

E. Massage Protocol

1. Duties:

The **Moving Touch Therapist (MTT)** will perform the following:

- collect study measurements on participating patients
- perform moving touch treatments as outlined in the research protocol
- return completed forms to the **ON-SITE STUDY COORDINATOR**

2. The Moving Touch Protocol

The moving touch protocol is based on the following guiding principles:

- a. Not harming the patient;
- b. Preserving the integrity of the moving touch session;
- c. Allowing for therapist's clinical judgment and patient preferences;
- d. Standardizing the protocol so that the treatment is recognizable and replicable;
- e. Maximizing therapeutic benefit;
- f. Eliminating extraneous variables that may account for treatment effect, such as attention, communication and therapeutic intent.

The moving touch session will be approximately 30 minutes of “hands on” time with each patient provided 6 times within 2 work weeks, since this length and frequency of treatment has been efficacious with similar outcomes in other studies and takes into account the short lengths of stay of hospice patients. These sessions must be scheduled *at least 24 hours apart*. The protocol is designed to permit the Moving Touch Therapists to exercise their judgment in planning the specific timing of the treatments during the week as well as allow sufficient flexibility in the order of the treatment to allow for the therapist to exercise their professional judgment in providing the most beneficial treatment possible for the patient within the guidelines below. For example, if an **MTT** realizes that moving touch may no longer be an appropriate treatment for a patient, he/she may provide “laying on of hands” if that is more appropriate. This modification in treatment should be recorded appropriately on Form 11 for each treatment session where applicable.

The moving touch treatment will consist of effleurage, petrissage and myofascial trigger point therapy. The American Massage Association defines effleurage as “a stroke generally used in Swedish massage treatment. This smooth, gliding stroke is used to relax soft tissue and is applied using both hands”. Petrissage (also called kneading) is defined by the same organization as “squeezing, rolling and kneading the muscles and usually follows effleurage during Swedish massage”. Trigger point therapy (also known as myotherapy or neuromuscular therapy) is the use of “concentrated finger pressure to ‘trigger points’, painful, irritated areas in muscles, to break cycles of spasm and pain”.

(<http://www.amtamassage.org/about/terms.htm>)

The following protocol, with precise operational definitions of each component, will be followed by the on-site **MTTs** and recorded on Form 11 [Treatment Form] and Form 12 [MPAC]

- a. Pre-treatment assessment: This will consist of identifying particular areas of pain and discomfort, sites of wounds and tumors; recording heart and respiratory rate for 60 seconds and assessing the intensity of pain, pain relief, and emotional distress;
- b. Preparation of the patient and environment: This will consist of explaining the procedure to the patient, obtaining assent to proceed with the moving touch session; creating a quiet and private environment conducive to therapeutic massage, and positioning and draping the patient for comfort. While the therapist should make every effort to facilitate a quiet environment conducive to privacy and relaxation, we have discovered that the home and inpatient hospice environments may contain distractions (pets, family members, background noise, etc.) that can not be controlled. The therapist should note the qualities of the ambient environment on Form 11 [Treatment Form]. The therapist should give the patient the choice to either remove clothing to receive the massage or receive the massage wearing light clothing such as pajamas or a hospital gown. The patient should be positioned comfortably in the most neutral and functional body alignment possible respecting his/her wishes. While most patients should be lying in bed, those that wish to receive a seated massage should be accommodated. The positioning of the patient should be noted on Form 11.
- c. Centering self: The therapist focuses attention to the patient and calms self.
- d. Effleurage and petrissage to the back, shoulders/arms, hands, neck, scalp, face, legs, buttocks and feet. This can be approached according to the style most comfortable to the therapist. Strokes should be administered with therapists' fingers or full hand. The amount of time spent in each type of stroke will vary based on individual therapist judgment. Massage should be modified and administered with very light pressure and appropriate modifications in persons with: skin fragility; postural limitations; edema; osteoporosis; and bone metastasis and should be modified to avoid sites of inflammation/infection; hyperesthesias; injury, surgery, ports, intravenous catheters; deep vein thrombosis; and tumors, or other conditions that are contraindicated for massage.
- e. During the treatment to the upper, middle and lower trapezius muscle regions, therapists may identify up to 3 myofascial trigger points. After locating these trigger points the therapists should gradually release the trigger points with gentle pressure, if possible. Trigger points should be noted on Form 11.
- f. Post-treatment assessment: The therapist should ask the patient to rate pain intensity, pain relief, and emotional distress and should note any patient comments as well as patient's heart and respiratory rate.
- g. Ending: The therapist should indicate the conclusion of the treatment and provide about 5 minutes of relaxation and quiet time. The therapist should offer the patient water to drink following the treatment.

