Philosophy of Education: Massage Therapy Education, Consciousness, and Normativity

Anne-Marie Côté
Simon Fraser University

> The thought manifests as the word; the word manifests as the deed; the deed develops into habit, and habit hardens into character. So, watch the thought and its ways with care, and let it spring from love, born out of compassion for all human beings. As the shadow follows the body, as we think, so we become.

This proverb, (often identified as coming from Siddhartha Gautama Buddha, but is still under contention) has always rung true to me. Although I have never had a real understanding of how consciousness of our feelings and emotions had such a deep role in how our thoughts are formed, my instinct was to trust it, believe in it, and incorporate it in my daily life and how I chose to conduct myself. Recently, I have been wondering how is thought formed, what influences and creates it, what comes before thought?

THOUGHT FORMATION

Antonio Damasio's book *The Feeling of What Happens, Body and Emotion in the Making of Consciousness,* attempts to answer these questions by bringing forth the hormonal and reflexive nature of how our thoughts come to be. He describes three levels of life regulation, which are a series of patterns that are part of the bioregulatory systems that we are born with. Beginning from basic life, the first level involves simple stereotyped patterns of responses to stimuli, including metabolic regulation, reflexes, and the machinery behind what becomes pain and pleasure, drives and motivations; the second level involves complex, stereotyped pattern of responses called emotions. Once emotions are felt, feelings arise, which are sensory patterns signalling pain and/or pleasure; emotions then become mental patterns in our brain. At this point, two things can occur, either consciousness comes into play, and we now become aware of our feelings and emotions, or consciousness does not get involved and

these emotions and feelings stay in our unconscious mind. I will focus on the former scenario. When consciousness kicks in, we are now in the territory of thoughts, also known as "high reason," where we are experiencing "complex, flexible and customized plans of responses formulated in conscious [mental images] that may be executed as behaviours."[1] In this moment, our brain starts to acknowledge the feelings and sensations. This is the point in time where we know we are feeling something and are now trying to make sense of these feelings and emotions.

An example of how these steps may occur in a real-life scenario could present itself as: you find yourself walking down the street casually enjoying a sunny day, suddenly you see Aunty Caroline (basic life regulation of visualization). Even if you have not seen her in a long time, chances are you will recognize Aunty Caroline immediately and have thoughts, but in that split second before you do, the process of emotion will continue to the next step. Signals will be sent to your brain, and it will immediately respond to the mental image of Aunty Caroline, past experiences with her will modulate the manner in which the neural pathways respond to the visual stimuli (emotions). The resulting triggering of emotions will send signals to other brain sites, and you are now experiencing feelings. At this point, all the activated neural pathways in your brain that represent Aunty Caroline and all your past experiences with her come to your consciousness and you then form an opinion of what you are feeling. This is where your thoughts come alive (high reason): "OMG, I haven't seen Aunty Caroline in so long, I am so happy she is here," or "OMG, Aunty Caroline is there, ugh! I haven't seen her in so long, how can I get out of here quick before she sees me?"

Essentially, consciousness is the link between inner life regulation and mental image making; it provides meaning, allows us to interpret the mental images and apply context to them. Damasio explains:

> Consciousness is, in effect, the key to a life examined, for better and for worse, our beginner's permit into knowing all about hunger, the thirst, the sex, the tears, the laughter, the kicks, the punches, the flow of images we call thought, the feelings,

> the words, the stories, the beliefs, the music and the poetry, the happiness and ecstasy. At its simplest and most basic level, consciousness lets us recognize an irresistible urge to stay alive and develop a concern for the self. At its most complex and elaborate level, consciousness helps us develop a concern for other selves and improve the art of life.[2]

Consciousness refers to us knowing we are feeling and emoting, whereas conscience is the interpretation of the goodness or evilness of what triggered those feelings and emotions in the first place. As we saw in the previous example, our person could have interpreted the visual experience of Aunty Caroline either positively, with excitement and joy, or negatively, with a need for flight. Once consciousness was triggered, conscience stepped in and evaluated the situation on its good-to-evil scale.

I would like to argue that the conscience aspect of our thought's formation is culturally and educationally biased. How we interpret the feelings and the conscious awareness of these feelings will be based on our past experience with and knowledge of the initial trigger. The Buddhist proverb from the beginning of this essay is attempting to educate us on this aspect of consciousness and conscience: watch your thoughts, as they lead to character formation. Unconscious biases, also known as implicit biases, are learned assumptions, beliefs, or attitudes that exist in the subconscious. We all have these biases and use them as mental shortcuts for faster information-processing. They have a considerable influence on our interpretations of our feelings and emotions and therefore our thoughts and behaviours.

