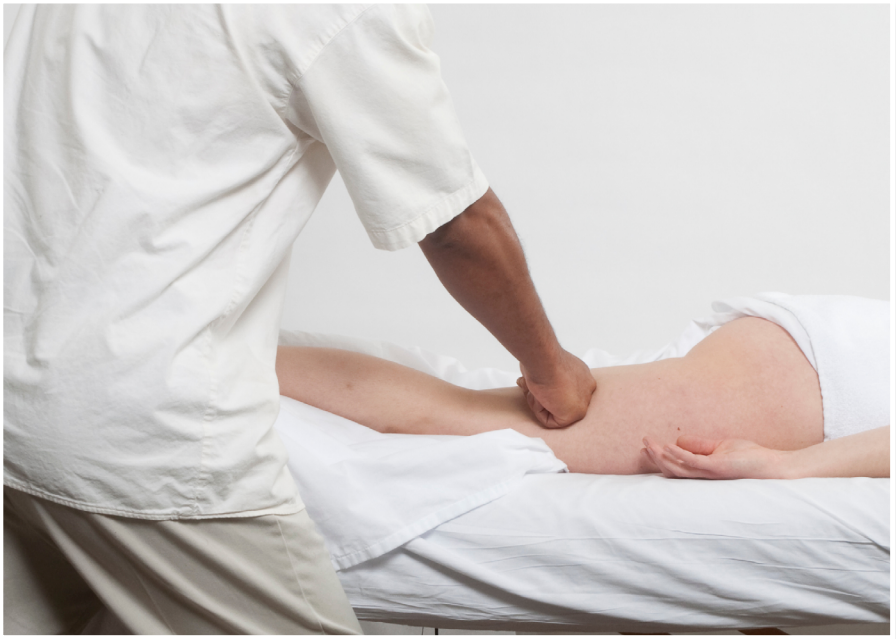
For the purposes of this article, when we use the term "male" we are referring to cis male, someone who was assigned male at birth and identifies as male. The issues in this article could also apply to trans women or trans men. We recognize that gender is a social construct. We also understand there is a great deal of discrimination faced by the gender minority community, which we would like to cover in a future issue.

MALE MASSAGE THERAPISTS AND GENDER-BASED DISCRIMINATION

By Rachel Ah Kit, RMT



In an industry dominated by women, are we surprised that gender-based discrimination could be reversed in massage therapy? Does this discrimination even occur in the New Zealand massage therapy industry? What does that look like? What can we do about it? This article investigates what little literature is available on the subject, and asks practicing therapists and clinic owners, both here and abroad, for their thoughts and experiences.

While there is a reasonable collection of literature related to gender-based discrimination in other professions, such as nursing and teaching, there is little related to massage therapy. On a positive note, one such study was actually undertaken by a massage therapy student at the Southern Institute of Technology (SIT). He investigated advantages and disadvantages faced by male therapists (MTs) in Southland. This study, while small, determined that although there was a perceived strength advantage for male MTs, there were several issues creating stigma and discrimination against them (O'Kane & Smith, 2014). Publicity relating to a small number of cases of inappropriate touching or sexual assaults by male therapists, homophobic beliefs, and body image issues amongst women clients could all negatively affect the perception of male MTs. O'Kane and Smith (2014) did however conclude these issues had minimal effect on the overall success of male MTs.

Another study by Baskwill and Vanstone (2017) asked male MTs for their experiences of gender in their professional lives. While the researchers found safety to be an issue too, the study also confirmed the belief that female MTs are more caring, empathetic, and nurturing than male MTs. This gender stereotype is often associated with nursing and teaching professions. Smith et al. (2009) also established comfort, contact, connection and caring as modulators in the culture of massage therapy when they explored attributes of the therapeutic encounter. These elements are stereotypically perceived as feminine traits, influencing the work roles and therefore professions deemed to be "suitable" for males – a wholly societal and cultural constraint (McDowell, 2015).

Moyer and Rounds (2009) also found that male clients had a very strong preference for female MTs and reported very low comfort receiving massage from a male MT. They felt this was probably a reflection of homophobia and "socially reinforced roles related to touching" (p31), and again the role of sexuality in the massage therapy profession comes into play. There is a long history of massage therapy being linked with the sex industry; a connection that massage associations all over the world have worked hard to break and continue to do so to this day. A recent

study by Munk et al. (2020), demonstrated a significantly strong preference for female MTs by both male and female clients, indicating there is indeed bias against male MTs.

Massage therapy is usually conducted in a private setting, a closed room, with the client mostly unclothed, covered only by a sheet or towel. There is touch that be quite intimate for both female and male clients. This environment, combined with historical links between massage and sexual services, can create a perception, in some clients, of a high-risk of inappropriate touch or assault. The reality is quite different, with very few reported cases of inappropriate touching or assault in New Zealand. We analysed data associated with complaints made to Massage New Zealand, including enquiries made by the NZ Police related to complaints made with them; these comprised both members and non-members. Of all complaints and enquiries since 2016 (41), there were nine related to inappropriate touching or assault, of which three were identified as male MTs. We also looked into complaints and decisions made by the Health & Disability Commissioner involving MTs. There were 11 complaints made between 2000 and 2020 and nine of these concerned male MTs. Seven complaints related to perceived or actual inappropriate touch and/or a lack of or inadequate informed consent (Health & Disability Commissioner, 2021). While there will be instances of assault which have gone unreported, the number of reported incidents is low. Despite the number being low, mainstream media often publish these incidents and it is easy to see how the perception of risk can become widespread. A comment made by the Health & Disability Commissioner for a decision made in 2005 stated that "...some of the massage clinics in New Zealand have not necessarily followed correct and professional procedures and this has lead to a downfall in the acceptance by the public of massage as a professional modality."

Interestingly, research into the effects of both client and therapist gender on the outcomes of massage therapy, showed "improvements were experienced equally among the male and female clients, and obtained equally from the male and female massage therapists." (Smith et al., 2012, p. 201). This study did not look at client beliefs regarding gender before receiving massage, so there is no way of knowing if their beliefs influenced outcomes, but any beliefs participants held did not result in a negative outcome. However, given participants received massage in a research setting they may have felt safer, and it could be that was enough to override any gender-based beliefs.

Male therapists in New Zealand comprise approximately 16% of the industry according to Figure NZ Trust (2021), which bases their data on the 2018 Census. Current membership data for Massage New Zealand (MNZ) indicates that only 12% of current members are male, indicating that a higher proportion of male MTs in the country are opting not to join. MNZ endeavours to ensure members maintain high standards of care and

professionalism, which in turn provide the public with a sense of safety; surely it would make sense for male MTs to be members as this would signal to potential clients they are in safer hands.