For massage administered skin-to-skin, all therapists will use Biotone massage crème provided by the PoPCRN Office. Universal precautions should be followed, including avoiding contact with any draining lesions. For the purposes of standardization and to mediate the presence of intervening variables, therapists should not introduce music as a supplement to moving touch. In addition, therapists will be instructed to limit their communication with participants during the moving touch session to providing instructions or requests, posing necessary questions related to the moving touch or providing responses to questions or comments by the participant.

F. Control (Simple Touch) Protocol

1. Duties:

The **Non-Moving Touch Volunteer (NMTV)** will perform the following:

- collect study measurements on participating patients
- perform non-moving touch treatments as outlined in the research protocol
- return completed forms to the **ON-SITE STUDY COORDINATOR**

2. Non-moving touch protocol

The non-moving touch intervention will be structured as follows and recorded on Form 11 [Treatment Form] and Form 12 [MPAC]:

- a. Pre-treatment assessment: This will consist of identifying particular areas of pain and discomfort, sites of wounds and tumors; recording heart and respiratory rate for 60 seconds and assessing the intensity of pain, pain relief, and emotional distress;
- b. Preparation of the patient and environment: This will consist of explaining the procedure to the patient, obtaining assent to proceed with the non-moving touch session; creating a quiet and private environment, and positioning the patient for comfort. As in the preparation for the moving touch session, the **NMTV** should try to facilitate a quiet environment conducive to privacy and relaxation and should note the qualities of the ambient environment on the Form 11 [Treatment Form]. The **NMTV** should give the patient the choice to receive the non-moving touch protocol draped and without clothes or wearing light clothing such as pajamas or a hospital gown. The patient should be positioned comfortably in the most neutral and functional body alignment respecting his/her wishes. While most patients will be lying in bed, those that wish to receive the non-moving touch in a seated position should be accommodated. The positioning of the patient should be noted on Form 11.
- c. The **NMTVs** will be instructed to interrupt conscious intention through mentally counting backwards from 100 by 7s or other mental distraction techniques. This should be done silently. This has been used in sham therapeutic touch studies, and controls for the role of conscious intent in the helping/healing process.

- d. The **NMTV** should place both hands on the patient in the following locations for 3 minutes each: Right shoulder blade; Left shoulder blade; Low back/ sacrum; Right heel; Left heel. Pressure should be light and consistent, no side-to-side movement of the **NMTV's** hands should occur. (15 minutes total) If the patient is lying he/she should turn over to face up. If seated, the **NMTV** should move to face the participant's front. Both hands of the **NMTV** should be placed in the following locations for 3 minutes each: Right patella; Left patella; Right elbow joint; Left elbow joint; Occipital ridge area of neck. (15 minutes). Pressure should be light and consistent, no side-to-side movement of the **NMTV's** hands should occur. Throughout the session, **NMTVs** should have no conscious intention of healing directed toward patient through using the technique described in part c above.
- e. Post-treatment assessment: The **NMTV** should ask the patient to rate pain intensity, pain relief, and emotional distress and should note any patient comments as well as patient's heart and respiratory rate.
- f. Ending: The **NMTV** should indicate the conclusion of the treatment and provide about 5 minutes of relaxation and quiet time; offering the patient water to drink following the treatment.

The non-moving touch session will be approximately 30 minutes of "hands on" time with each patient provided 6 times within 2 work weeks. These sessions must be scheduled *at least 24 hours apart*.

A minimal amount of Biotone Massage crème, supplied by the PoPCRN Office, will be applied to the **NMTV's** hands for consistency across groups. Universal precautions should be followed, including avoiding contact with any draining lesions or other areas with evidence of infection. For the purposes of standardization and to mediate the presence of intervening variables, **NMTVs** should not introduce music as a supplement to the intervention. In addition, **NMTVs** should limit their communication with participants during the non-moving touch session to providing instructions or requests, posing necessary questions related to the non-moving touch or providing responses to questions or comments by the participant.