***Partnership of***

College of Massage Therapists of Ontario

## Project Topic:

Patients' Experiences of Ending Massage Therapy Care

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## Date:

December 15, 2018

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| **Current Date:** | October 15, 2018 |
| **Project Title:** | Patients' Experiences of Ending Massage Therapy Care |
| **Amount of Grant:** | $13, 209.00 |
| **Year Grant Awarded:** | 2017 |
| **Indicate Extensions Granted:** | Extension granted until December 2018 |
| **Project Completion Date:** | December 15, 2018 |
| **Institution:** | Humber College |
| **Applicants and Collaborators:** | Suzanne Michaud |

## Abstract

**Background.** It is generally believed by healthcare practitioners that the quality of the therapeutic relationship developed with patients impacts the success of the treatment. The interaction between therapist and patient during care is complex, and both parties bring their unique perceptions to the relationship. The patient's comfort with intimacy may be an important factor in determining the success of a developing therapeutic relationship. Knowing this, healthcare professionals who provide intimate care should consider patients' perceptions. Massage therapists are one such professional group who provide intimate care.

**Methods.** Descriptive phenomenology was used to describe the experience of ending care for patients of massage therapy. Data were collected through semi-structured interviews and analyzed using Colaizzi's methods.

**Results**. Seven participants described their experience of ending massage therapy care as awkward and uncomfortable. They felt responsible for managing potential conflict. The discomfort was so intense that participants rarely communicated to their massage therapist that something was wrong and they would not be returning. Future research should continue to explore the phenomenon of ending care. From this study, it is clear that communicating concerns during massage therapy treatment was difficult for these participants. It was easier to leave when they felt uncomfortable, rather than exacerbate the discomfort with confrontation. Much remains to be explored in this area.

## Contents



## 1. Introduction

### Background

It is generally believed by healthcare practitioners that the quality of the therapeutic relationship developed with patients impacts the success of the treatment (Bachelor, 2013; Eubanks-Carter, Muran, & Safran, 2010; Horvath, 2000). The interaction between therapist and

patient during care is complex, and both parties bring their unique perceptions to the relationship (Bachelor, 2013; Fitzpatrick, Iwakabe, & Stalikas, 2005). When these perceptions are divergent, they may create ruptures (Eubanks-Carter et al., 2010), that is issues, or moments of tension, within a therapeutic relationship.

A rupture is a breakdown in the relationship and can be caused when there is perceived lack of collaboration or stress on the emotional bond (Eubanks-Carter et al., 2010). When unresolved issues arise during care, patients may respond by ending their care, or seeking treatment from another practitioner (Fitzpatrick et al., 2005). If practitioners are able to repair the rupture, it may contribute to a renewal within the therapeutic relationship (Eubanks-Carter et al., 2010). The patient's comfort with intimacy may be an important factor in determining the success of a developing therapeutic relationship (Fitzpatrick et al., 2005). Knowing this, healthcare professionals who provide intimate care (Chur-Hansen, 2002) should consider patients' perceptions.

Massage therapists are one such professional group who provide intimate care. Massage therapy treatment commonly occurs one-on-one, in a private treatment area, where the patient is asked to remove clothing and lie on a massage table covered by a sheet and blanket. The treatment primarily consists of hands-on manual techniques, where the skilled application of touch is used to address primarily musculoskeletal complaints (Government of Ontario, 1991a). This environment inherently renders the patient vulnerable (Fitch, 2014), making the establishment of comfort and trust paramount to the successful development of a therapeutic relationship.

During informal discussions with massage therapists, and through the researchers' own professional experience, it was noted that there are times when patients decide independently, and without notice, to end the care they are receiving. Similarly, massage therapists hear from patients that they have previously received treatment from another massage therapist with whom they were dissatisfied. This dissatisfaction led to them eventually leaving that therapist's practice and seeking out care from someone else.

