



President's Message

By Tamsin Rossiter

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Who would have thought? The ghost of Kevin Rudd was no match for the army of therapists who descended on Canberra for AMT's keynote event of the year. Wow, what a fantastic conference! Thank you to those who attended and made the conference such a successful and enjoyable event. The feedback has been fantastic and our presenters were particularly popular this year. Turns out Bill Bryson was wrong. Canberra is cool!

I would like to expand on the question raised by an astute member during the open panel session at the end of the conference, "Where do you think the profession is heading?"

I believe that AMT is on the cusp of developing into a world-class professional organisation of which you can all be proud - one that not only protects and nurtures its members but, just as importantly, projects a robust competent face to affiliated organisations, the government and the public. We have a common cause and we should all be recognised as professional, dedicated people who care deeply about what we do.

The continuing success of our organisation requires individual members to understand their role in the promotion of AMT. The quality of our membership and the professionalism of the Board have ensured that we are moving in a direction that is exciting, positive and groundbreaking.

I am confident that the Australian massage community is united in supporting the advancement of massage therapy within mainstream and complementary health fields.

The formulation of AMT's Standards of Practice and Scope of Practice is a cornerstone of the drive towards professionalism. Our aim in developing these policy documents is to standardise both the practice of Massage Therapy and the delivery of training at undergraduate and post-graduate level. The Standards will also be used to open dialogue with government agencies on regulation of our profession and to guide practitioners in their clinical practice. They will become the benchmark, not just for current practice but also a measurement tool for research.

To foster transparency and gather a representative range of opinions, we will seek feedback on our Standards from the wider Australian massage and health community. AMT members are also strongly encouraged to participate in this collaborative process. Obviously, there is no point in developing recommended standards without practitioner input or if the underpinning knowledge and skills are not an integral part of massage therapy education. We are committed to standardising both the practice of massage and the delivery of education.

In service of this commitment, we held our second and most successful national educators' forum at the conference. Educators from every state except Tasmania and the Northern Territory were present, representing both public and private sector Registered Training Organisations. The event provided educators with the opportunity to give feedback directly to DEEWR and the Industry Skills Council.



in good hands

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Workshops advertised in this Journal are not necessarily endorsed by the AMT. The views, ideas, products or services in this Journal are not necessarily endorsed by the AMT.

Such opportunities have been starkly lacking in the past and we have AMT to acknowledge in providing the platform and sponsoring the event.

The educators' forum also gave AMT the opportunity to table draft versions of some of our Standards of Practice with the aim of opening dialogue and seeking feedback from massage therapy educators, many of whom belong to different associations.

As the Standards of Practice are a key focus for 2011, we will theme Massage Therapy Awareness Week around them. We therefore encourage regional executives to promote this theme, not just to local members but also within their local communities. It is crucial that the rollout includes government regulatory agencies and the general public to enhance the professional image of Massage Therapy as a serious health intervention.

The greatest moral challenge of our time is not climate change! Rather, it is to establish AMT as Australia's number one professional massage therapy association – an organisation that is founded on professionalism, ethical practice, transparency and honesty.

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Secretary's Report

by Rebecca Barnett

There has been a tidal wave of productivity since I last reported on the AMT Board's current projects. Significantly, the data collection phase of our 2010 industry profiling project is now complete, with 300 telephone interviews conducted. My sincere thanks go again to all members who generously gave their time to participate in the phone survey.

The next phase of this project is to analyse and synthesise the results of the survey in preparation for publication next March, along with the release of our 5-year strategic plan. This will give us a clear baseline against which to measure our progress in the coming years, substantially enhancing both our accountability and our capacity to deliver relevant benefits to AMT members and, ultimately, the profession at large.

Results from both the quantitative and qualitative surveys will be incorporated into our planning. We have already been actively responding to feedback from the 160 written surveys we received, specifically working on enhancing our network of regional branches and branch activities. This includes the recent formal establishment of a local regional branch in Melbourne to allow greater networking and educational opportunities to our growing member base in and around metropolitan Melbourne. I am very excited to be publishing our first Melbourne branch news amongst the other regional reports in this edition of *In Good Hands!*

As Tamsin emphasised in her report, we also aim to actively involve all of AMT's local regional branches in the rollout of our Standards of Practice in the latter half of 2011.

AMT members have the opportunity to preview one of these Standards in this issue of the Journal, with our update on Working with Children provisions across Australia.

NSW members need to pay particular attention to the rollout of the Certificate for Self-Employed People in NSW. Self-employed therapists who work with clients under 18 years of age will need to obtain a Certificate by 1 May 2011. The Certificate helps you to demonstrate that you do not have criminal records that prohibit you from working with kids. It also helps parents, carers and employers to make an informed decision about who will work with their children.

The Certificate for Self-Employed people costs \$80 and is valid for 3 years. Please visit the NSW Working with Children website for information about how to apply: <https://check.kids.nsw.gov.au/#self-employed>



Please note, however, that the draft AMT Standard of Practice for the Treatment of Minors recommends that you do not have unsupervised contact with children in your clinic, regardless of which jurisdiction you are working in.

Standards of Practice rollout timetable

We have made significant progress on the Standards of Practice over the past 3 months. Our deadline to launch the final draft version of the Standards is the 2011 AGM, after which we will embark on a 5-month consultation period,

seeking feedback from a wide range of stakeholders. The aim is to have the Standards formally endorsed in time to promote them during Massage Therapy Awareness Week in September 2011.

Health fund update - Medibank Private

For those of you who are yet to respond to our call for your Medibank Private provider number and associated practice details, please contact Head Office as soon as practicable so we can insure that your status with the Fund is maintained without interruption.

2011 Annual General Meeting

Our next AGM will take place in Melbourne on 27 March 2011. Full details and the agenda will be circulated early in 2011. For the time being, please note the date in your diary so we can have a good crack at matching attendances at our last three GMs!

2011 Conference

AMT's 2011 Conference will be held in Sydney on 14-16 October. In response to the incredible feedback we received from Art Riggs' conference presentations, we are currently negotiating with two US presenters to incorporate more new faces and advanced trainings into next year's program.

On a personal note, I'd like to thank Art for his incredible generosity throughout the weekend of the conference. He made himself available during breaks and at the end of the day to field questions from delegates, and generally charmed the living daylight out of everyone present. Thank you, Art, for setting a big-hearted tone to proceedings from the outset. As one of our delegates noted in the feedback ... he had us all at "hello".