We asked five male massage therapists, based here and in North America, for their experiences. All five therapists are trained to at least Level 6, or the equivalent of, and each are registered with their state or national governing body. Here is a snapshot of their experiences:

- Each of them had experienced multiple occasions where clients (mostly female, but occasionally male) had specifically requested a female MT
- Each had experienced clients opting NOT to book in because the MT was male
- One MT recalled having a client walk out once she realised, she'd been booked with a male
- One had been "hit on" by clients of both genders
- One MT had male clients refusing treatment because they weren't "...gay, I'm not getting treated by a dude."
- One MT reported receiving derogatory comments from female MTs, claiming "being a male therapist was the only reason I was hired"
- One MT described an interaction with a clinic owner who claimed that while she felt he was a perfect fit for her clinic, she had a "policy of not hiring male MTs"

Three of the MTs believed that some female clients were simply "more comfortable" with a female MT, indicating they accept that gender does play a role in client perception and did not feel this choice was discrimination. But when all male

MTs are excluded by some clients, rather than being judged on individual merit, that is discrimination. In most cases, that "comfort" is borne out by the preconceived idea that being treated by a male MT is somehow dangerous, however given the fact most physical and sexual assaults against females are committed by men (World Health Organization, 2021), it is not hard to see where the belief stems from.

For clients, both female and male, who have personally experienced assault at the hands of a male aggressor at some time in their lives, the perceived risk involved in receiving massage therapy from a male MT will be exponentially higher. It is understandable there would be hesitation from clients to make themselves vulnerable to a male MT. However, in the right setting, possibly under supervision, trauma-informed massage therapy can play an important role in recovery from sexual abuse (Benjamin, 1995; Campbell, 2015) by providing clients with nurturing, non-sexual touch in a safe environment. Baskwill and Vanstone (2017) also noted there was a potential role for "caring masculinity through MT" (p4), providing the opportunity for female clients to receive "non-sexual, nurturing, comforting touch" (p4). Appropriate touch in the massage therapy context was also valued for "its contribution to an effective outcome as well as for enjoyment" (Smith et al., 2009, p. 184).

Each of the therapists we spoke to went on to explain that while these cases impacted them early in their career, they have all gone on to establish successful practices. This also supports what O'Kane and Smith (2014) concluded.

None of the therapists we questioned felt that discrimination was really covered in their training. Most were simply told that "being male was going to make it more difficult, and that is how things are," that it "wasn't fair, but that was reality" and even that "males have it good everywhere else, so we may as well have it bad here." So, it seems that gender-based discrimination against male MTs is generally accepted.

Massage clinic owners also have a part to play in this, as seen by the example above, when one stated she would not hire a male MT. Discriminatory employment practices were commonly experienced by participants in the study by Baskwill and Vanstone (2017), but were not reported to authorities as participants felt it was a systemic issue that was too large to fight. One New Zealand clinic owner we asked stated "I've tried to position our clinic as 'qualified, registered, professional' and feel that the more clinical setting helps people feel more secure if they find themselves out of their comfort zone" and has always hired male MTs based on their merit and work ethic. This clinic owner also maintains that the clinic embraces diversity or age, ethnicity, and gender and that being a well-established brand, with a well-defined "clinical space" has helped overcome the gender-issues. Supporting new male MTs and allaying fears with prospective new clients, are important to ensure those MTs can establish themselves in the industry.

What else can male MTs do to help themselves if they encounter discrimination? There are several massage industry magazine articles dedicated to this topic (Ames, 2016; Cutler, 2013; Osborn, 2016), with many themes in common. These articles, along with recommendations from the study by Baskwill and Vanstone (2017) could help males MTs succeed. As a male MT, you might like to assess if you could improve any of your current practices by considering the following:

- Be clear how you communicate your treatment plan; be specific about which areas you will work, especially if you plan to treat areas such as the chest, abdomen, buttocks, and inner or upper thighs. This is where the client could misunderstand your intentions if they are not certain of what you are doing
- Be VERY clear about gaining informed consent from the client before working any of the aforementioned areas, and always encourage them to speak up if they feel uncomfortable
- Take care with appearance – both your own and that of your clinic space, ensuring both are professional and trustworthy
- Maintain good draping techniques and communicate with the client about when you are moving the draping. If you are not confident with draping work working certain areas, seek help from others in your area. Inadequate or inappropriate draping can result in the client, especially female, feeling vulnerable and uncertain.
- Consider the messages in your marketing. Ensure your website content, especially the images you choose, and social media posts will always be viewed as professional and safe. There can be no ambiguity
- In the initial stages of a new client-therapist relationship, think about ways you can minimize risk and increase their feelings of safety and comfort. It may not be possible to avoid the areas mentioned above, so perhaps use techniques where you work through the sheet. Once you have established the relationship more and they are comfortable with you, introduce skin contact in those more vulnerable areas
- Use testimonials from both male and female clients to further strengthen the perception of your practice being a safe space, with clear professional boundaries
- Reflect on your level of compassion towards your clients. Even the hardiest of athletes would appreciate
- Should you ever have feelings of attraction towards a female client, "think of her as your sister and get yourself back into your mind, not your hormones. Your job is not to exploit vulnerability, because it's not

kind or loving" (Osborn, 2016)
- Any time someone outside the massage industry makes comments which sexualize the profession, use it as "an opportunity to teach and help them understand the professionalism of our business" (Osborn, 2016)

While there is some research and anecdotal evidence to indicate gender-based discrimination does exist, it seems to be largely perception-based. Many of the concerns clients have, particularly female, regarding male MTs seem to be related to societal expectations and beliefs related to sexualization of the industry. While a small number of female clients will have legitimate reasons for not choosing a male MT, such as a previous history of assault, evidence supports the idea that gender does not affect the outcome of massage therapy.

As an industry: therapists, clinic owners and training institutes, we need to work together to ensure that ALL therapists, male and female have equal opportunities. This will require more widespread education regarding the professionalism and the safety, comfort, and nurturing touch that clients can expect from of male massage therapists.

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AUTHOR BIO

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REFERENCES

Ames, M. (2016). How to succeed as a male massage therapist. *Massage Magazine*, 2021(14/9/2021). https://www.massagemag.com/how-to-succeed-as-a-male-massage-therapist-2-40856/

Baskwill, A., & Vanstone, M. (2017, Nov 17). "Just don't be creepy": A phenomenological study of the experiences of men in massage therapy. *J Complement Integr Med*, 15(1). https://doi.org/10.1515/jcim-2017-0075

Benjamin, B. (1995). Massage and bodywork with survivors of abuse. *Massage Therapy Journal*, 12(15).

Campbell, D. (2015). *The effect of trauma-informed massage therapy on the long-term negative consequences of childhood sexual assault in males* [Doctoral, dissertation, Acadia University].