There are no studies investigating the discontinuation of massage therapy care. There are two studies from the complementary and alternative medicine literature that offer some description of why patients discontinue care. A study by Kim et al. (2013), investigated factors associated with discontinuation of complementary and alternative medicine (CAM) in Korean cancer patients. They found that financial burden, lack of effectiveness, harmful events, and physician opinion were some of the reasons for discontinuation of CAM in this population. A second study investigated the use of CAM two years after treatment for prostate cancer (Porter, Kolva, Ahl, & Diefenbach, 2008). The results suggest that CAM use was less common two years after treatment than it had been following diagnosis. Participants cited ineffective treatment, harm, physician advice to discontinue, and unsuitability as reasons for ending CAM therapies.

The dearth of literature about massage therapy patients' experiences of ending care suggests that patients may not have a forum through which to share these experiences. Through this study, we sought to describe the experience of patients who have chosen to end massage therapy care. For the purpose of this study, ending massage therapy care was defined as the point at which the patient terminated the therapeutic relationship with his or her

massage therapist. While some of the reasons may be the same as listed above, a description of patients' experiences will help to inform massage therapists' clinical decision-making in practice. In addition, this study provided an opportunity for the voices of patients to be heard, especially those who have previously remained silent.

**Research Question**

The research question was, "What are patients' lived experiences of ending massage therapy care in Ontario?" As there is nothing at this time published on ending massage therapy care, from either the practitioner or the patient's perspective, this study is a foundation for future research into massage therapy practice.

## 2. Materials and Methods

Descriptive phenomenology was used. Data were collected through semi-structured interviews and analyzed using Colaizzi's methods.

**Context**

Massage therapy has been regulated in Ontario since 1991 under the *Regulated Health Professions Act* (Government of Ontario, 1991b). Under this regulation, the College of Massage Therapists of Ontario is tasked with protecting the public interest. As a part of the standards and policies that regulate massage therapists, they have also published a code of ethics which guides the ethical behaviour of practitioners (College of Massage Therapists of Ontario, 1999). Within the *Code of Ethics*, massage therapists are responsible for listening and respecting patients' values, encouraging and being responsive to patients' choices, and ensuring patients are an integral part of the decision-making process. Communication, setting professional

boundaries, and obtaining consent are other expectations the regulatory body has of its registrants (College of Massage Therapists of Ontario, 2017).

It is important to note that massage therapy is not covered under the provincial healthcare insurance model. As such, patients pay out-of-pocket or using extended healthcare insurance to cover treatments. This can create some tension between the need of therapists to provide care that is within the best interests of their patients and the ability of their patients to pay for ongoing care. In addition, it means that some patients are less tolerant to pay and return for care that does not meet their expectations. These factors make understanding patients' perceptions of care, and the relationship of satisfaction to retention of patients, of interest to massage therapists.

**Sampling and Recruitment**

Participants who had received massage therapy from a registered massage therapist in Ontario, with the intention of returning for continued care, were invited to participate. Individuals who had ended massage therapy care, with at least one registered massage therapist were interviewed. Snowball sampling was used and participants were asked to share the researchers' contact information with people they knew who had also experienced the phenomenon of interest (Palinkas et al., 2015). Participants were recruited through study information provided to healthcare clinics in Toronto, Mississauga, Sudbury, and Newmarket, and through word of mouth.

**Data Collection**

Data were collected through 45-minute semi-structured interviews. Participants selected a mutually agreeable time and place for the interview to be conducted. Telephone interviews

were offered where face-to-face was not feasible. The researcher who conducted the interviews (SM) kept a research journal, in which to record statements from participants, as well as the thoughts of the researcher during and after the interviews. These memos were considered during data analysis.

**Data Analysis**

Data analysis followed Colaizzi's method (Abu Shosha, 2012; Saunders, 2014; Wojnar & Swanson, 2007), which uses a seven-step process: 1) develop a sense of the whole interview by reading and re-reading the transcript; 2) extract of significant statements keeping them in the participant's own words; 3) restate the significant statements and formulate meaning; 4) cluster formulated meanings into themes; 5) create an exhaustive description of the phenomenon of interest; 6) distil the exhaustive description into a fundamental structure of the phenomenon; and, 7) share findings with the participants for feedback and member checking.