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News from the regions



Melbourne by Kerry Hage

It is with much excitement that I can announce that a Melbourne Branch of AMT has been formally established. Our first official meeting was held on Sunday 12 September with 10 members present.

Our guest speaker was Myotherapist and Exercise Physiologist, Michael Osborne. Michael has been involved in the health and wellness industry for over 15 years in both private and public practice. He spoke about Exercise Physiology, what it is and how it can be a valuable addition to a massage therapist's referral base.

The rest of the meeting was a tentative one, initially working through the Regional Executive Handbook to outline exactly what people were signing up for if they were elected to an official post. Two of the three office bearers were elected: Kerry Hage as Secretary and Gabby Griffiths as Treasurer. It was decided that, until someone was able to commit to being Chairperson, the responsibility would be shared in upcoming meetings. We also agreed that the branch should meet 3 to 4 times per year, with at least one more meeting in 2010.

Once these official duties were completed we opened the floor to general questions and conversation. The main topic of interest was CEUs, which was subsequently tabled as a separate agenda item for the next meeting. We also established an in-house email list to be exclusively used by the Secretary to contact meeting attendees.

A special thank you to Ross Housham who minuted the inaugural meeting in the absence of an elected Secretary. Ross has also offered to host the branch's upcoming meeting, which is set for 5 December.



Blue Mountains by Nicole Benaud

In August, the Blue Mountains region held a well-attended meeting on the topic of Massage Therapy for infants. Thank you to our wonderful presenter, Annette Markham, for sharing her insights into the course she recently completed through the Infant Massage Information Service.

Annette discussed the benefits of massage for premature babies, including results of research that has found that massage improves weight gain and hastens release of premature babies from hospital. She discussed the importance of gaining consent from infants prior to massage and demonstrated techniques to achieve this, as well as massage and holding techniques for babies. Annette also showed four simple clothed massage techniques to teach preschool aged children. It is believed that introducing children to massage in this way encourages empathy and respect for others, teaches them to gain consent for touch, and positively affects their learning and concentration.

We hope to have lawyer Karen Ford discussing legal issues for Massage Therapists at our next local meeting. Karen works for the Health Care Complaints Commission and deals with cases where complaints have been made against unregistered health practitioners. Please stay tuned for further details when we have confirmed them.



Hunter by Paul Lindsay

The planned guest speaker for our September meeting was unable to attend due to personal circumstances. Fortunately, we were able to procure Dr Marc Russo, a specialist in pain medicine at Hunter Pain Clinic, to give a presentation. Hunter Pain Clinic treats patients suffering from chronic pain, both cancer and non-cancer related. Dr Russo gave an excellent talk on the identification of myofascial pain, treatment techniques, and the importance of restorative sleep, correct posture and appropriate exercises to aid in recovery. The talk was very relevant to remedial massage therapists and was well received.

A fundraising massage to aid breast cancer research was planned for Sunday 24 October this year at the Avon Race for Research. Unfortunately, the proposed massage effort was rained out this year but we will try again next year. On the positive side, we have now obtained all the disposable and support equipment necessary to participate in these kind of volunteer events, and most of this is now stored in our locker. This will reduce the amount of organisation required by committee members in the future.

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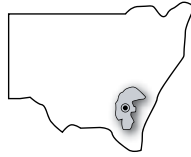
Riverina by Jodee Shead

Results from our local regional survey led us to trialling our July branch meeting on a Sunday instead of our usual Friday evening time slot. We had one extra person attend and no other apologies. The majority of attendees felt that Sunday was a difficult time to get to a meeting due to family commitments. With travel taken into account, it can mean sacrificing an entire day with families.

Our meeting on November 19 was a Christmas gathering, which included dinner, dessert and a post-conference debrief.

Next April, the branch will be involved with a National Health Expo in Kyabram. Called "Back to Basics", it is scheduled for April 16 and 17 and the region has agreed to take out a stand to promote AMT, local therapists and massage therapy generally. Volunteers who choose to help at the stand will have the opportunity to promote their own business while they promote AMT.

Merry Christmas everyone and I wish you a happy, safe and prosperous new year.



ACT by Karin Cavanagh

ACT has not held any meetings since September, largely due to our conference hosting duties. We were busy preparing for the conference, as I hope the accompanying photo amply demonstrates.



▲ Conference satchel stuffing, Canberra style.

Vince Cosentini, a Soft Tissue Therapist from the AIS, presented a workshop at our November 28 meeting. I will report on this in the March journal.

In terms of our 2011 calendar, we are also planning a trip to Wollongong early next year for a wet lab. We will give you more details as soon as we have them.

Our next regional AGM is in March.

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AMT Standards of Practice - Treatment of Minors

With new Working with Children checks for self-employed people rolling out in NSW in 2011, we felt that it was timely to include an updated state-by-state scan of relevant legislation and requirements in the AMT Journal. We present here AMT's draft Standard of Practice for the Treatment of Minors, which details the Working with Children provisions and relevant legislation across Australia.

Please read the information that is relevant to your jurisdiction carefully to ensure that you comply with local Working with Children procedures.

Self-employed NSW practitioners who treat clients under 18 will need to obtain a Certificate for Self-Employed People by 1 May 2011 or face heavy penalties.

Purpose

The purpose of this policy is to provide massage therapists with a clear understanding of their legal and ethical responsibilities in relation to working with minors.

Background

Child protection is covered under State legislation in Australia. As such, there is no single national framework that sets out the requirements for obtaining Working With Children Checks or Police Checks. Each state and territory has its own procedures. It is therefore necessary to fulfil the requirements of the specific jurisdiction(s) you work in.

Statutory requirements

The following is a state-by-state overview of the legal requirements for Massage Therapists working with children.

ACT

In the ACT a minor is legally defined as a person less than 16 years of age.

There is currently no legal statute in the ACT requiring Massage Therapists to undergo a Working with Children or Police Check. Individual employers may have a screening process in place.

Relevant Act:

Children and Young People Act 2008

NSW

In NSW a minor is legally defined as a person less than 16 years of age. However, the NSW Working with Children Check provisions apply to persons less than 18 years of age.

The NSW Working With Children Check is an employer driven "point-in-time" system entailing background checks of employees and the exclusion of prohibited persons from child-related occupations. This check only applies to Massage Therapists employed in childcare settings, such as childcare centres, schools and paediatric wards, and the screening would be undertaken by the employer.

From 1 May 2011, self-employed massage therapists who have direct unsupervised contact with minors in their practice will need to obtain a Certificate for Self-Employed People. Please visit the NSW Working with Children website for information about how to apply: <https://check.kids.nsw.gov.au/#self-employed>

Please note that, under the terms of this policy, AMT requires therapists to have a parent, legal guardian or caregiver present at all times during treatment.