Cutler, N. (2013). *Males Massage Therapist Bias*. Institute for Integrative Healthcare. Retrieved 14/9/2021 from https://www.integrativehealthcare.org/mt/male-massage-therapist-bias/

Figure NZ Trust. (2021). *Massage therapists in New Zealand*. Retrieved 24/9/2021 from https://figure.nz/chart/JXuIJCTLca48B3FR

Health & Disability Commissioner. (2021). *Decisions*. Retrieved 22 Oct 2021 from https://www.hdc.org.nz/decisions/search-decisions/?keywords=&filterType=1&filter=%7B%22Occupations%22%3A%5B%22Massage%20Therapist%22%5D%2C%22Rights%22%3A%5B%5D%2C%22GroupProviders%22%3A%5B%5D%2C%22Page%22%3A1%2C%22Keywords%22%3A%22%22%7D

McDowell, J. (2015). Masculinity and Non-Traditional Occupations: Men's Talk in Women's Work. *Gender, Work & Organization*, 22(3), 273-291. https://doi.org/10.1111/gwao.12078

Moyer, C. A., & Rounds, J. (2009, Jan). The attitudes toward massage (ATOM) scale: reliability, validity, and associated findings. *Journal of Bodywork and Movement Therapies*, 13(1), 22-33. https://doi.org/10.1016/j.jbmt.2008.01.002

Munk, N., Church, A., Nemati, D., Zabel, S., & Comer, A. R. (2020, Jul 8). Massage perceptions and attitudes of undergraduate pre-professional health sciences students: a cross-sectional survey in one U.S. university. *BMC Complement Med Ther*, 20(1), 213. https://doi.org/10.1186/s12906-020-03002-6

O'Kane, P., & Smith, J. (2014). *Do males have advantages or disadvantages in the massage therapy industry? - Southland male practitioners' perspectives* [Poster presentation],

Osborn, K. (2016). *Gender in the Profession: Massage from Mars or Venus?* MassageTherapy.com. Retrieved 14/9/2021 from https://www.massagetherapy.com/articles/gender-profession

Smith, J. M., Sullivan, S. J., & Baxter, G. D. (2009, Aug). The culture of massage therapy: valued elements and the role of comfort, contact, connection and caring. *Complementary Therapies in Medicine*, 17(4), 181-189. https://doi.org/10.1016/j.ctim.2009.05.003

Smith, T. E., Valentine, P., & Tyer, B. A. (2012). Gender effects in massage therapy. *Journal of Alternative Medicine Research*, 4(2), 201-206.

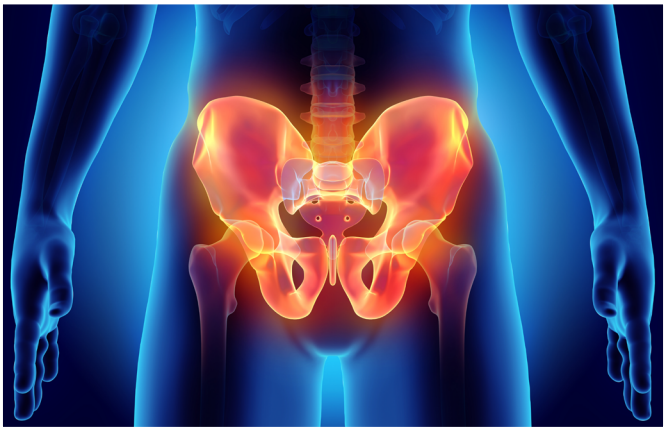
World Health Organization. (2021). *Violence against women*. Retrieved 22 Oct 2021 from https://www.who.int/news-room/fact-sheets/detail/violence-against-women

ANATOMY & PHYSIOLOGY

CHRONIC NON-BACTERIAL PROSTATITIS AND CHRONIC PELVIC PAIN SYNDROME

By Becky Littlewood, RMT

WHAT IS IT

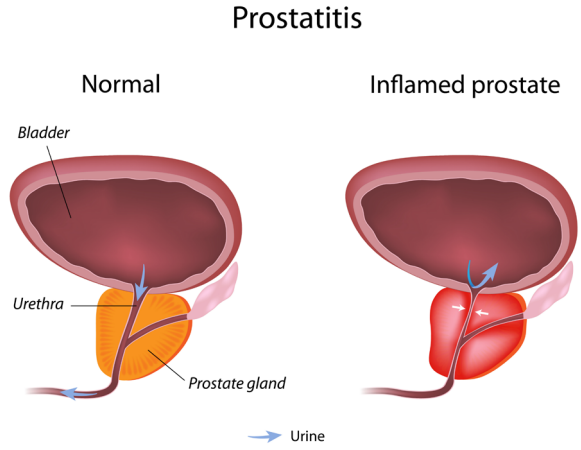


Chronic non-bacterial prostatitis (CP) and chronic pelvic pain syndrome (CPPS) are conditions with heterogeneous sets of symptoms that cause considerable pain and discomfort in the pelvis, perineum and genitals, as well as contributing to pain on urination and ejaculation, and lasting more than 3-6 months (Mehta et al., 2013, Breser et al., 2017). Whilst CPPS can also impact women, this article will focus on CPPS in the male population.

There are four different types of prostatitis; type I (acute bacterial prostatitis), type II (chronic bacterial prostatitis), type III (chronic non-bacterial/chronic pelvic pain syndrome) and type IV (asymptomatic inflammatory) (Nursing Times, 2017).

CP and CPPS can be broken down into two subtypes:

- Subtype (a) - Inflammatory chronic prostatitis/chronic pelvic pain syndrome is associated with leukocytes in the expressed prostatic fluid, post-prostate massage urine or seminal fluid.
- Subtype (b) - Non-inflammatory chronic prostatitis/chronic pelvic pain syndrome with no evidence of urogenital inflammation.



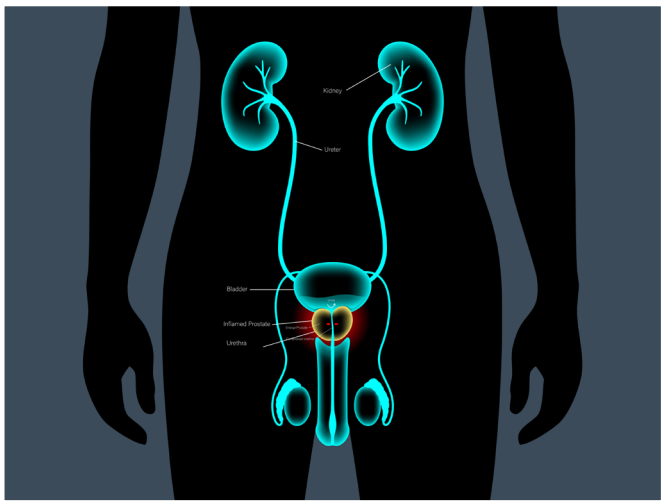
Both CPPS and CP can greatly impair quality of life (QoL) and treatment can be difficult to determine and lengthy, due to the many differential diagnoses that mimic CP/CPPS (Physiopedia, n.d.). It is thought that chronic inflammation correlates with these conditions and that a history of CP may lead to prostate cancer (Magri, et al., 2019). CPPS and CP are categorised by the National Institute of Health (NIH) as the same condition (Polackwich & Shoskes, 2016).

AETIOLOGY

Zhang et al., (2020) state that the aetiology and pathophysiology of CP/CPPS are not clear and the percentage of men impacted is variable. They state that different countries report different rates, spanning 8.4% to 25%, and that there is a lack of large scale, evidence-based research into the long-term effects of medical intervention for this condition. They go on to say that the current National Institute of Health definition of CP/CPPS, from 1999, is the presence of leukocytes in prostatic and seminal fluids, and urine after prostatic massage. However, they also

note that CP/CPPS have diverse presentations and it has been found that some groups of patients have symptoms that are not supported by laboratory evidence (leukocytes in urine and seminal fluids), and some that present with laboratory evidence whose symptoms have not been alleviated with associated targeted medical intervention.

One line of research proposes that several inflammatory mechanisms combine to create a chronic recruitment of leukocytes contributing to a 'neural sensitivity' around the prostate, leading to the establishment of CP/CPPS (Breser et al., 2017).