THE LIMITATIONS AND INJUSTICES OF NORMAL

In massage therapy education, our students spend their days being taught how to think critically based on the best available medical knowledge. We teach them to use patient's descriptions of their signs and symptoms to diagnose conditions and make the best treatment plan. Essentially, we teach pattern recognition and tell our students that those patterns are based on the best scientific knowledge. Rupa Marya and Raj Patel in *Inflamed: Deep Medicine*

DOI: 10.47925/80.4.061

and the Anatomy of Injustice explain the role of story in diagnosis:

> Every diagnosis, according to conventional Western medicine, is a story pulled apart, a narrative told out of joint. The story begins in the middle, with a symptom. Doctors then weave a tale in flashback, one that began with a healthy body that next suffered some insult, trauma, or infection that fits a known pattern of disease. The story of diagnosis—at least the way doctors tell it—concludes with a treatment that may return the body to health at some point in the future, or at least allow the patient to manage illness. But these kinds of stories don't always work.[3]

This pattern recognition in medical education relies on the belief that the body functions as a machine that can and will eventually break down and will need fixing by a knowledgeable person. What would occur if we were to refute this body-as-machine belief and instead started to view the body as an alive and ever-changing entity? What if we started accepting each patient as unique and living in this world with their own patterns and designs of body movements and metabolic biometrics? This would involve us letting go of the concept of normal as a baseline comparison for all our patients. Lennard J. Davis describes how pervasive the idea of normalcy is in our present world:

> We rank our intelligence, our cholesterol level, our weight, height, sex drive, bodily dimensions along some conceptual line from subnormal to above average. We consume a minimum daily balance of vitamins and nutrients based on what an average human should consume. Our children are ranked in school and tested to determine where they fit into a normal curve of learning, of intelligence. Doctors measure and weigh them to see if they are above or below average on the height and weight curves. There is probably no area of contemporary life in which some idea of a norm, mean, or average has not been calculated.[4]

We now live in a world that is dominated by a need to compare everything to a norm. Our medical education is geared towards teaching the norm so we can find patterns of deviation from the norm in our patients. According to Davis, the concept of a norm as "conforming to, not deviating or differing from, the common type or standard, regular, usual" only appeared in the English language over the period of 1840 to 1860. Prior to this time, there was a concept of the ideal body, but only for gods: a divine body was expected of them, but there were no expectations for the human populations to conform to this ideal. The human population was thought of as grotesque, "a visual form inversely related to the concept of the ideal and its corollary that all bodies are in some sense disabled. In that mode, the grotesque is a signifier of the people, of common life."[5]

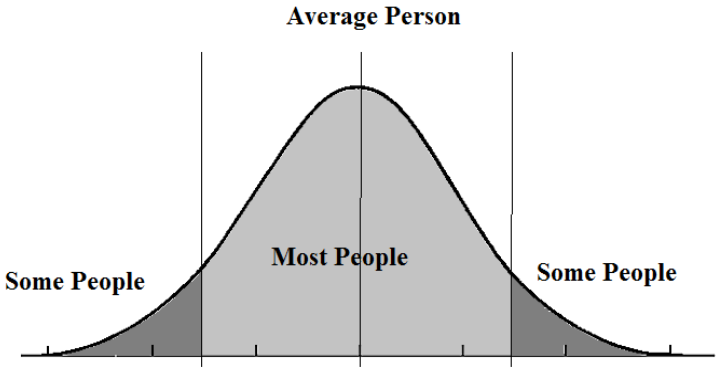
French statistician Adolphe Quetelet brought the notion of the "norm" into common knowledge by appropriating the "law of error" used by astronomers to formulate the idea of the average man (*l'homme moyen*), which he saw as a combination of a physical and moral average. In one fell swoop, Quetelet created a moral ideology where humans could be classified. Davis explains: "The average then becomes paradoxically a kind of ideal, a position devoutly to be wished. As Quetelet wrote, 'an individual who epitomized in himself, at any given time, all the qualities of the average man, would represent at once all the greatness, beauty and goodness of that being.'"[6]

Over time, even the average became not good enough. When eugenicists began using this norm to measure deviations, or the extremes from the curve, the concept of below or above average came to the surface. Being above average was now the new ideal, whereas being found below average was quite concerning. Davis notes that "a symbiotic relationship exists between statistical science and eugenic concerns. Both bring into society the concept of a norm, particularly a normal body, and thus in effect create the concept of the disabled body."[7] Developed by Sir Francis Galton, incidentally Charles Darwin's cousin, eugenics concerned itself with how to arrange human reproduction to increase the chances of desirable heritable characteristics. Its main goal was to improve the human race and eliminate its "undesirables," such as the Jewish people,

DOI: 10.47925/80.4.061

disabled people, and other minorities. With the acceptance of the average and the norm, Galton redefined the concept of the "ideal" person in relation to the general population. By having a "normal," then the idea of a deviant body becomes obvious; with the ranking of how bodies "should" be, a bell curve was now divided into quartiles and ranked in order of desirability. See figure 1 below.