Relevant Act:

Children and Young Persons (Care and Protection) Act 1998

Victoria

In Victoria a minor is legally defined as a person less than 18 years of age.

Massage Therapists are not currently captured by the Victorian Working with Children Act. A Working with Children Check would only apply to Massage Therapists who are employed in childcare settings, such as childcare centres, schools and paediatric wards, in which case a Working with Children Check would be required. Please visit the Victorian Working with Children website for information about how to apply:

<http://www.justice.vic.gov.au/workingwithchildren>

Relevant Act:

Working with Children Act 2005

Queensland

In Queensland a minor is legally defined as a person less than 18 years of age.

Massage Therapists are required to apply for a Working With Children Check, known as a "Blue Card". Valid for two years, Blue Cards entitle individuals to engage in child-related occupations/volunteering.

The Queensland Blue Card is administered by the Commission for Children, Young People and Child Guardian. Please visit the CCYPCG website for information about how to apply: <http://ccypcg.qld.gov.au>

Relevant Act:

Child Protection Act 1999

South Australia

In South Australia a minor is legally defined as a person 18 years or less.

The South Australian system is an employer driven "point-in-time" system requiring employers and responsible authorities to obtain criminal history checks for those engaged in child-related occupations/volunteering. A police check would only apply to Massage Therapists employed in childcare settings, such as childcare centres, schools and paediatric wards, and the screening would be undertaken by the employer.

Relevant Act:

Children' Protection Act 1993

Western Australia

In Western Australia a minor is legally defined as a person less than 18 years of age.

Massage Therapists are not currently captured by the West Australian Working with Children Act. A Working with Children criminal check would only apply to Massage Therapists who are employed in childcare settings, such as childcare centres, schools and paediatric wards, in which case a Working with Children Check would be required. Please visit the WA Working with Children website for information about how to apply:

<http://www.checkwwc.wa.gov.au/checkwwc>

Relevant Act:

Working with Children Act 2004

Tasmania

In Tasmania a minor is legally defined as a person less than 18 years of age.

There is currently no legal statute in Tasmania requiring Massage Therapists to undergo a Working with Children or Police Check. Individual employers may have a screening process in place.

Relevant Act:

Children, young persons and their families Act 1997

Northern Territory

In the Northern Territory a minor is legally defined as a person less than 18 years of age.

From 1 March 2011, the Working with Children Clearance Notice applies to Massage Therapists seeking employment in childcare settings such as childcare centres, schools and paediatric wards. For information on how to apply, please visit the Northern Territory Working with Children website: <http://www.workingwithchildren.nt.gov.au/>

Relevant Act

Care and Protection of Children Act 2007

Policy

When treating a minor, massage therapists are required to:

- comply with relevant local statutes relating to child protection and working with children
- seek informed consent for treatment from a parent, legal guardian or caregiver
- have a parent, legal guardian or caregiver present throughout the treatment

Do not:

- have unsupervised contact with a minor

Principles

Therapists should be mindful of the following principles in relation to the treatment of minors:

- Children are people too. Involve minors in the decision-making process as much as possible. Empower children by explaining the treatment in age-appropriate terminology and seek consent for treatment from them too, wherever practicable.

- Respect boundaries. Children may feel uncomfortable about some elements of the treatment such as removing clothing or lowering/adjusting underpants to access the lower back muscles, and working close to the groin and buttocks. Look for signs of discomfort and be flexible in your approach. Develop strategies that enable you to work with the particular sensitivities of your client.

References

NSW Working with Children Check website
 Victorian Department of Justice website
 Queensland Commission for Children and Young People and Child Guardian website
 West Australian Working with Children check website
 Northern Territory Working with Children website

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Workshop Review: Kinesio Taping

by Dave Moore

Having studied several taping techniques, my curiosity was aroused recently by images of an unusual-looking tape that had started appearing on the bodies of elite athletes. The tape formed complex wavy patterns and curves rather than the usual straight lines of more traditional tape.

Investigation revealed that this was the latest innovation in sports taping - Kinesio Tape. Its popularity surged after the 2008 Beijing Games, where it was frequently sported by Olympic athletes. The most notable proponent was Kerri Walsh who used the tape in competition following surgery on her rotator cuff. Also, Lance Armstrong, 7-time winner of the Tour de France, describes the effectiveness of the tape in his book and Serena Williams has used it during competition.

Kinesio Tape was developed in the 1970s by Dr Kenzo Kase, a Japanese chiropractor. It is made of an acrylic elastic thread wound with cotton, with a thermo-sensitive adhesive that gives the tape its unique stretching and adhesion properties. The adhesive is applied in a wave pattern that assists in its functional properties.

Kinesio Tape can be used for treating athletic injuries and a variety of other physical disorders. In therapy, it is used to relax overused muscles and, in rehabilitation, to facilitate underused muscles by using a precise amount of stretch around the muscle. The wave pattern in the tape's adhesive has a lifting effect on the skin which can reduce swelling, inflammation and lymphoedema by improving circulation, and reduce pain by taking pressure off pain receptors.

Thuy Bridges offers the only certified Kinesio Taping workshops in Australia. She delivers the training over 3 two-day workshops.

When I arrived at Thuy's clinic for the first workshop, it quickly became apparent that I was the only massage therapist in a group of over 20 physios.

Each participant was provided with an excellent spiral-bound course manual and rolls of Kinesio Tape.

Thuy started the workshop by explaining the special qualities of Kinesio Tape. We soon got stuck in, cutting small strips of tape and sticking it to our hands to feel its properties for ourselves. We experimented with various amounts of stretch to assess the effect.

Thuy explained that, to use Kinesio Tape effectively, you must dismiss all past taping experience and approach the tape with an open mind. Given the totally different feel of the tape, this presented no problem. It has been meticulously designed to match the stretch, thickness and density of human skin, enabling it to function effectively without causing discomfort.

Thuy went on to explain that muscle testing is a key element in the successful application of Kinesio Tape. She demonstrated the correct basic application techniques, which includes the direction of tape application (origin-insertion/insertion-origin), the amount of tape stretch, and the correct amount of stretch and position of the part being treated.

The tape can be cut into strips to create different shapes, including a web-like application for treating lymphoedema and bruising. Lines on the tape's backing paper make accurate cutting much easier.

Thuy allowed time for us to practice the basic techniques of cutting and applying the tape. She made sure we were all competent in the basic skills, and offered individual advice and tips as we practised on each other.