Research shows that CP/CPPS is best considered as a set of symptoms rather than a pathology, and that addressing it through a biopsychosocial lens will have a better outcome (Zhang et al., 2020, Huang, et al., 2020). According to Huang et al. (2020) there is a high level of pain catastrophising associated with CP/CPPS, 24.83%, estimated by the pain catastrophizing scale (PCS). They state that a high PCS score correlates with higher UPOINT score (Bryk & Shoskes, 2021) (see symptoms section) and that pain catastrophising includes rumination, magnifying and helplessness, leading to worsening urinary function and QoL.

They note that improving the understanding and awareness of psychological states in men impacted by CP/CPPS and the diversity of symptoms is considered paramount to improving outcomes.

Pain presentation can differ between people, and this contributes to the delay in diagnosis and treatment (Polackwich & Shoskes, 2016).

Some theories being used to explain the onset of symptoms are as follows (Mehta et al., 2013):

- genitourinary tract infections
- idiopathic neuralgia
- abnormal pelvic floor muscle tone
- psychological stress
- genetic polymorphisms affecting signalling via the androgen receptor

In a 2016 sexual medicine review, Cohen (2016) states that shortening of the levator ani (pelvic floor muscles made up of pubococcygeus, puborectalis and iliococcygeus) and hip external rotators are possible contributors to the pathophysiology of CP/CPPS. He goes on to say that pelvic floor muscle spasm and tension impact men with CP/CPPS and data shows that there is a 50% increased likelihood of spasm and tension in men impacted by CP/CPPS than in men who have no symptoms of CP/CPPS. In addition, Cohen states that research has found that tenderness of the pelvic floor muscles, psoas and adductors exist in men with CP/CPPS as well as poor function of the pelvic floor muscles. The implication being that pelvic pain may be due to dysregulation of the pelvic floor muscles, suggesting a central nervous system component.

EPIDEMIOLOGY

Prostatitis, in all its forms, effects millions of men globally (Cohen et al., 2016; Krieger, et al., 2008). Males who have experienced one episode of prostatitis have an increased likelihood of subsequent episodes; 20% in males age 40, 38% in males aged 60, and 50% in males aged 80 years old (Krieger, et al., 2008). CP/CPPS are the most common presentations of prostatitis (Smith, 2016). A lack of understanding of the mechanism of CP/CPPS, and the contribution of genetics, culture and ethnicity, education, nutrition, health status and current psychosocial status all impact the prevalence of CP/CPPS globally and create barriers to treatment (Zhang, 2020).

SYMPTOMS

The UPOINT system is used to determine the clinical symptoms in those with CP/CPPS, and to assist in choice of therapeutic intervention. This system points to 'urinary, psychosocial, organ specific, infection, neurologic/systemic, and tenderness of skeletal muscle (UPOINT)' (Smith, 2016). However, a 2015 meta-analysis shows that sexual dysfunction (premature and painful ejaculation, erectile dysfunction, low libido) is high among men with CP/CPPS and this symptom is not currently part of the UPOINT system (Li & Kang, 2016, NHS UK).

To assess the severity of symptoms in men with CP/CPPS, the NIH-Chronic Prostatitis Symptom Index (NIH-CPSI) is used. This questionnaire contains 13 items and scores range from 0-43. It covers pain, urinary symptoms and QoL (Clemens, et al., 2009). Men experiencing CP/CPPS measured the same level of scores in the Sickness Impact Profile as those impacted by conditions such as 'myocardial infarction, angina, and Crohn disease' (Cohen et al., 2016).

Symptoms present as follows (Strauss & Dimitrakov, 2010):

- Perineum pain
- Scrotal pain
- Rectal pain
- Testicular pain
- Pain in the penis

- Lower back pain
- Urethral pain
- Inflammation of the prostate
- Voiding and sexual dysfunction
- Urinary frequency

TREATMENT OPTIONS

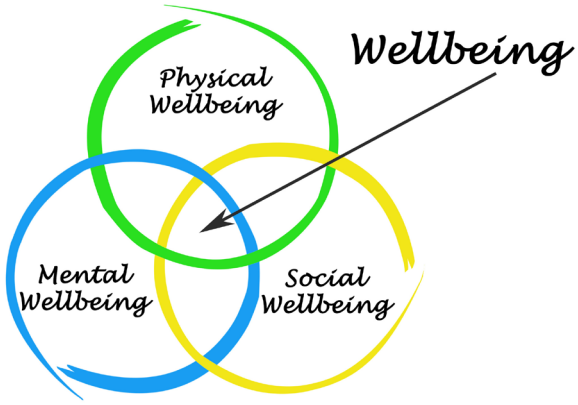
Men presenting with CP/CPPS symptoms are generally treated with the three 'A's': antibiotics (when infection is present), anti-inflammatories (to counteract inflammation) and alpha-blockers (for treatment of lower urinary tract symptoms). Neuromodulators such as gabapentin and amitriptyline are used to treat neuropathic pain and recent research shows benefits when interstitial cystitis, painful bladder syndrome and idiopathic pelvic pain symptoms are concomitant with CP/CPPS (Polackwich & Shoskes, 2016). However, as CP/CPPS are commonly not associated with infection, there is a move away from automatic prescribing of antibiotics and a move towards different treatment options (Strauss & Dimitrakov, 2010).

In 2013, research into low-intensity pulsed ultrasound (LIPUS) was shown to effect change in CP/CPPS due to its ability to transfer energy into tissues, creating a vibration at the molecular level and inducing biological change. Results showed a highly effective treatment via transperineal ultrasonic therapy (Lin et al., 2016).

Cohen et al. (2016) state that pelvic floor dysfunction has been shown to be significantly involved in the pain presentation of men with CP/CPPS, and that neuromuscular re-education of the levator ani is beneficial in treating this condition due to the chronic tension and muscle spasms attendant in the pelvic floor of effected men. Their research demonstrates that neuromuscular re-education with a trained facilitator of this method has been shown to reduce the overall score and pain ratings on the NIH-CPSI. Equally, they state that soft-tissue dysfunction by way of tenderness on palpation of the psoas, adductors and pelvic floor is common in men with CP/CPPS.

The Stanford Protocol for male chronic pelvic pain was developed by Anderson et al. (2005) which specifically utilised 'myofascial trigger point therapy and paradoxical training therapy' (pp 30-31). The protocol was put together by a urologist, physiotherapist and psychologist, using a combination of 'myofascial muscular release therapy and cognitive behaviour paradoxical relaxation therapy' (pp 30-31). Weekly pelvic floor physiotherapy sessions alongside a weekly home based, audio-guided relaxation practice were given and more than half of participants reported a 50% improvement in symptoms.

CBT has been shown to improve outcomes due to the high level of depression, somatisation and life-stress involved in CP/CPPS (Polackwich & Shoskes, 2016). Self-efficacy has been shown to improve outcomes for men when they have the education and the tools to dampen down pain flares (pain science education, stress reduction, breathing, self-massage) for more information see the following website www.thepelvicpainclinic.co.uk



MASSAGE THERAPY IMPLICATIONS

It is important for massage therapists to have an understanding of this condition. As seen above, it impacts many men, and specific symptoms may drive people to seek massage (low back pain). It is known that within a biopsychosocial framework, social support plays an important role in management and recovery of illness. Massage therapists are well placed to offer social support to men experiencing this condition.