Figure 1: Bell Curve of the Average Person[8]



Dominant western medical sciences rely heavily on this curve and reproduce the underlying problematics and assumptions of eugenics. For example, blood pressure has been measured as being an average of 120/80, meaning that any measurements above or below this average will be, at the least, monitored regularly, or, at the most, treated medically. Stats Canada has defined this average by measuring male and female Canadians between the ages of 20 and 79. As with any research, the exclusion factors here are quite interesting: "The observed population excludes: persons living in the three territories; persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; the institutionalized population and residents of certain remote regions."[9]

Reading this makes me question the reasonability of basing our clinical critical thinking on a "normal average" that is based on data that excludes specific communities and implies that white city dwellers are the normal to be

measured against. Davis further explains:

> As coded terms to signify skin color—black, African American, Negro, colored—are largely produced by a society that fails to characterize 'white' as a hue rather than an ideal, so too the categories 'disabled,' 'handicapped,' 'impaired' are products of a society invested in denying the variability of the body.[10]

When our "averages" are created by a system that already discriminates and excludes body variability, the terms "science informed care" and "patient centered care" become empty buzz words.

NORMAL AS COLONIAL DOMINANCE

In their book *Inflamed; Deep Medicine and the Anatomy of Injustice*, Rupa Marya and Raj Patel illuminate the relationship between our bodies and health and the injustices of our political and economic structures. "Most doctors—most humans, really—have unwittingly inherited a colonial world-view that emphasizes individual health, disconnecting illness from its social and historical contexts and obscuring our place in the web of life that makes us who we are."[11] This world we now live in is not only under the influence of the mythical normal, as mentioned earlier, but also dominated by the legacy of Cartesian philosophy. "Humans who were capable of allegedly rational thought—usually white, Christian, landowning men—comprised 'society.' The rest of the planet—non-Europeans, women, animal, rivers, and plants—were defined as 'nature,' purely physical things without mind."[12] Stats Canada's choice to exclude "all persons living in the three territories; persons living on reserves and other Aboriginal settlements in the provinces" and "the institutionalized population and residents of certain remote regions" from their research on average blood pressure levels in Canadians, demonstrates that some people are not seen as being worthy of inclusion in the 'normal,' and instead fall in the category of "physical things without mind."

In massage therapy education, normal anatomy and especially normal posture and body function are taught right from the get-go, and then continually reinforced throughout the entire program through teaching of assessment

DOI: 10.47925/80.4.061

and treatment of different pathologies or dysfunction. The idea of teaching this "normal posture and function" is to help the students create a baseline to work from to better recognize when a dysfunction is occurring. Because of time constraints and conscious of not overwhelming the learners, curriculums have been streamlined and refined in a way that no longer leave space to teach all the variations from normal that can be found in humanity, which would be an impossible task. Kale et al. argue in "Normalizing Normal in Medical Education: A Call to Action" that reframing this problematic in medical education is of importance as "it might be argued that the 'normal' anatomical structures presented to learners in medical school are not, in fact, normal but prototypical (or even idealized). This could have important implications for physicians' constructions of what is 'normal.'"[13] When our students graduate from Registered Massage Therapy School (RMT) they enter the profession with an established unrealistic expectation of what a healthy, functional human being is supposed to present as. This places them in a position of potentially causing unintentional harm to people coming into their clinic, as they might misinterpret a healthy deviation from normal as the cause of their pain or discomfort, leading to unnecessary treatment, or worse, harming the patient by correcting a supposed positional fault leading to further injury.