▲ Thuy demonstrates a Patella treatment

The rest of the workshop continued in similar style with Thuy demonstrating specific techniques for various body parts and conditions of increasing complexity. Several class members had conditions that benefit from Kinesio Tape so we were able to get some real world experience and feedback. One (hairy) class member even let us shave his leg.

Thuy made great use of presentation technology, with power-point slides and movies used throughout the workshop.

I got a great deal of satisfaction from attending this workshop. The organisation, content and presentation were extremely professional. I have started using Kinesio Tape on some of my clients when indicated and believe that I will find more applications as my confidence and experience develops.

About the presenter

Physiotherapist Thuy Bridges is the director of PhysioWISE, with two Sydney physiotherapy and pilates clinics. She has been using and refining Kinesio Taping techniques since its introduction to Australia in 2004 and is a leader in the clinical applications of Kinesio Tape within the context of other therapy modalities.

Thuy also presented a Kinesio Taping workshop at the AMT conference and received rave reviews from delegates who attended her sessions. We are looking at bringing back Thuy for an encore presentation in 2011.

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Reviewing Scoliosis - A Three Dimensional Approach Part B

by Linda McClure, Structural Integrationist, MA Counselling

Treatment ideas for scoliosis

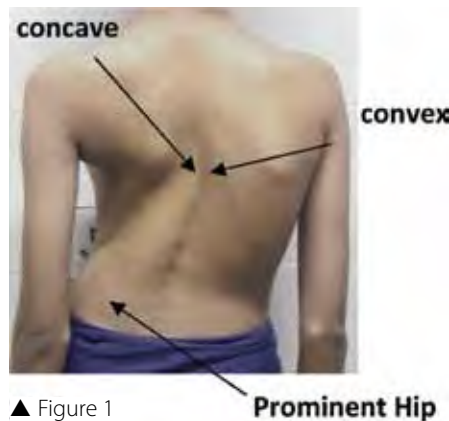
In the first part of this article, published in the June 2010 issue of *In Good Hands*, I provided an overview of scoliosis and put forward the contention that a 3-dimensional view of this condition leads us logically to a 3-dimensional treatment approach. In this article, I will focus on where to direct our efforts to effect change in the spine, and describe rotational breath work, massage and exercise approaches. I will not attempt to cover every possibility regarding where to work but rather give you a general amalgam of manual and movement treatment options that can stand alone or be used in combination.

How does the spine mechanically deform?

In scoliosis, there is a lateral shift and rotation of the vertebral column. This happens because a lateral flexion automatically compresses the intervertebral discs on one side, propelling the viscous fluid of the nucleus pulposus in a contralateral direction and pushing against the annulus. Kapandji likens the nucleus to a swivel that gives each vertebral joint 6 degrees of freedom (Kapandji 1995:30) so, in combination with gravity, lateral flexion is always accompanied by rotation towards the side of flexion. Because of our primal need to keep vertical with eyes facing forward, there is a compensatory action that brings the spine at a certain point back toward the central axis in contralateral flexion. In scoliosis, this compensation influences the creation of either single or multiple curvatures.

What happens to the soft tissues?

In Figure 1A we see an anatomical schematic of what happens to the soft tissue of the paraspinals when scoliosis occurs.



▲ Figure 1



▲ Figure 1A (Schroth 2007)

In areas of concavity, the fascial structures shorten and become somewhat dense and rope like, restricting muscular action. On the convex side, the myofascia tends to migrate laterally and spreads out as the vertebrae rotate and selectively compress out of their normal alignment.

We also need to consider the core muscular structures such as the multifidi, rotatores and iliopsoas, which become contralaterally shortened and locked long in response to the rotational dysfunction caused by scoliosis. There is a tendency toward sensory motor amnesia in these structures and a strong need for them to be 'woken up' when we are formulating a treatment plan. This entails engaging proprioceptive awareness through micro-movement and breath work while we perform manual release and targeted strength and lengthening activity. Research suggests that a kinaesthetic dystonia occurs, interfering with normal functional awareness of alignment in scoliosis. This is eloquently discussed in more detail by Colin Rossie in the September 2006 edition of the AMT journal.

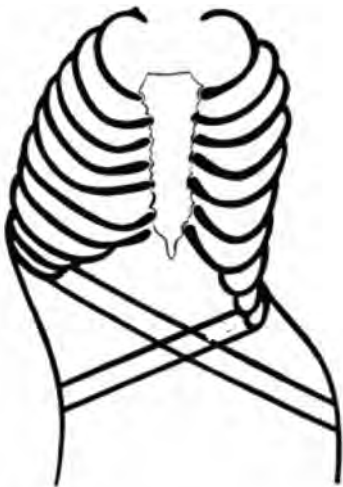
Reviewing core structures for manual release and strength therapy

Paraspinals, iliocostalis/lumborum, longissimus, multifidi and rotatores intercostals, internal/external obliques, quadratus lumborum, iliopsoas.

Integrating and balancing the length and strength of supporting structures will greatly enhance the fascial unwinding of the spine. In Figure 1B we can observe how the obliques conform to the spinal rotations by bringing the hip and lower rib cage closer together on one side and further apart on the other. These structures must be appropriately released and strengthened respectively to support the work on the spine.

There will be similar disparity in the pectorals, trapezius, latissimus and quadratus lumborum.

In addition, we will need to attend to the impact of the spinal rotations in the neck. The cervical spine will express similar patterns of rotation and compression as it tries to create a level platform for the shoulder girdle to rest on. The neck is the final opportunity for the body to level itself out and get the eyes orienting forward and horizontal.



▲ Figure 1B (Schroth 2007)

Integrating structures for manual release and strength therapy focus are:

Latissimus dorsi, trapezius, pectorals, adductors/abductors, lower body Superficial Back Line, and the cervical spine (especially the sub-occipitals which are myofascial and neurological power spots).

Lateral line treatment on the massage table

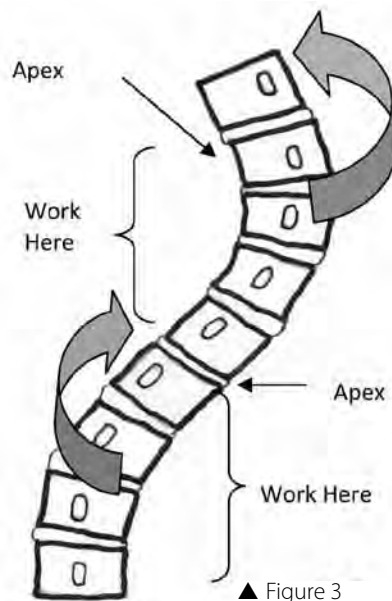
Lie the client on the concave side with the arm underneath the head and stretched up or outwards. A pillow can be added to rest the head on. The inferior leg is bent. If the hip on this side is prominent (see Figure 1), place a cushion underneath it to encourage it back into alignment (very small baby cushions are good or a hand towel folded to the required height). If the hips are relatively even, then place the cushion under the lumbar convexity as shown in Figure 2. The aim is to positionally de-rotate, extend and align the pelvis at all times while working, calling for breath into areas of concavity and flatness.

