



## Advancing health promotion through massage therapy practice: A cross-sectional survey study

Ann Blair Kennedy<sup>a,\*</sup>, Jerrilyn A. Cambron<sup>b</sup>, Jennifer M. Dexheimer<sup>c,1</sup>, Jennifer L. Trilk<sup>d</sup>, Ruth P. Saunders<sup>e</sup>

<sup>a</sup> Department of Biomedical Sciences, Division of Behavioral, Social, and Population Health, University of South Carolina School of Medicine Greenville, USA

<sup>b</sup> College of Allied Health Sciences and Distance Education and Department of Research, National University of Health Sciences, Lombard, IL, USA

<sup>c</sup> Department of Research, National University of Health Sciences, Lombard, IL, USA

<sup>d</sup> Department of Biomedical Sciences, University of South Carolina School of Medicine Greenville, USA

<sup>e</sup> Department of Health Promotion, Education, and Behavior, University of South Carolina, Columbia, USA

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### ABSTRACT

The human resources needed to provide health promotion services to improve health behaviors in populations are currently limited. Health promotion and education is included in the definition of massage therapy, and many within the massage therapy profession understand that health promotion and education are a part of massage therapy practice. However, the amounts and types of health promotion activities in massage therapy practice have not been thoroughly explored. The objective of this study was to investigate the current attitudes, practices, and barriers toward providing health promotion in a national sample of practicing massage therapists. A descriptive cross-sectional survey disseminated May to August 2016 to practicing massage therapists in the United States. The majority (90.2%) of the 182 participants agree or strongly agree that it is important for massage therapists to provide health promotion. Therapists with less favorable attitudes about providing health promotion reported more barriers to providing the messages to their patients. Barriers to providing health promotion included a lack of guidelines, knowledge, and skills. Training and guidelines for massage therapists regarding health promotion would be a reasonable next step for future research development. Utilizing massage therapists as health promoters may provide opportunities to deliver more prevention messages to patients which may impact public health.

### 1. Introduction

According to the World Health Organization, 60% of all deaths are related to chronic diseases (World Health Organization, 2017), many of which could be reduced by health behavior modification. Health promotion interventions which attempt to improve health behaviors that cause chronic disease, poor dietary choices, smoking, and lack of physical activity can have large impacts on disease outcomes, quality of life, and mortality (Glanz et al., 2002; Gorin and Arnold, 2006; Lee et al., 2012; Planning health promotion programs, 2006). Currently, more than half of the United States health costs are associated with chronic conditions (Druss et al., 2001), and exposing more patients to health promotion could significantly contribute in the area of chronic disease management. Yet, the human resources needed to provide health promotion services are currently limited. Yarnall et al.

documented that it was not feasible for primary care physicians to deliver all the recommended chronic disease management messages and prevention/health promotion services to patients in a given day (Yarnall et al., 2003). Additionally, the Associations of American Medical Colleges reports that due to population growth and the aging population, a shortage of > 100,000 physicians will occur by the year 2030 (Mann, 2017). Furthermore, the Public Health workforce is shrinking with concerns about future accelerated reductions in workforce based on planned retirements, budget cuts, and voluntary departures; some of the greatest reductions in workforce include health education and health services (Beck and Boulton, 2015; Liss-Levinson et al., 2015; Pourshaban et al., 2015). Therefore, it is necessary to investigate other potential avenues for health promotion and behavioral modification for patients.

The Institute of Medicine (IOM) conducted a summit to discuss the

\* Corresponding author at: University of South Carolina School of Medicine Greenville, Department of Biomedical Sciences, Division of Behavioral, Social, and Population Health, 701 Grove Road, Greenville, SC 29605, USA.

E-mail address: [Kenneda5@greenvillemed.sc.edu](mailto:Kenneda5@greenvillemed.sc.edu) (A.B. Kennedy).

<sup>1</sup> Is now in private massage therapy practice.

topic of Integrative Medicine in the health of the public; at this summit, the IOM suggested that complementary and integrative therapy providers can help to increase patient adherence with conventional therapies (Summit on Integrative Medicine and the Health of the Public, 2009). A recent article investigating which Americans use, and what predicts use of, massage therapy<sup>2</sup> (MT) found that 12.8% of the US adult population had used MT at some point in their life time, and 56.3% of these adults used MT for wellness or disease prevention purposes (Sundberg et al., 2017). Researchers concluded that gaps in the literature exist specifically around MT and health promotion/disease prevention (Sundberg et al., 2017). The American MT Association estimates that United States has > 350,000 massage therapists (American Massage Therapy Association, 2017) and the US department of Labor estimates the growth potential of this profession to be upwards of 22% by the year 2024 (U.S. Bureau of Labor Statistics, 2015). With a need to increase the health promotion workforce to meet the needed demand for assisting in delivering health promotion messages, the MT profession may be an untapped resource for interdisciplinary care in patient health.