Through the nurturing touch provided by massage, the parasympathetic nervous system response can be activated, helping to alleviate stress, and improve QoL.

Alongside manual therapy to the pelvic floor, performed by pelvic health physiotherapists, remedial massage therapists can reduce tenderness on palpation of the psoas, adductors, and obturator internus as noted by Cohen et al. (2016), using a variety of soft tissue techniques, such as neuromuscular therapy, muscle energy and myofascial techniques, and dermoneuromodulation. Teaching relaxation and breathing techniques designed to relax pelvic floor muscles and dial-down the nervous system will also be beneficial.

Working through a pain-science and evidence-informed lens will enable massage therapists to discuss the impact of catastrophising, rumination, magnifying and helplessness on the severity and amplification of symptoms.

Having a good referral network of clinicians that can help with the various symptoms of this condition will be beneficial e.g. pelvic health physiotherapists, mental health support and GPs who are up-to-date with current research in treating this condition.

Sharing resources, including support groups that provide both positive and informative discussion, will be beneficial to provide social support.

More than anything, providing a safe space where male clients can freely talk about their symptoms will help them to feel less alone, less afraid and less ashamed, three attendant psychological aspects to CP/CPPS that impact many who have these conditions

REFERENCES

Anderson, R. U., Wise, D., Sawyer, T., & Chan, C. (2005). Integration of myofascial trigger point release and paradoxical relaxation training treatment of chronic pelvic pain in men. Journal of Urology, 174(1), 155–160. https://doi.org/10.1097/01.ju.0000161609.31185.d5

Breser, M.L., Salazar, F.C., Rivero, V.E., Motrich, R.D. (2017). Immunological mechanisms underlying chronic pelvic pain and prostate inflammation in chronic pelvic pain syndrome. Frontiers in Immunology, https://doi.org/10.3389/fimmu.2017.00898

Bryk, D. J., & Shoskes, D. A. (2021). Using the UPOINT system to manage men with chronic pelvic pain syndrome. Arab Journal of Urology, 19(3), 387–393. https://doi.org/10.1080/2090598X.2021.1955546

Clemens, J. Q., Calhoun, E. A., Litwin, M. S., McNaughton-Collins, M., Dunn, R. L., Crowley, E. M., & Landis, J. R. (2009). Rescoring the NIH chronic prostatitis symptom index: nothing new. Prostate Cancer and Prostatic Diseases, 12(3), 285–287. https://doi.org/10.1038/pcan.2009.22

Cohen, D., Gonzalez, J., Goldstein, I., (2016). The role of pelvic floor muscles in male sexual dysfunction and pelvic pain. Sexual Medicine Reviews. 4(1), 53-62. https://doi.org/10.1016/j.sxmr.2015.10.001

Chronic pelvic pain and prostatitis: symptoms, diagnosis and treatment. (2017). Nursing Times (online). https://www.nursingtimes.net/clinical-archive/pain-management/chronic-pelvic-pain-and-prostatitis-symptoms-diagnosis-and-treatment-18-04-2017/

Chronic pelvic pain syndrome. (2021). https://www.physio-pedia.com/Chronic_Pelvic_Pain_Syndrome_-_Male#cite_note-7

Huang, X., Qin, Z., Cui, H., Chen, J., Liu, T., Zhu, Y., & Yuan, S. (2020). Psychological factors and pain catastrophizing in men with chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS): A meta-analysis. Translational Andrology and Urology, 9(2), 485–493. https://doi.org/10.21037/tau.2020.01.25

Krieger, J. N., Lee, S. W., Jeon, J., Cheah, P. Y., Liong, M. L., & Riley, D. E. (2008). Epidemiology of prostatitis. International Journal of Antimicrobial Agents, 31Suppl 1(Suppl 1), S85–S90. https://doi.org/10.1016/j.ijantimicag.2007.08.028

Li, H.J., & Kang, D.Y. (2016). Prevalence of sexual dysfunction in men with chronic prostatitis/chronic pelvic pain syndrome: a meta-analysis. World Journal Urology 34, 1009–1017. https://doi.org/10.1007/s00345-015-1720-3

Lin, G., Reed-Maldonado, A.B., Lin, M., Xin, Z., & Lue, T.F. (2016). Review: Effects and mechanisms of low-intensity pulsed ultrasound for chronic prostatitis and chronic pelvic pain syndrome. International Journal of Molecular Sciences. 17, 1057.

Magri, V., Boltri, M., Cai, T., Colombo, R., Cuzzocrea, S., De Visschere, P., Giuberti, R., Granatieri, C. M., Latino, M. A., Larganà, G., Leli, C., Maierna, G., Marchese, V., Massa, E., Matteelli, A., Montanari, E., Morgia, G., Naber, K. G., Papadouli, V., Perletti, G., … Wagenlehner, F. (2019). Multidisciplinary approach to prostatitis. Archivio italiano di urologia, andrologia : organo ufficiale [di] Societa italiana di ecografia urologica e nefrologica, 90(4), 227–248. https://doi.org/10.4081/aiua.2018.4.227

Male sexual problems. (2019). National Health Service. https://www.nhs.uk/live-well/sexual-health/male-sexual-problems

Mehta, A., Stember, D.S., O'Brien, K., Mulhall, J.P., (2013). Defining the aetiology of erectile dysfunction in men with chronic pelvic pain syndrome. Andrology, 1(3), 483-486 https://doi.org/10.1111/j.2047-2927.2013.00066.x

Polackwich, A., Shoskes, D. (2016). Chronic prostatitis/chronic pelvic pain syndrome: a review of evaluation and therapy. Prostate Cancer Prostatic Diseases, 19, 132–138. https://doi.org/10.1038/pcan.2016.8

Smith C. P. (2016). Male chronic pelvic pain: An update. Indian Journal of Urology, 32(1), 34–39. https://doi.org/10.4103/0970-1591.173105

Strauss, A. C., & Dimitrakov, J. D. (2010). New treatments for chronic prostatitis/chronic pelvic pain syndrome. Nature Reviews Urology, 7(3), 127–135. https://doi.org/10.1038/nrurol.2010.4

Zhang, J., Liang, C., Shang, X., & Li, H. (2020). Chronic prostatitis/chronic pelvic pain syndrome: A disease or symptom? Current perspectives on diagnosis, treatment, and prognosis. American Journal of Men's Health, 14(1), 155798832090320. https://doi.org/10.1177/1557988320903200

AUTHOR BIO

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

HOW TO GAIN YOUR MASSAGE DEGREE THROUGH SIT BLENDED DELIVERY

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

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

BECKY LITTLEWOOD – BTSM GRADUATE

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

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

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

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

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

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

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

SIT ZERO FEES SCHEME

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

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

BLENDED DELIVERY

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

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

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

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

NZ's First Massage Therapy Degree and Research Centre

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

SIT established The NZ Massage Therapy Research Centre (NZMTRC)

in 2009, to foster massage therapy research in New Zealand. The NZMTRC aims to promote research and teaching across the wider massage community and provide access to New Zealand-based research findings.