▼ Figure 2 (Schroth 2007:38)



Work myofascially on the concave side to release the shortened erector spinae, with the focus on the apices of the curve (Figure 3).

On the convex side, the longissimus and Iliocostalis or paraspinals migrate laterally (Figure 1A) and need to be encouraged toward the spine. Use client movement such as micro undulation and lengthening from the hip and leg to open up spinal concavities while at the same time contracting the migrated and overstretched paraspinals on the convex side. Refer to the movement section of this article for more advanced off-the-table ideas.



▲ Figure 3

Back line treatment

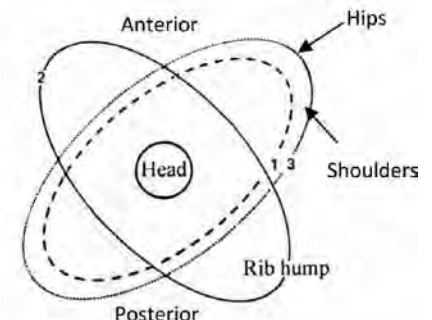
We need to be mindful of any difficulty our clients may have with prone positioning, however, if this is positively indicated we can proceed. On the concave side we want to focus on de-rotating and lengthening the shortened deep spinal rotators below the rib hump (Figure 1A). To assist in this, we position our client in the prone position and place cushions under the pelvis to lengthen the lumbar, and an additional cushion under the hip and shoulder on the convex side, remembering that in a 3-curve scoliosis the pelvis and shoulders follow each other (see Figure 5). By doing this, we bring the pelvis and shoulders towards level.

We also place a cushion under the frontal rib hump to lift and fill out the flattened posterior ribs. Work as detailed in the previous lateral line treatment.

Practice taking the time to assess where the rib or lumbar humps are and the overall flow of your client's scoliosis, so you will be able to accurately place the cushions to positionally 'even out' the scoliotic curvatures in all 3 dimensions while you perform your soft tissue releases. Over time, you will achieve excellent results with this approach.



▲ Figure 4 (Schroth 2007)



▲ Figure 5 (Schroth 2007)

Client micro movement

You can achieve more potent results by asking your client for movement while you perform targeted manual release techniques. This approach can be used either on the table or in seated work. Asking the client to perform micro undulatory/spiral movements will help, not only to create a more potent release but also to make the work more proprioceptively embedded in the client's kinesthetic awareness. The area gets 'woken up' so that new postural options can be taken on board because of the 'felt sense' acquired. We also need to integrate newly gained postural awareness in mindful movement awareness lessons including breath work (Figure 7).

There is a tendency to want to work on the rib hump, which has more prominent and laterally migrated paraspinals on the convex side. However, we need to remember that these structures will only need general integrative manual techniques to encourage their medial repositioning once the more precise decompression and lengthening of the core myofascial structures is complete. Again, I stress the importance of having the client perform micro extensional and de-rotational movements while you decompress and lengthen these structures. This gives the client a new sense of their posture and proprioceptively moves them towards a more accurate alignment.

Movement Therapy Focus

Skill Set

- Any undulation exploration. Spiraling into - and especially out of - the scoliotic pattern is encouraged, often achieving best results in a seated position.
- Strength work involving a level pelvis that is stabilised, then clear two directional extension with breath work into concave rib areas.
- Rotational Angular Breathing (RAB) with de-rotation and extension of the spine and rib cage (defined below).

Figure 6 shows an exercise from the Schroth Institute in Germany (Schroth 2007:36) where a young boy is lifting and elongating his trunk by pressing two poles down with his hands, creating an eccentric contraction, then applying Rotational Angular Breathing. The second image in the series shows the flat and compressed section on his left side filling out and lengthening with the directed breath work, as the rib hump is restricted by the eccentric contraction.

▼ Figure 6



Rotational Angular Breathing

Breathing directions follow the sides of an imaginary right angle with the second side running cranially. The patient directs the breath into the concavity or flattened area with the mental image of lowering the diaphragm, while counter-moving the body above and below e.g. the two directional extension shown in Figure 6, where the trunk is elongating and de-rotating while the patient applies RAB and 'down-weights' through the poles. In Figure 8, there is 'down-weighting' into the left knee and anterior lower leg, and active lengthening of the lumbar/thoracic concavity as the patient breathes space into it, stabilising the right ribcage (rib hump area) with eccentric contraction. Figure 7 shows the therapist giving proprioceptive cues to the patient as she performs RAB.

Persistence and focused attention to the breath work, along with targeted and specific myofascial release and strengthening of the weak complementary muscles such as psoas, adductors and obliques can make a positive difference to the degree of curvature. This, in turn, can reduce pain and improve vital capacity.

Any of these movement ideas can be adapted for use on the massage table or with seated work.



▲ Figure 7 Scoliosis Rehabilitation at Moramarco Chiropractic Clinic, Massachusetts



▲ Figure 8 Scoliosis Rehabilitation at Moramarco Chiropractic Clinic, Massachusetts

Conclusion

This article has sought to introduce the reader to a user-friendly approach to non-surgical treatment options for sufferers of scoliosis, including practical suggestions to add to the toolbox. I hope that it will further encourage practitioners to study and learn more about this fairly commonplace condition, and give inspiration to our scoliosis clients that change is possible.

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This Sporting Life: A Volunteer's View

by Karin Cavanagh

"In this era of globalisation and continuous change, the world is becoming smaller, more interdependent and more complex. Volunteering either through individual or group action is a way in which: human values of community, caring and serving can be sustained and strengthened. Individuals can exercise their rights and responsibilities as members of communities, while learning and growing throughout their lives, realising their full human potential. Connections can be made across differences that push us apart, so that we can live together in healthy, sustainable communities, working together to provide innovative solutions to our shared challenges and to shape our collective destinies."