As a teacher in a post secondary professional diploma program focused on health education and the promotion of well being, I find myself quite torn by this new-to-me knowledge of this "fake" normal. Karen McKinlay Kurnaedy relays in her book, *Our Love Affair with Dance*, wise words from one of her dance teachers Magda Hanh:

> What power does the teacher hold? Perhaps not always realizing the delicate, fragile egos that may rest in his or her hands. The short and tender impressionable years of youth when one is most open to learning should be cherished by the teacher and pupil. The learner only wishing for acceptance, inclusion, and being part of something that imparts proof that one is progressing in this thing called life. For the student, praise and encouragement are like rain on a parched landscape. The welcome moisture of

> validation can heal dry and thirsty souls and impart courage, confidence, and aid in the fulfillment of dreams.[14]

When my students walk into my classroom they expect and deserve to learn the best approach to care, a way to accompany their future patients positively through, and hopefully out of, their pain and injury journey. I teach them to the best of my knowledge, with the best of intentions, somewhat aware that I am seeing the information I teach them through the veils of the inherited interpretations of my own schooling. I was taught through this same system; it is culturally ingrained in me to look for deviations from the norm, to find patterns that do not fit the desired and accepted bodily functions. Trying to see outside of this "normal" is difficult. It demands I "hack" my thought formation on a regular basis. It can also be quite uncomfortable to find myself with no "normal,"' as if I am no longer anchored properly.

DIFFICULTY IN CHANGING OUR EDUCATIONAL INHERITANCE

Recently, at my workplace, a group of teachers entered into a conversation on how to properly teach and review the quality and usefulness of the pain scale. The pain scale is a tool used by students—and Registered Massage Therapists (RMTs) all over British Columbia—to help monitor the amount of pressure being used during the massage treatment. It is meant as a communication aid to bridge the gap between the patient's private experience of sensations during the massage and the therapist trying to gauge the therapeutic effect of the treatment. As I read back through the many emails going back and forth between all parties involved, I notice telling language keeping the conversation well within the accepted norms, and can see how some instructors were having a difficult time seeing outside their cultural and educational blind spots. Below I share some of their emails. (As a note, I have previously asked the parties included in the emails and they have all consented to me sharing their communications in this essay).

The emails start with one instructor voicing concern over the name and use of the scale as encouraging patients and students to look for a painful stimulus during the treatment as opposed to a relief of pain or a greater level of

DOI: 10.47925/80.4.061

comfort. "The thing I want to get away from," they write, "is hearing students say we are 'looking for a 3, which is good pain.' Encouraging clients to aim for pain of any kind does not feel appropriate." As a reply, another instructor sent this idea for a new scale, but is clearly still quite attached to the word "pain" and was then somewhat corrected by a 3rd instructor, as seen in italics:

> The 1-5 Pain Scale can be used to simplify things for both the client and the therapist.
>
> 0 -1: Zero pain or discomfort felt during a technique.
>
> 2: Zero pain, but slight discomfort might be felt over a sensitive area. *Instructor #3 suggests that there shouldn't even be discomfort at this level. Just touch.*
>
> 3: Zero pain, but a moderate amount of discomfort might be felt during a therapeutic technique. Any discomfort is well tolerated and of short duration. *Instructor #3 uses the term "feels therapeutic" which might feel good for some people.*
>
> 4: Mild to moderate pain is present, indicating the technique is too deep, or the area is too sensitive. Modification to treatment is required. *Instructor #3 adds that this may be tolerated only if the patient can breathe through and remain relaxed.*
>
> 5: Intense pain is present, or the client withdraws consent for any reason. Treatment stops! *Instructor #3 agrees with this.*

Instructor #3's counterargument against calling it a "pain scale" for treatment purposes, is that it confuses it with the scale used for assessment. She uses pressure not to mean that everyone experiences pressure the same way, but that the pressure the therapist applies has a subjective feeling to the client. Instructor #3 explains:

> I think after more consideration, I am going to suggest getting away from the pressure/pain scale entirely, if it is misleading. Perhaps "Comfort Scale"? might also help differentiate between the treatment and the assessment scales? That is just

> off the top of my head though. "Perceived Pressure Scale" does feel clunky, and students will just revert back to pressure scale, I think.

As I read through these sections of emails, I notice the insistence on using the word pain, even though twice an instructor has suggested removing this misleading word. Following is the final email in which a consensus on a new scale seems to have been reached. Students now learn and use this scale in their clinical work:

> 1: No pain, or discomfort is felt.
>
> 2: No pain, or discomfort is felt. Touch is perceived as comfortable, and beneficial.
>
> 3: No pain, but a mild to moderate discomfort might be felt during a therapeutic or specific technique. Sensations are perceived as therapeutic, are of short duration, and are well tolerated.
>
> 4: Mild to moderate pain is present, indicating the technique is too deep, or the area is too sensitive. With client consent treatment may proceed with modifications like breathwork or change in approach to prevent muscle guarding.
>
> 5: Intense pain is present, or the client withdraws consent for any reason. Treatment stops!