The body of work after 20 years - from research conducted by SIT massage therapy staff and students - has resulted in: 2 PhD theses, around 12 publications in academic journals, numerous articles in the Massage New Zealand magazine, over 70 research posters (accessible via NZMTRC), and numerous conference presentations, including a keynote address at the 2016 International Massage Therapy Research Conference.

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

BTSM BENEFITS – GRADUATE PERSPECTIVE:

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

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

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

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

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

Applications are being taken now, apply online at:

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

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

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

Material fees for the year's study are around $1,050. Further information is at: https://www.sit.ac.nz/programme/course/Bachelor%20of%20Therapeutic%20and%20Sports%20Massage.

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

STUDENT PROFILE

Hi, I am Jo Boardman. I live and work in Murrays Bay on the beautiful North Shore of Auckland. I currently operate my business from my home clinic and love working for myself. My business is JSRM Massage Therapy.

My interest in Massage Therapy started with Sports Massage Therapy. I am a regular runner and appreciate the benefits of massage therapy for recovery. I did two short certificate courses at AUT in Sports Massage Therapy and then spent hours practising and treating my friends and family cohort for free. I love geeking out on anatomy, so the course was perfect for me.

Next up was New Zealand College of Chinese Medicine. They offer a Level 5 Diploma Course in Wellness and Relaxation Massage. A blended course mainly taught online. This meant I could still work full time in my day job in Purchasing and Supply Chain and study as well.

It was all working fine until the first blast of Covid hit NZ in 2020. I was made redundant from my day job. But, when life gives you lemons, you make lemonade, right? I took the opportunity to do Massage Therapy fulltime.

It took a while to build up, but I was lucky enough to get a self-employed spot working at the local hospitals, providing Relaxation Massage Therapy to staff (admin, nurses, doctors, surgeons etc). The rooms were provided free of charge in exchange for my reduced rate. It helped me get my business off the ground.

I was approaching the end of Level 5 and wanted more learning, but was unsure where I could have the same study structure. Luckily for me, my college announced that they would be operating a Level 6 Advanced Diploma Course in Remedial Massage, as a blended, online delivered course. It was perfect timing. I signed up.

Now I'm nearly at the end of the Level 6 Diploma and loving every minute. I do the study as a full-time student, with Block Courses throughout the year. Lockdown in Auckland has made things a bit tricky with timings, but I am guessing the course will just be extended a few weeks, so that we have time to catch up with our clinical supervised hours after we come out of lockdown. Working for myself means that I can plan my time in and out of clinic, with only myself to ask for permission to take time off, so it's not all bad. My only hope is that I can complete Level 6 before February 2022, when I am due to start the Level 7 Bachelor of Therapeutic and Sports Massage at SIT.

I joined MNZ as a student member at the beginning of this year and I am so glad I did. I love the access to the wealth of information available. MNZ is invaluable for keeping me up to date. My membership also adds to my credibility as a therapist. I will become a full registered member once my studies are complete.

My goal for the future is to operate a modern and professional clinic with various other disciplines of self-employed therapists working with me, to complement what I do: Physiotherapy, Osteopathy, Chiropractic, Occupational Therapy, Podiatry, Counselling, Nutrition, Sonography, an exercise studio, and of course more awesome Massage Therapists to cover specialist modalities such as infant and pregnancy massage and Manual Lymphatic Drainage. The options are endless. I have the vision in my mind, I just need to make it physical. Watch this space. I will make it happen one day soon.

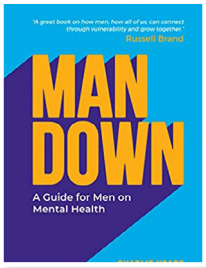
You can find me at www.jsrm.co.nz , on Instagram @jsrmmassage, on Facebook @JSRMassage

REGULAR

BOOK REVIEWS

MAN DOWN: A GUIDE FOR MEN ON MENTAL HEALTH

By Charlie Hoare



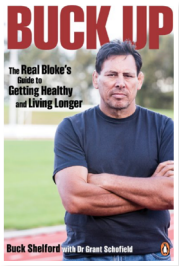
https://www.amazon.com/Man-Down/dp/1787832503

From tips on how to reach out, to advice on navigating mental health issues, this volume is full of guidance on how to look out for your well-being. Topics covered include:

- Anxiety and depression
- Stress
- Suicidal thoughts
- Dealing with traditional gender expectations
- Self-care and mindfulness methods
- How to open up and communicate
- Where to seek help

BUCK UP: THE REAL BLOKES GUIDE TO GETTING HEALTHY AND LIVING LONGER

By Buck Shelford with Dr Grant Schofield



https://www.penguin.co.nz/books/buck-up-the-real-blokes-guide-to-getting-healthy-and-living-longer-9781742539270

Accessible and user-friendly, Buck Up draws on All Black legend Buck Shelford's personal experience with health issues, but goes far beyond – along with highly regarded sports scientist Dr Grant Schofield, Buck offers a wide array of information and realistic tips to improve the quality of life for Kiwi males and their loved ones.

THE BLOKES BOOK

by the Canterbury Men's Centre

https://canmen.org.nz/wp-content/uploads/2019/10/Blokes-Book-10th-Edition-Nov-2019-Web.pdf

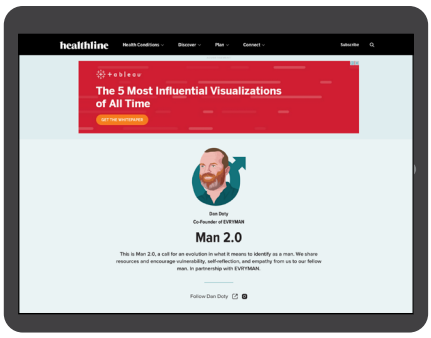
This eBook is a project of the Canterbury Men's Centre: Tāne Whai ora. Whilst many of the resources are Canterbury based, there are many national ones, with useful tips across many aspects of health and wellbeing including mental health, exercise, addiction and parenting, with sections dedicated to older men, Māori and Pasifika men.

ONLINE RESOURCES

MAN 2.0

https://www.healthline.com/content-series/man-2-0

A call for an evolution in what it means to identify as a man. This site shares resources and encourage vulnerability, self-reflection, and empathy. A useful site for therapists and clients.



MEN'S HEALTH

http://menshealthnz.org.nz/

A New Zealand resource promoting good health for the men of New Zealand. They want all men to make good health choices, to take action to live healthier every day, and to have easy access to health information that relates directly to them.

MEN'S HEALTH WEEK

https://www.menshealthweek.co.nz/

Part of a global health awareness campaign, the week focuses on the health issues all men face, and raises awareness of steps men can take to help address these.

PROSTATE CANCER FOUNDATION NZ

https://prostate.org.nz/

The Prostate Cancer Foundation has a significant role in promoting public awareness of this disease. Early detection leads to better outcomes, it is important that men are aware of the signs of potential disease and also of the checking and screening tests that are available from their doctor.

RURAL SUPPORT

https://www.rural-support.org.nz/Help-Support/Health-Wellbeing

Their primary goal is to support rural people heal and recover; returning to farming and family sooner rather than later. While this is not specifically targeting men, they do still make up the half of the farming community and often face additional challenges due to geographic isolation.