Extract from Universal Declaration on Volunteering
<http://www.volunteeringaustralia.org>

You may be wondering "Why would I want to volunteer at an AMT conference? Sounds too much like hard work and I wouldn't get to listen to any of the presenters." I hope that sharing my experiences at the AMT conference will help to answer that question.

In the lead up to the Conference there's product samples to organise and possibly collect; sample bags to assemble and transport to the venue; and delegates or presenters to meet at the airport. During the conference itself, there are lecture rooms to set up; dozens of massage tables to erect; conference attendees to greet; delegates to scan into sessions; presenters to assist and support; rooms to dismantle and reset; and the kind of general "go to" duties you would expect at a complex event.

AMT conference volunteers start their day well before any of the delegates arrive and leave last as well. They are integral to making the event more enjoyable for delegates, taking a huge amount of work away from AMT staff. Members and non-members alike said they thoroughly enjoyed themselves. One non-member even wants to switch associations!

BEFORE THE CONFERENCE

Stuffing sample bags

Conference volunteering can begin 6 months before the event! With 300 sample bags to compile, sourcing suppliers is just the beginning but AMT Head Office staff organise most of this.

Not everything turned up on time. Some products arrived after we had assembled half the bags, even though we didn't start stuffing until 2 days before the conference.

After stuffing just 20 bags, your beloved home looks like a warehouse. In spite of that, it's fun. It took 3 of us around 6 hours to stuff 300 satchels.

I would like to extend a massive thank you to Maxine O'Callaghan for organising and storing the samples, turning her lounge room into a warehouse for several weeks.

AT THE CONFERENCE:

Friday 29th October

We arrived at the hotel around 8:30am and were thrown into the thick of things straight away. We had to unload about 20 boxes of sample bags from the car then it was all hands on deck, setting up 20 massage tables and 40 chairs in each of the breakout rooms. There was a minor kerfuffle when it became apparent that we were short of massage tables but these arrived by morning tea and conference proceedings went ahead relatively uninterrupted.

We learned to use the delegate trackers and "beeped" everyone into their respective rooms. It's fun when technology works well...

At the end of the day, we packed up one of the rooms in readiness for the plenary sessions on Saturday morning and then finally headed home.

Saturday 30th October

With a 6.30am start, we delivered yet more boxes of sample bags to the venue.

We manned the reception area, welcomed delegates, assisted the exhibitors with setting up their displays, and then set up 2 more breakout rooms with 15 tables, 30 - 45 chairs and associated notes.

The plenary session started and we got to sit down for a couple of hours. Phew!

During the delegates' lunch break, there were more massage tables to put up but then we were able to participate in the afternoon workshops.

Heavy afternoon rain forced us to resort to plan B for dinner, which meant packing up massage tables... again! A fun and yummy dinner compensated for the extra work though.

Sunday 31st October

Sunday was a bit more civilised with an 8.30 start. Everything was set and ready to go.

We volunteers had lunch a little earlier than delegates because of the massive changeover required for the final afternoon session - we needed to set up 200 chairs and 40 massage tables during the official lunch break.

When it was all over bar the shouting, delegates had afternoon tea and headed off bleary-eyed but content. However, the volunteers' job was not quite done. We spent an hour packing massage tables back into boxes - blue tables went into boxes marked with a blue sticker, green into green, large tables into large boxes, and so on. Fortunately, there were many hands to help out with this final, brain-busting task!

The wrap

I had a fantastic weekend. Volunteering added to my conference experience rather than detracting from it. I got to rub shoulders with some of the big names in our industry, heard about what is happening in the training sector from delegates at the Educators' Forum, met a few people from different regions, and helped AMT staff run things smoothly.



Sale of the Century prize girls



I'm sure your hip was here somewhere ...



Assessing for pelvic instability



He had us at hello - Art Riggs balances a knee



The next best thing to wax - kinesio taping



Dan Alter gets down to work



Desley Scott burps an Oov ... as you do



Daniel Vladeta puts Walter through his paces



Grooving in glorious monochrome

Deep Seated Hip Pain

by Jeff Murray

The aim of this article is to:

- increase awareness of a number of issues associated with deep-seated thigh pain
- outline how to assess for femoral head translation
- differentiate the structural and functional components that present as hip pain
- review the anatomy of the femoral triangle and its influence on pathology and outcomes
- develop a treatment protocol from the objective assessment.

The most common pathologies of the hip that present in the clinic are (Wisbey-Roth 2010):

- Labral tears
- Chondral damage
- Trochanteric and iliopsoas bursitis
- Slipped epiphysis
- Degenerative disease
- Capsular
- Femoral acetabular Impingement
- Instabilities
- Inflammatory pathologies.

Overview

To ascertain where a problem exists, the therapist must have a sound assessment protocol. Without assessment, we are merely relying on pain as our guide to treatment. Those of us who have been practising for some time will know that pain is often a poor indicator of where the pathology really is. In most cases, pain is the result of compensation - somewhere in the body muscles are suffering from what Janda calls sensory motor amnesia (Janda 1987). Once this occurs, the brain recruits other muscles in an attempt to recreate stability and homeostasis, creating a crossover between phasic and tonic muscles.

Tonic and phasic muscle systems

Janda explained the concept of sensory motor amnesia through his research, identifying two groups of muscles based on their phylogenetic development (Janda, 1987). Functionally, muscles can be classified as “tonic” or “phasic”. The tonic system consists of the “flexors” – muscles that are involved in repetitive or rhythmic activity and are activated in flexor synergies. The phasic system consists of the “extensors”, muscles that work eccentrically against the force of gravity and emerge in extensor synergies.

Janda noted that the tonic system muscles are prone to tightness or shortness, and the phasic system muscles are prone to weakness or inhibition (Table 1).