Within the MT profession, it is understood that health promotion and education are a part of MT practice and generally relate to improving patient outcomes (Kennedy et al., 2016a). Additionally, health promotion and education has recently been included in the definition of MT: “Massage therapy consists of the application of massage and non-hands-on components including health promotion and education messages for self-care and health maintenance...” (Kennedy et al., 2016b). Yet, the amounts and types of health promotion activities in MT practice have not been thoroughly explored. Furthermore, no study to date has investigated the barriers to health promotion in MT practice and how expanding health promotion activities may impact MT scope of practice.

Our primary objective was to investigate in a national sample of practicing massage therapists the current attitudes, practices, and barriers toward health promotion. Specifically, we investigated four research questions: 1) What are the attitudes about and practices of health promotion among massage therapists? 2) What health promotion practices/messages do massage therapists provide their patients? 3) What barriers prevent massage therapists from focusing more on health promotion? And 4) What attitudes and/or characteristics of massage therapists relate to the number of barriers they face with health promotion?

## 2. Methods

### 2.1. Design, sample and setting

A descriptive cross-sectional survey design was used to gather evidence about health promotion in MT practices in the United States. The participants were practicing massage therapists recruited through MassageNet (MassageNet Research Network, 2013), the National University of Health Sciences practice-based research network and through social media (Facebook, Twitter, and LinkedIn). To be included in the study, individuals had to be willing to participate in the survey and be a practicing massage therapist in the United States.

### 2.2. Measures

The survey was adapted from previously created surveys (Kennedy and Trilk, 2015; Luquis and Paz, 2015) to gather information about massage therapists and their practices (Kennedy and Trilk, 2015) and their health promotion practices (Luquis and Paz, 2015). Specifically, survey content included participant and practice demographics (categorical variables), importance and priority of health promotion, and behavior around providing or referring patients on specific topics (e.g.

physical activity, mindfulness, stress management etc.). The inclusion of the specific health promotion topics were based upon themes surveyed in medical practice (Luquis and Paz, 2015) and those determined by the authors and content expert reviewers. Not all topics included are evidenced based and some may be considered out of scope of practice for massage therapists. Finally, participants were asked about where they find health promotion information and their barriers to providing health promotion to their patients. The survey was sent to five content experts, in either MT or health promotion, to determine content validity (DeVellis, 2012). Revisions were made based upon experts' feedback.

The survey was disseminated in two waves due to low response rate and during initial wave and some confusion over the survey wording. During the first wave of survey dissemination, one participant emailed the primary investigator with confusion over the wording and terms “health promotion” and “self-care messages” being asked simultaneously. Discussion within the research team indicated these terms were combined into the term “Health Messages” for the second wave of data collection.

### 2.3. Procedures and statistical analysis

To reduce social desirability bias and elicit truthful responses, anonymous online surveys were sent to the massage therapists (Davies, 2016). Invitations to participate were sent through email from MassageNet and the respondents were redirected to take the self-administered questionnaire electronically through SurveyMonkey. MassageNet members were contacted three times and invited to participate in the survey. Those who began but did not complete the survey were contacted via email to encourage survey completion.

Survey distribution and participant recruitment of both waves can be seen in Table 1. Recruitment for wave 1 had a total of 58 responses; one participant did not consent to the survey, eight were not US residents, and one did not complete the survey past question two and were therefore removed from analysis, leaving a total of 49 responders. Feedback indicating confusion around the grouped terms “Health Promotion” and “Self-care Messages” in several questions led to the survey modification and low response rate led to a change in recruitment strategy to include not only MassageNet, but also social media recruitment. Specifically, MassageNet members were again recruited by email up to three times. MassageNet also posted links to the survey on its Facebook page three times and was then shared by the primary investigator (PI) and Co-Investigators (CoIs) to their personal pages and MT professional group pages. The study PI posted links to the study on Twitter and LinkedIn, as MassageNet does not currently have a presence on those social networks. The survey remained open for three months. Only one web link was used to collect the data for wave 2 and this was sent via email and posted on the different social media platforms. We can extrapolate that a majority of the responses to wave 2 came from social media because only 34 of the MailChimp responders clicked on the survey link. Likely this means that the remaining 164 respondents were from social media (Table 1); however, due to sharing of the survey by other individuals as well as posting on differing social media platforms by the PI, we cannot determine specifically where the participants encountered wave 2. The revised recruitment strategy for wave 2 resulted in 198 individuals opening the survey, however 25 recruits did not complete the survey past the second question. Of those 25 participants, one participant did not consent to the survey, ten were not US residents, and the rest did not continue leaving the total number of responses to 173. It should be noted the default SurveyMonkey setting used allows for participants to respond to the survey only one time per device used.

Results from both waves were pooled into one database; a total of 222 individuals responded and 182 individuals completed the survey and those data were used for analysis. Participants from both waves were compared for homogeneity on key variables to determine if pooling the data sets were appropriate. To control for response bias, we

<sup>2</sup> Abbreviation: MT = massage therapy.

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