HEALTH NAVIGATOR - MEN'S HEALTH

https://www.healthnavigator.org.nz/healthy-living/m/mens-health/

The New Zealand Health Navigator web resource has an excellent section on men's health, covering topics from bladder control, testosterone deficiency and impotence to health and masculinity, respectful relationships, physical activity and maintaining a healthy lifestyle. These are resources you can direct your male clients to to support them to find out more information.

SURPRISED, FRUSTRATED, FURIOUS: MASSAGE THERAPY RESEARCH AND MEN'S MENTAL HEALTH

Greetings, MNZ Readers!

This research column was a particular challenge to write. I fully support the theme of men's health for this Massage New Zealand issue, and I was looking forward to diving into articles about how our male-identifying clients may benefit from our work. But I was first surprised, and then frustrated, and then furious at the lack of data (especially any available without prohibitive subscription fees) on the role of massage therapy for men.

Outside the realm of prostate massage which is a) not within our scope of practice and b) almost always a diagnostic procedure, not a therapeutic one, almost nothing is in the research literature about massage specifically for men. What's up with that?

It turns out I stumbled into an evidence gap that is much more complicated than it seems.

Eventually I settled on different strategy for this column. Instead of looking at the role of massage therapy in men's health, I decided to look for research on men's mental health, regardless of any reference to massage.

I ended up choosing three reviews: not research projects per se, but compilations of studies with recommendations for future work.

From the outset I need to clarify that for the purposes of this discussion, gender will be discussed on a binary scale. None of the articles I am bringing to you address issues of the gender spectrum, nor do they address the mental health challenges of men who are not strictly heterosexual. I will return to this gap in my conclusion, but for now I ask you to apply what we discuss here to your perceptions of straight, cisgender males in your practice.

I'd like to start with a quote from one of the articles that summarizes certain aspects of all three. I invite you to sit with this for a moment. Roll it around in your mind, and decide if you agree with it:

"Extant research suggests that men are less depressed, less anxious, and more likely to be aggressive and have substance abuse problems than women." (Smith et al., 2018)

- Do you agree that men are less depressed and less anxious than women?
- Do you agree that men are more likely to be aggressive and have substance abuse problems compared to women?
- (And do you think that's connected to their lower rates of depression and anxiety?)

Already we have some complicated issues to consider.

Our first article is from a group in Canada, discussing the possible sources of obstacles to men seeking mental health care services, and how those obstacles might be overcome.

MEN'S MENTAL HEALTH: SOCIAL DETERMINANTS AND IMPLICATIONS FOR SERVICES

Affleck, W., Carmichael, V. and Whitley, R. (2018) Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 63(9), pp. 581–589. doi:10.1177/0706743718762388.

Abstract (edited for form and length)

Introduction: Numerous scholars have stated that there is a silent crisis in men's mental health. In this article, we aim to provide an overview of core issues in the field of men's mental health, including a discussion of key social determinants as well as implications for mental health services.

Methods: Firstly, we review the basic epidemiology of mental disorders with a high incidence and prevalence in men, including suicide and substance use disorder. Secondly, we examine controversies around the low reported rates of depression in men, discussing possible measurement and reporting biases. Thirdly, we explore common risk factors and social determinants that may explain higher rates of certain mental health outcomes in men.

Fourthly, we document and analyze low rates of mental health service utilization in men. This includes a consideration of the role of dominant notions of masculinity (such as stubbornness and self-reliance) in deterring service utilization. Fifthly, we note that some discourse on the role of masculinity contains much "victim blaming," often adopting a reproachful deficit-based model.

Conclusion: We argue that these factors can deflect attention away from social determinants as well as issues within the mental health system, such as claims that it is "feminized" and unresponsive to men's needs. We conclude by calling for a multipronged public health–inspired approach to improve men's mental health, involving concerted action at the individual, health services, and societal levels.

Ruth's thoughts:

This was a compelling article that explored the obstacles to identifying and getting appropriate treatment for men's mental health issues, especially depression (they did not put as much focus on anxiety).

The authors noted an interesting phenomenon: common male-predominant mental health challenges (attention deficit and hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, and some others) are identified by objective observation. By contrast, female-predominant issues (e.g., depression, various forms of anxiety) are diagnosed by patient surveys, questionnaires, and self-reporting. This means that men who have depression or anxiety who are reluctant to divulge their negative mood states are less likely to get a helpful diagnosis. That's a serious problem.

The authors also point out (and this was reiterated in the other studies too) that women tend to "act in" in response to stressors—that is, they turn negative thoughts and emotions against themselves, to perseverate on negative thoughts, and to withdraw from support systems. When men have stressors, it is more common for them to "act out" in the form of risk-taking, aggression, and substance misuse. The authors suggest that these "acting out" behaviors may not be so much habits that need correction, as they are symptoms of underlying depression. Interestingly, in cultures where alcohol and drugs are prohibited, the diagnostic numbers for depression in men and women are closer.

The risk factors for male mental health disorders that the authors elucidate include employment issues, family stressors, adverse childhood experiences, and other transitions (interestingly, parenthood is a big stressor, especially for first-time fathers).

The difficulties in seeking mental health care included some surprises. Firstly, men are coached by their families, societies, and even their health care teams to be stoic and self-reliant—that's a burden in itself. But men who do pursue mental health treatment tend to feel blamed for their own problems. Mental health care providers are predominantly female, and this can be an obstacle for some patients. And this was the most surprising for me: research suggests that mental health care providers have some implicit bias against treating men with the same time, generosity, and compassion than they use with women.

This bias against men receiving mental health care was a new idea for me, but it appeared in the other articles that I have brought to this column as well.

Our second article had a new term for me: "scoping review." A scoping review is similar to a systematic review, but it tends to focus on identifying gaps in the literature and suggesting solutions for identified problems. This article definitely did that.

MEN'S MENTAL HEALTH PROMOTION INTERVENTIONS: A SCOPING REVIEW

Seaton, C.L. et al. (2017) American Journal of Men's Health, 11(6), pp. 1823–1837. doi:10.1177/1557988317728353.

Abstract (edited for form and length)

Introduction: There is an increasing need for mental health promotion strategies that effectively engage men. Although researchers have examined the effectiveness of diverse mental wellness interventions in male-dominated industries, and reviewed suicide prevention, early intervention, and health promotion interventions for boys and men, few have focused on sex-specific program effects. The purpose of this review was to (a) extend the previous reviews to examine the effectiveness of mental health promotion programs in males, and (b) evaluate the integration of gender-specific influences in the content and delivery of men's mental health promotion programs.

Methods: A search of MEDLINE, CINAHL, PsycINFO, and EMBASE databases for articles published between January 2006 and December 2016 was conducted. Findings from the 25 included studies indicated that a variety of strategies offered within (9 studies) and outside (16 studies) the workplace show promise for promoting men's mental health.

Results: Although stress was a common area of focus (14 studies), the majority of studies targeted multiple outcomes, including some indicators of positive well-being such as self-efficacy, resilience, self-esteem, work performance, and happiness/quality of life.

Conclusion: The majority of programs were offered to both men and women, and six studies explicitly integrated gender-related influences in male-specific programs in ways that recognized men's interests and preferences.