**Establishing Trustworthiness**

Establishing trustworthiness is a process and as such, we have considered issues of trustworthiness during the development of the study. Part of establishing credibility was to engage in reflexivity. We cannot remove who we are from the research process so instead we must recognize, to the best of our ability, what we bring to the research. By acknowledging the knowledge, attitudes and beliefs we bring to this study, we can try to set these aside in order to discover the phenomenon from the perspective of the participant (Wall, Glenn, Mitchinson, & Poole, 2004). Reflexive journals in which we recorded thoughts, ideas, and beliefs about the phenomenon of interest helped us examine this.

To enhance the trustworthiness of the data, we have described the research process, and the resulting description, so that it may be useful to other groups, such as other healthcare providers. Describing the context of the study will help readers determine whether the results should be considered within their own geographical or socio-political context.

## 3. Results

Seven interviews were conducted. All participants were women and had experienced ending massage therapy care at least once. Most had returned to receive care from another massage therapist. The participants described the experience of ending massage therapy care as awkward and uncomfortable. So much so, they rarely communicated to the massage therapist that something was wrong and they would not be returning.

**Feelings of Being Uncomfortable**

Participants described feeling uncomfortable in treatment, either physically or emotionally. Physical discomfort occurred when the pressure applied by the massage therapist was too much or too deep. "[One massage therapist] was way too rough. I told him I wanted it rough, but it wasn't enjoyable. I told him not too rough, just a little bit less torture." They described experiences where the massage therapist did not ask about or check in on their comfort. "She never asked, but I think she could tell because I would stiffen up when she would press in a certain spot." Several participants shared that they felt they were not listened to. "Frequently the massage therapist would ask, 'how's the pressure?' That's a good thing. But, then I would say, 'too much for me', and then they'd say, 'oh, I'm sorry'. Then they'd lighten it up, but they'd kind of default back into the really deep pressure. …Either they were forgetting what I was saying or

deciding what they were saying was better". Communication about pressure was felt to be easier in established relationships. "Once you get that relationship with your therapist, it becomes easier [to communicate] because they know what you like versus what you don't like."

One additional physical discomfort that participants described was having areas of their body treated to which they did not provide consent. "[The massage therapist] wasn't discussing which parts of the body she would be working on. I came for [treatment of] feet and leg issues. Then she would start massaging my shoulders… [The massage therapist] hadn't given me the opportunity to say 'no, don't work on that area'. They didn't mention that that would be involved at all".

Emotional discomfort was described as occurring when the massage therapist asked questions that were too personal or talked too much about themselves. Several participants shared occasions when their massage therapist asked questions that seemed overly personal and not germane to the treatment. They described wanting to lead the conversation. "If I don't want to talk [my massage therapist] gets the hint and then we don't talk. But, if I want to talk then it's fine." They did not want the massage therapist to share too much personal information about themselves. "[I don't like] when the massage therapist kept talking about her personal life a lot and asking about my personal life. …I don't really want to know about their personal life and I don't really want to tell them about my personal life".

There was a feeling that emotional discomfort could be tolerated for longer than physical discomfort.

> I think for me, physical discomfort …is worse than just being awkward… if it's just personal awkwardness, it's easier to have hope that it was just a one-time thing or [the massage therapist will] get the hint and stop talking. …In terms of physical

> discomfort, or doing something I hadn't discussed or consented [to]… I don't even want to allow for [it to happen] once.

There was more of an allowance given for social awkwardness, but little tolerance for physical boundary violations or lack of adherence to requests for changes in pressure.

**Managing Potential Conflict**

When it came to sharing their feelings of discomfort, many didn't.

> I think it's easiest for most people just not to come back. It's very hard to criticize someone, especially someone you've just met. ... [There is also] a bit of a power differential since they're the health professional who is treating you and supposedly knows all these things. Most people want to be polite and [not coming back] seems to be the most polite thing to do.