What stands out to me here is how minimally different this perceived new scale is from the original one. The first instructor's question on how we could change the pain scale to become more embodied and inclusive of positive sensations during the treatment ended up forgotten. Although all instructors involved tried to work out of their cultural and educational hermeneutics, they did not stray very far from the box they started in. The interesting part is, in the end, there was unanimous approval. Even the instructor who requested the change initially was happy with the new version of this pain scale. Note that the name of the scale was also not changed in the end. These instructors are

DOI: 10.47925/80.4.061

well-educated, professional, and focused on the student experience and their potential as future RMTs. The strength of our cultural and educational biases overwhelmed and overpowered all the best intentions these instructors had to create better curriculum for their students.

Natasha Levinson, in her article "A New Situation: Philosophy of Education and Medical Education" writes of Nicholas Burbules' theory on situated philosophy, which she describes as "what happens when philosophers of education work along side practitioners in a field—in this case, medical educators—to explore how the animating concerns and normative ideals of a given practice play out in particular institutional and social contexts."[15] From this point of view, I would think a collaboration between philosophers and RMT educators would be beneficial in helping our team critically think about our curriculum conundrum and guide us out of our normative way of thinking.

The Buddhist epigraph on thought and how it forms character and Damasio's theory of thought formation and the importance of consciousness and conscience in the interpretation of arising emotions and feelings, make me feel it is important to start teaching my students to communicate in a more embodied way. I have recently changed my wording with my students when I teach them about therapeutic massage. I am now asking them to focus on early body reactions. Essentially, I would like them to teach their patients to notice their emotions earlier and to acknowledge them consciously and not let them stay in the unconscious realm to linger and cause more pain and discomfort than needed. The following is an example of what I now teach my students to use instead of the pain scale during treatment to help their patients start their process towards a more embodied life:

> As I work on you, I want you to stay focused on how your body feels. I would like you to pay attention to the small reactions you might experience as my hands apply pressure. Things you might notice would be you holding your breath, or maybe you have a thought that you want to run away from the table and be somewhere else or are counting the seconds until I stop. You may feel other body parts tensing, like your hands balling into

fists, your toes scrunching, or you find you are clenching your jaw. All of those situations are signs that you are uncomfortable and that I need to change the focus of your treatment. When these happen, pay attention to them, the best way for you to do so is to keep scanning your body as I work, stay focused on your body, breathe slowly and deeply. Make sure to let me know as we go along so I can adjust my treatment. I will periodically remind you and ask you to do this body scan.

WHERE DO WE GO FROM HERE

If we accept that the conscience aspect of our thought's formation is culturally and educationally biased, then it becomes imperative that our educational curriculum be mindful of its consequence on the development of our students as future healthcare practitioners. Teaching the students that variability is the only norm and that humans are complex embodied beings requiring constant communication to find the "normal" that is unique to them, is the pathway to a better education for RMTs.

REFERENCES

1 Antonio R. Damasio, *The Feeling of What Happens: Body and Emotion in the Making of Consciousness* (New York: Harcourt, Inc. 1999), 55.

2 Damasio, *The Feeling of What Happens,* 5.

3 Rupa Marya and Raj Patel, *Inflamed: Deep Medicine and the Anatomy of Injustice* (New York: Picador, 2022), 9.

4 Leonard J. Davis, *Enforcing Normalcy: Disability, Deafness, and the Body* (London: Nota, 2016), 23.

5 Davis, *Enforcing Normalcy*, 24; 25.

6 Davis, *Enforcing Normalcy*, 27.

7 Davis, *Enforcing Normalcy,* 30.

8 Hickler, Hans. "Pay Attention to the Middle of the Bell Curve." *HuffPost* (blog), December 7, 2017. https://www.huffpost.com/entry/pay-attention-to-the-midd_b_5924640.

DOI: 10.47925/80.4.061

9 Statistics Canada, "Blood Pressure of Adults 2016-2019," Catalogue no.82-625-X, last modified March 23, 2021, https://www150.statcan.gc.ca/n1/pub/82-625-x/2021001/article/00001-eng.htm

10 Davis, *Enforcing Normalcy*, xv.

11 Marya and Patel, *Inflamed*, 12.

12 Marya and Patel, *Inflamed*, 17.

13 Mruganka Kale, Glenn Regehr, Sarah McQuillan, and Kayla Nelson, "Normalizing Normal in Medical Education: A Call to Action," *Journal of Pediatric and Adolescent Gynecology* 35, no 6 (2022): 612-613. https://doi.org/10.1016/j.jpag.2022.08.003

14 Karen M.K. Kurnaedy, *Our Love Affair With Dance* (Altona: Friesen Press, 2022), 16.

15 Natasha Levinson, "A New Situation: Philosophy of Education and Medical Education," *Philosophy of Education* 69, (2013): 155-158, https://doi.org/10.47925/2013.155.