Ruth's thoughts:

This article was essentially a program evaluation, looking at 25 mental health programs designed for both men and women. Some were community-based,

and some were in the workplace. I especially appreciated that they gathered data from a truly diverse set of cultures; this study looked at programs from the U.S., the U.K., Australia, Japan, Korea, Germany, Ireland, Brazil, Finland, and Italy.

All in all, they collected information from over 4,000 individuals who enrolled. Twenty-two programs reported positive changes, and the other three reported no improvements.

The interventions offered in these programs varied a lot, from yoga to team sports, fitness classes, cognitive behavioral therapy, breathing exercises, and relaxation techniques. Massage therapy was not among the options, but it's not hard to imagine how our work could be included in programs of this type.

The outcomes they looked for included self-reports on well-being and mood, plasma cortisol, cognitive function, active coping, assertive behavior, stress reduction, self-efficacy, self-esteem, mental fitness, and emotional resilience.

Can we see a problem here? The interventions and outcomes were so diverse that it is difficult to draw a lot of comparisons between them. Nonetheless, the researchers landed on a few common themes that can be useful to guide mental health programs targeted for men:

- Workplace programs are more successful if they can be time-flexible and the language is sensitive toward male interpretation (i.e., don't identify "depression", call it "stress-management"; don't call the program "therapy."
- Incorporating sports, team-based activities, and respecting privacy are important.
- Other popular activities included gardening, drumming, and football.
- Having male providers and leaders in the groups was effective.
- Men are homogenous; no single approach will work for everyone.

Our last article for review was interesting because it called some well-accepted assumptions into question. However, although its title includes "an exploration of the gender binary", in this context it refers to how measurement and treatment bias towards traditionally feminine experiences may cause the misinterpretation of male behavior and pathology. Like the other articles in this column, it does not address any other male experience outside of cisgender heterosexuality.

REVIEWING THE ASSUMPTIONS ABOUT MEN'S MENTAL HEALTH: AN EXPLORATION OF THE GENDER BINARY

Smith, D.T., Mouzon, D.M. and Elliott, M. (2018) American Journal of Men's Health, 12(1), pp. 78–89. doi:10.1177/1557988316630953.

Abstract

Many researchers take for granted that men's mental health can be explained in the same terms as women's or can be gauged using the same measures. Women tend to have higher rates of internalizing disorders (i.e., depression, anxiety), while men experience more externalizing symptoms (i.e., violence, substance abuse). These patterns are often attributed to gender differences in socialization (including the acquisition of expectations associated with traditional gender roles), help seeking, coping, and socioeconomic status. However, measurement bias (inadequate survey assessment of men's experiences) and clinician bias (practitioner's subconscious tendency to overlook male distress) may lead to underestimates of the prevalence of depression and anxiety among men. Continuing to focus on gender differences in mental health may obscure significant within-gender group differences in men's symptomatology. In order to better understand men's lived experiences and their psychological well-being, it is crucial for scholars to focus exclusively on men's mental health.

Ruth's thoughts:

This article spotlights some of the biases that interfere with men's ability to access needed mental health care. They cite publication bias that limits important information from entering the literature (this would refer to papers that do not find substantial differences in diagnostic rates between men and women in terms of mood disorders); screening and measurement bias in the diagnostic process; and treatment bias in terms of how men are and aren't cared for in the mental health care environment.

It also questions the internalization/externalization paradigm, suggests that both men and women internalize and externalize negative emotions, more often than we think.

The authors list four main factors that help to explain gender differences in mental health care: socialization; help-seeking behavior; coping strategies, resources, and social support; and gender stratification.

Frankly, a lot of this paper went over my head, and I don't have the wherewithal to figure it all out. But one thing it did that was extremely helpful was to analyze specific points in the mental health care process where men with depression and anxiety often get filtered out or turned away, so they don't get the help they need.

Some general thoughts:

I chose three papers that proposed to explore challenges that males have in the realm of identifying and getting care for mental health disorders, especially depression and anxiety. All of them were well written, thoroughly supported with other research, and they all cited an impressive depth of literature. And not one of them addressed any male experience outside of cisgender heterosexuality. Indeed, the words "cis", "gay", "bisexuality", "homosexuality", and "transgender" appeared in none of them. It's as if males who are not cis-het don't exist.

I would have expected to see at least some reference to the mental and mood challenges of men who are gay or bisexual, and of men who are transgender or non-binary—if only to say it's an important topic but not the focus of this project. But there was nothing—which, given that ideas about male identity and gender roles seems to be a factor for a lot of men's obstacles in getting care, I found surprising. (And frankly, a little appalling.)

However, going down this rabbit hole revealed some things to me that I had not been aware of or sensitive to before—namely, the specific challenges that many men have in recognizing and getting care for mental and mood disorders.

I am not accustomed to feeling a great deal of concern about under-addressed health problems of straight cisgender men. This population is, after all, the point of focus for most medical research. Many health parameters are set around the conventional male experience. Standards for cardiovascular health and disease are set according to male norms. Expectations for pain management, renal function, respiratory capacity, and much more are based on male comparisons. Even prosthetics for joint replacements are made to male proportions and angles. Medications are developed using mostly male study subjects—and sometimes that has serious implications for the women who are prescribed them.

It is only recently that we have come to realize that women's health challenges (outside the realm of the reproductive and endocrine systems) are not the same as men's, and they sometimes require some different strategies to treat them successfully.

One place where women's experience of health challenges has not been shortchanged is in the domain of mental and mood disorders. The surveys, questionnaires, and screening tools we use to identify depression and anxiety are more accurate in the context of women's tendencies to "act in" compared to men's tendencies to "act out." This is a type of measurement bias that has influenced our understanding of mental and mood disorders throughout the population.

I have been aware since I first started writing and teaching about mental and mood disorders that women are diagnosed with depression far more frequently than men. I attributed that to cultural biases and the stigma men may face when they live with this disorder, and that assumption is at least partly validated by the papers we covered in this column. But those obstacles go much deeper than "men hate to go to the doctor" and "men hate to ask for help" stereotypes. The prejudices against men receiving help for their depression or anxiety are not held just by the men who are struggling; they are also held by virtually everyone else in society: their partners, their colleagues, and peers, and—worst of all—their health care providers and health care policy makers.

The consequences of not recognizing mood disorders in men are significant. Quality of life is one issue, but the fact that men account for about three quarters of all cases of substance use disorder and suicides points out that this gap in care has life-threatening consequences.

This realization will change the way I teach and write about this topic from now on.

None of the studies we looked at today address massage therapy as an intervention for men who are living with depression and anxiety. However, exercise, team sports, yoga, and other body-based activities are listed, and it seems reasonable to propose that massage therapy—which has a substantial evidence base that supports its use for depression and anxiety—could be helpful in this setting as well.

How might this impact our work? It is likely that every reader of this column has male clients who have depression or anxiety, regardless of whether it has been identified. I do not recommend that massage therapists now try to diagnose and counsel their male clients who show signs that they might be dealing with a mood disorder. But I do suggest that it would serve us and our clients well if we work to establish relationships with doctors, therapists, and social workers who understand this problem, so that if our clients ask us for help, we can send them to a safe and sympathetic care provider.

AUTHOR BIO

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

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

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