It was also common not to express feelings of discomfort during the treatment because it was awkward. Several participants described wanting to avoid confrontation. "Since I don't really like confrontation, it's just easiest for me not to book another appointment. I just consider the lesson learned and I won't go back there. Maybe the next one will be better". Participants expressed feeling awkward commenting on the therapist's conduct, as they were not sure how it would be received. "I'm sure they don't take it that way, but it feels like by [commenting], by making suggestions to their treatment style, that it could be perceived as a judgement". As a result, most did not provide feedback on their experience.

Some shared that when they had taken the risk to share their experience it worked out well, but that the outcome was not consistent. "I find it quite difficult to [give feedback] to an RMT. I've been working on that lately and I will let them know. Sometimes people respond exceptionally well. They really listen. They check in again to make sure it's ok. And, sometimes the RMT doesn't. They have a treatment style and they stick with it". There was a feeling that it

was hard to find a good massage therapist. Participants who found someone who would listen to them would continue to see them. "When I've worked with RMTs who respond to what I'm saying, it fosters the relationship and I tend to go back and see them. If I am dealing with someone [who doesn't] listen, then it tends to end the relationship".

## 4. Discussion

This study revealed that participants ended care with a specific therapist as a result of the therapist not adjusting to verbal or non-verbal communications. More specifically, it was identified that participants discontinued care when they felt that the massage therapist had dismissed their communication about physical discomfort, or that the massage therapist did not sufficiently respond to their use of silence to achieve quiet. However, this did not dissuade the participants from using massage therapy. They simply sought out other therapists.

Silence was used to end care. This was done by not communicating any information regarding their decision to seek another therapist and by not scheduling future appointments with their original therapist. Patients did this in order to avoid the potential awkwardness and uncomfortableness that they thought would arise from providing negative feedback. It has been noted in other studies that patients feel uncomfortable providing direct criticism and would prefer others to infer what was hindering care (Henkelman & Paulson, 2006; Marcinowicz, Grebowski, & Chlabicz, 2009; Staniszewska & Henderson, 2004).

**Dismissal of Communication about Physical Discomfort**

The most common reason participants ended treatment with a given practitioner was that they experienced a dismissal of their communication about the physical discomfort. Participants

indicated that they communicated their discomfort only to have the therapist continue, justify, or return to the pressure that prompted them to verbalise their discomfort. Due to the therapist's non-responsiveness, patients concluded that their feedback was irrelevant. As a result, they refrained from restating their concerns.

Participants also indicated that communication of discomfort to the therapist could be interpreted by the massage therapist as a judgment of their abilities. The patients did not want to engage in these types of communications during the treatment due to the possible risk of damaging the therapeutic relationship. This sentiment was shared by participants in a study conducted by Ojwang, Matu, and Ogutu (2010) that found patients utilised silence to ensure that they would not be perceived as challenging the health professional. Patients did not wish to disrupt the treatment, and used silence as a method to curtail potential strain on the therapeutic relationship.

Given that massage therapy is considered part of the private healthcare system in Ontario, patients have greater agency to select their provider than in the public system. Patients that utilise the private healthcare system often have the ability to choose from which therapist they want to receive treatment. This freedom also permits patients to end treatment plans easily by not scheduling future appointments. Regardless of these options, patients used silence similarly to patients in the publicly funded system. They use 'significant silence' which is the intentional withholding of verbal communication to manage their concerns (Knapp, Enninger, & Knapp-Potthoff, 1988). Their silence is a purposeful response by the patient to convey their disagreement with how they are treated, and assist in avoiding confrontation (Ojwang et al.,

2010). Participants preferred discontinuing care in this manner because it assisted in the avoidance of possible conflict (Ojwang et al., 2010).