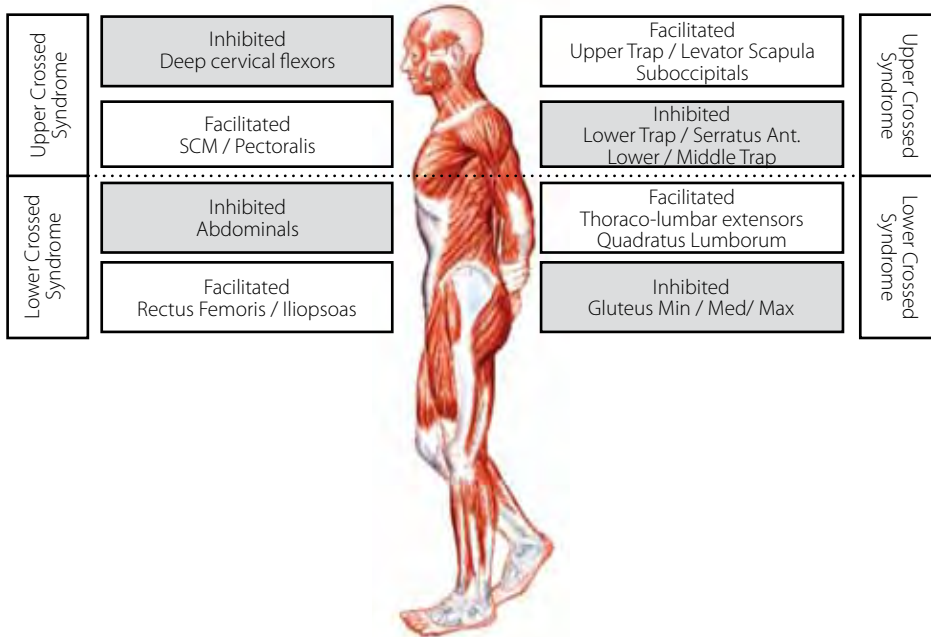
Following on from his research on phasic and tonic muscles, Janda identified two syndromes that occur in the shoulder and pelvic girdles. These findings are noted in Janda’s research papers and are now well known and recognised as upper and lower crossed syndrome.

The essential features of upper and lower crossed syndromes are summarised in Figure 1.

Janda’s work is significant because it explains the implications of an imbalance in the musculoskeletal system. An analogy can be drawn with structural imbalances in the hip that involve obturator externus, iliacus and the femoral triangle, providing us with a clearer understanding of the consequences of instability.

▼ Table 1: Tonic and Phasic Muscles

Tonic Muscles Prone to Tightness or Shortness	Phasic Muscles Prone to Weakness or Inhibition
Gastroc-Soleus	Peroneus Longus, Brevis
Tibialis Posterior	Tibialis Anterior
Hip Adductors	Vastus Medialis, Lateralis
Hamstrings	Gluteus Maximus, Medius, Minimus
Rectus Femoris	Rectus Abdominus
Iliopsoas	Serratus Anterior
Tensor Fascia Lata	Rhomboids
Piriformis	Lower Trapezius
Thoraco-lumbar extensors	Deep neck flexors
Quadratus Lumborum	Upper limb extensors
Pectoralis Major	
Upper Trapezius	
Levator Scapulae	
Scalenes	
Sternocleidomastoid	
Upper limb flexors	



▲ Figure 1: Janda's Muscle Imbalance Syndromes

If we find that a client is not responding to our general treatments we may need to delve a little deeper into our assessment protocols. When a client presents with unrelenting deep-seated hip pain and gross restriction of internal hip rotation, the position of the femoral head in relation to the acetabulum should be assessed. Recommended internal hip rotation is 45 degrees (Phaigh 1991) so, if your client has deep-seated hip pain, neural symptoms in the anterior thigh and only 0-15 degrees of internal hip rotation, the position of the femoral head and the labrum may be implicated.

Most therapists have a solid understanding of the shoulder complex, the rotator cuff muscles and the affect that tight pectoral muscles have on the position of the head of the humerus in the glenoid. However, fewer therapists generally consider the clear mechanical parallels with the pelvic girdle, specifically the influence of the hip rotators over the position of the femur in the acetabulum. Piriformis is well documented as a cause of sciatic problems (piriformis syndrome) but the most important role of piriformis and the other stabilising muscles of the hip is to provide congruency between the head of the femur and the acetabulum. To stabilise an unstable hip, the brain will recruit piriformis and the other stabilising muscles to pull the femur deeper into its socket, thereby creating more congruency.

The affected innominate will also adopt an anterior pelvic rotation to further create stability and congruency by encapsulating the head of the femur. We see this condition commonly with faulty Q angles, pronated feet and dysfunction of the force closure complex of the sacroiliac joint.

Again, most of us have a broad understanding of the sciatic nerve and its associated neural problems but there seems to be less awareness and understanding of nerve entrapment in the femoral triangle and associated anterior thigh pain.

Boundaries of the femoral triangle

The femoral triangle is bounded by the inguinal ligament superiorly, the medial border of the adductor longus medially, and the medial border of sartorius laterally. Figure 2 overleaf shows the femoral triangle.

The base or floor of the femoral triangle is formed by the adductor longus, pectineus and iliopsoas from medial to lateral. The floor is not flat but forms a gutter shape. The roof of the femoral triangle is formed by the fascia latae. Seated in this gutter is the femoral artery which can be palpated approximately 3cm inferior to the midpoint of the inguinal ligament. Posterior to the femoral artery lies the femoral head.

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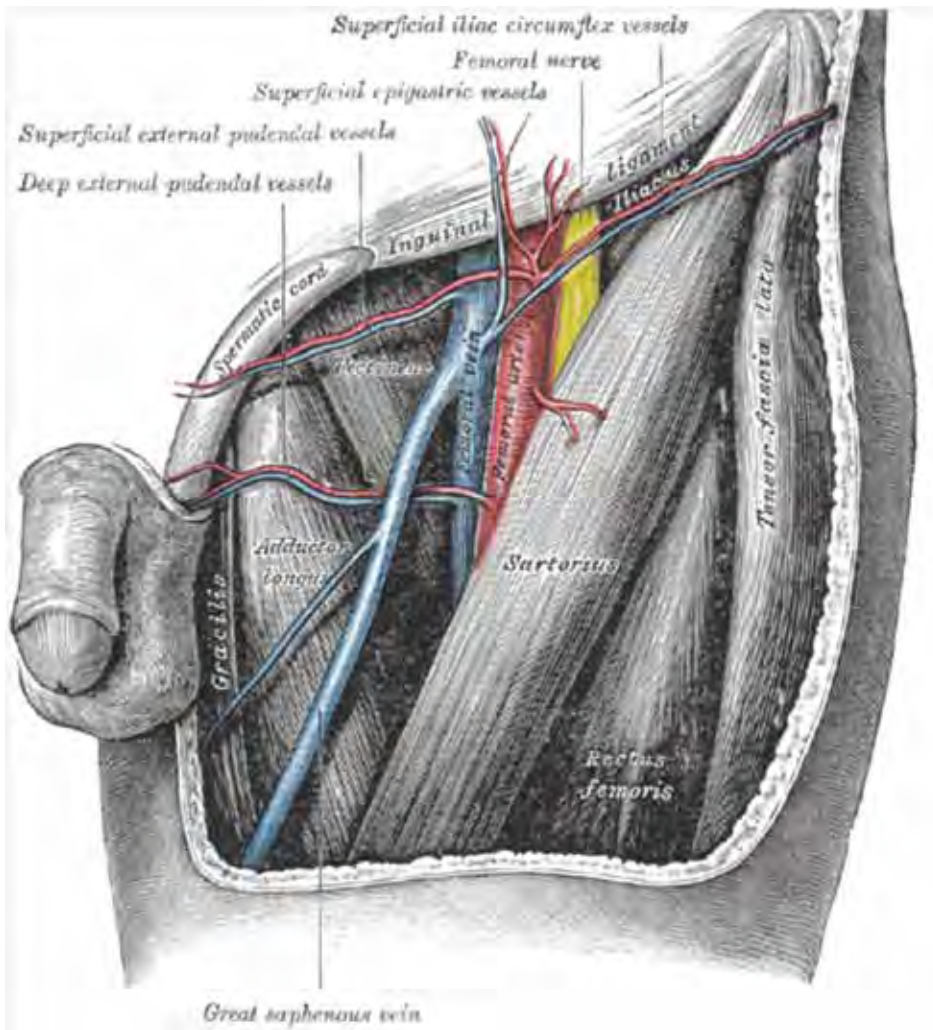
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▲ Figure 2: Femoral Triangle (Grays Anatomy)