**The Impact of the Power Differential**

Patients voiced that they did not communicate certain questions, concerns or experiences to the massage therapist due to their lack of knowledge of massage therapy. This acknowledgement of therapist's specialised knowledge contributes to an imbalance of power in the therapeutic relationship. Power differentials are inherent in therapeutic relationships due to the patient seeking assistance from a professional and that the flow of information is one-sided (Austin, Bergum, Nuttgens, & Peternelj-Taylor, 2006). Patients are required to share information about themselves and answer questions posed by the therapists, placing the therapist in powerful position and the patient in a vulnerable position (Austin et al., 2006). This disparity of power is felt by massage therapy patients despite the philosophical orientation of the profession to be patient-centered (College of Massage Therapists of Ontario, 1999). Recognising the greater context of massage therapy is helpful to understanding this aspect of the therapeutic relationship.

Massage therapy is a healthcare profession, and as such is part of the Ontario healthcare system, which is comprised of a public and a private. Individuals who practice massage therapy are governed in similar ways as the other 25 health professions. For that reason, it is necessary to know the historical and current underpinnings of the paternalistic model of care which has an "inhibitory effect on giving negative evaluation" (Marcinowicz et al., 2009). Patients are socialised to behave in a particular ways when engaging with healthcare professionals, and the same is true for patients of massage therapists. Patients and massage therapists alike have had experiences

within the public system which has a tendency of performing in a paternalistic style (Marcinowicz et al., 2009). These existing patterns are the social framework that determines the ways in which the respective individuals conduct themselves in healthcare interactions. These habits are often transferred to the massage therapy interaction by either patient or therapist.

Even though patients are regarded as having less power than the therapist, they are not cemented in this social position. Patients are empowered through their choices during and after their therapeutic encounter. Patients viewed their discontinuation of care with a particular therapist as a sufficient response. They enact their agency by not rescheduling future appointments with the massage therapist who was perceived to have violated their boundaries. Also, participants acknowledged that they had chosen to remain silent in order to navigate what was occurring and accredited their discomfort to their own personal preferences. However, through this research we reveal that ending care is not unique to one patient, rather we have learned that the reasons for ending care and the process by which it is done appears to be a shared phenomenon for users of massage therapy.

**Lack of Responsiveness to Silence**

Silence was a strategy used not only for leaving the care of a practitioner, but also for withdrawing from conversations occurring during treatment. Several participants recalled that they tried not responding to indicate to the therapist that they wanted to the conversation to end. This was done by letting their turn pass in the conversation and they trusted that the lack of response would signal their desire to end the conversation. In some cases, the void of verbal communication did not stop the conversation, and this led to the rupture of the therapeutic alliance.

Patients viewed this experience differently than the dismissal of physical discomfort. Patients were more tolerant of this type of transgression. The participants attributed this lack of discernment to an oversight or to the possibility that the therapist was having an 'off' day. They sympathised with therapist for not being perceptive to the non-verbal communication and did not terminate care solely based on that one incidence. However, when the patient experienced a habitual lack of attention to non-verbal communication to achieve quiet or change the subject, they did discontinue care.

**Challenges and Limitations**

The recruitment of participants was a surprizing challenge for this study. As time passed and recruitment had stagnated, an amendment was made to widen our recruitment pool from the Greater Toronto Area to all of Ontario. This modification did produce participants. However, we were unable to reach the a priori sample size of 10 to 12. One reason that could help explain this occurrence is that patients are not comfortable sharing their negative views (Staniszewska & Henderson, 2004). Marcinowicz et al. (2009) attribute the suppression of negative feedback to the social positioning of patients and the importance they place on their health.

An additional challenge was experienced by the researcher (SM) during the interviews. When participants were asked to describe an ideal massage therapist, it was easy for them to respond. But, when they were asked to share the experience that provoked discontinuation of care, some responded carefully. As a result, the researcher felt uneasy probing about some topics, such as intrusive questioning, due to the complexity of the experience and the uncertainty of the depth of the perceived boundary violation. Therefore, it was difficult to get participants to share greater details about an experience that they used silence to resolve.

Additionally, this study uncovered that the data collection methods selected for this project were not effective in enlisting the number of participants desired. As previously stated, negative expressions by patients are more difficult for patients to verbalize than positive assessments. Patients use silence as a conflict management strategy and asking individuals to express, in a formal way, something they have made speechless was challenging.

**Future Research**

The findings from this study are important as they highlight the existing power differential experienced in therapeutic relationships that occur within the healthcare system. Patients are compelled to remain silent within the therapeutic encounter due to knowledge inequities and the perceived disregard of their communication. Massage therapy does differ from other healthcare and more research is required to understand these preliminary findings.

Further research into methods that could assist in capturing or encouraging the patient's expression of negative feedback is needed. Understanding the impact of cultural beliefs about voicing negative views would be helpful in designing studies to encourage and promote sharing of negative experiences. Identifying novel ways of gaining access to patient's negative assessments of care are required. Cultivating methods that promote the sharing of discomfort and dissatisfaction by patients can assist in changes that will alter care in positive ways by bridging the communication gap generated by power imbalance and silence.

Research into what is discouraging patients from continuing care is important if stakeholders are to address them. These findings are significant for all researchers attempting to solicit negative assessments of healthcare providers from patients. Also, examining cultural beliefs of negative discourse and how it can impact the practice of massage therapy and other health

professions would assist in understanding how to best elicite patient feedback without reproducing the social awkwardness.

Nevertheless, this study provides an opportunity for massage therapists and stakeholders to reflect on the communication practices occurring within their profession. Specifically, the communications that occur about discomfort during treatment and lack of response from a patient during treatment. Massage therapists can recognise that voicing negative feedback is a challenge for their patients and that it places them in a vulnerable position and that discomfort whether it is physical or social is undesirable. Therefore, acknowledgment and careful consideration by the therapist is required when a patient verbalises it. The knowledge produced by this study can assist therapists to begin to understand the silence occurring in their massage rooms and perhaps assist them in contemplating strategies to cultivate responses that will strengthen the therapeutic alliance. They can engage in creating environments that may alter what is considered negative feedback by framing it as assistance in providing quality care that is customized to the patient. Furthermore, they may attempt to balance the power in the therapeutic relationship by: acknowledging what the patient contributes to the therapeutic relationship, framing them as experts and the sole person capable of conveying their experience, and reinforcing that sharing their unique insight is a valuable part of the therapy. Furthermore, empathising with the discomfort that arises from providing negative feedback, but highlighting the positive aspect of sharing such information might bring comfort to the patient. Reframing feedback as a constructive and required communication could encourage patients to participate in care while reducing patients ending treatment plans prematurely.

## 5. Conclusion

Seven participants described the experience of ending massage therapy care as awkward and uncomfortable. They shared they felt responsible for managing potential conflict and that this discomfort was so intense that participants rarely communicated to their massage therapist that something was wrong and they would not be returning. Future research should continue to explore the phenomenon of ending care. From this study, it is clear that communicating concerns during massage therapy treatment was difficult for these participants. It was easier to leave when they felt uncomfortable, rather than exacerbate the discomfort with confrontation. Much remains to be explored in this area.

## 6. Project Plan

| Milestone | Deadline | Completed? | Comments |
|---|---|---|---|
| Create list of clinics for recruitment | 5 Oct 2017 | Yes | |
| Research assistants hired | 17 Nov 2017 | Yes | |
| Contact clinics to begin recruitment | 27 Nov 2017 | Yes | |
| Request amendment to recruitment from MTRF | 16 Apr 2018 | Yes | |
| Submit amendment to REB | 25 Apr 2018 | Yes | Approved on April 30th |

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|---|---|---|---|
| Contact clinics to begin recruitment | 1 May 2018 | Yes | |
| Conduct interviews with 10-12 individuals | 31 Jul 2018 | Yes | |
| Complete Data analysis | 31 Aug 2018 | Yes | |
| Manuscript for publication | 15 Nov 2018 | Yes | |
| Poster presentation | 09 Nov 2018 | Yes | Accepted for poster presentation at the INCAM Research Symposium, November 9-10, 2018, Montreal, QC |
| Submit final report to Humber, all project deliverables have been met | 15 Dec 2018 | Yes | |

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