Contents of the femoral triangle

The femoral triangle encloses the femoral artery and its tributaries; the femoral nerve and its branches; the femoral vein and its tributaries; the cutaneous nerve; the femoral branch of the genitofemoral nerve; lymphatic vessels and inguinal nodes. The saphenous nerve extends from the femoral nerve, passing out of a canal from under sartorius and piercing the fascia latae about 10cm superior to the knee.

If there is a problem in the femoral triangle, clients may feel pain when the saphenous nerve is palpated where it exits superior to the knee.

Internal hip rotators

The internal hip rotators comprise gluteus minimus and medius, and tensor fascia latae. (Kapanji, Vol II. 1987)

External hip rotators

The external hip rotators comprise piriformis, gemelli superior and inferior, obturator externus and internus, and quadratus femoris. (Kapanji, Vol II. 1987)

A direct analogy can be drawn between these muscles of the femur and the rotator cuff muscles of the humerus.

Flexors of the hip

Flexors of the hip comprise iliopsoas, sartorius, tensor fascia latae, pectineus (primarily an adductor), adductor longus, gracilis, and the anterior fibres of gluteus medius and minimus. (Kapanji, Vol II. 1987)

Current research posits that psoas major is more of a compressor of the spine than a hip flexor. Iliacus is now considered to be the major hip flexor.

Assessment for deep-seated thigh pain

With client supine and hip and knee flexed to 90 degrees, assess internal hip rotation range of motion (ROM). If ROM is restricted to below 20 degrees suspect a structural restriction due to the femoral head not sitting in the centre of the acetabulum. We must also rule out a labral tear.

Assessing for a labral tear

With client supine and hip and knee flexed to 90 degrees, palpate the femoral artery and then move laterally. As discussed earlier, the head of the femur is located posterior to the femoral artery. Your palpating fingers are now located over pectineus (posterior wall of the femoral triangle). Move slightly more laterally towards iliacus and find the septum that divides pectineus and iliacus. Using extended fingers like a knife blade, push your fingers into the septum and palpate over the femoral head onto the labrum. Assess the pain threshold of the client. If pain is 9-10 on the pain scale and the client says that their pain is reproduced, suspect a labral tear and refer them for a medical diagnosis (Wisbey-Roth 2010).

Assessing for anterior femoral head distraction

With the client supine and hip and knee flexed to 90 degrees, palpate over iliacus and apply flat hand pressure over the femoral head, distracting it anteriorly/posteriorly (AP). Assess if there is an increase in medial hip ROM (Wisbey-Roth 2010). If ROM increases significantly, obturator externus may be causing the structural/functional restriction. You may also notice that the gluteus maximus is no longer full and round, but drawn in at its inferior fibres. This lack of fullness can be the result of a tight obturator externus drawing on the gluteal muscle.

Obturator externus creates three planes of motion on the shaft of the femur:

- a. lateral
- b. extension
- c. abduction

This movement of the shaft of the femur forces the femoral head anteriorly within the acetabulum which, in turn, causes mechanical restriction in the acetabulum and a compressive load on the back of pectineus, thereby compressing the femoral triangle and disrupting its neural and vascular contents.

Assessing for a posterior femoral head distraction

With the client supine and hip and knee flexed to 90 degrees, distract the femur by placing the forearm under the knee and lifting the femoral head slightly, creating a posterior/anterior (PA) distraction of the femoral head (Wisbey-Roth 2010). If ROM increases significantly, iliacus may be tight and pushing the shaft of the femur in three planes of motion:

- a. medial
- b. flexion
- c. adduction

This posterior shift causes a mechanical restriction in the acetabulum and a compressive load over iliacus and onto the anterior wall of pectineus, thereby compressing the femoral triangle and disrupting its neural and vascular contents.

Releasing obturator externus

With client supine and hip flexed to approximately 45 degrees, palpate adductor longus down to its origin at the pubic ramus, as shown in Figure 3. Ensure that you have discussed your therapeutic rationale and protocols with your client, and have received informed consent before you commence.

Once you palpate the pubic ramus, run your fingers along the inferior posterolateral aspect and drop into the obturator foramen, as shown in Figure 4. Maintain constant pressure over the obturator externus and passively medially rotate the thigh. This should increase tension on the muscle and provide you with proprioceptive feedback, indicating that you are in the correct position.



▲ Figure 3: Locating adductor longus



▲ Figure 4: Locating obturator foramen

Releasing iliacus

Iliacus is a deep anterior stabiliser of the hip that pulls the femur deeper into the acetabulum posteriorly (Wisbey-Roth 2010). The majority of its fibres insert onto the lateral side of the tendon of psoas major to form the conjoint tendon.

With client supine and hip flexed to approximately 45 degrees, palpate iliacus over the iliac fossa. While controlling abduction of the hip, release the overlying fascia as shown in Figure 5.



▲ Figure 5: Releasing fascia

Palpate the Golgi tendons at the conjoined tendons of iliacus and psoas situated at the musculotendinous junction, just medial to the iliofemoral ligament (Phaigh 1991).

The iliofemoral ligament is a band of great strength which lies in front of the joint. It is intimately connected with the capsule and serves to strengthen it. It is attached above to the lower part of the anterior inferior iliac spine and below it divides into two bands, one of which passes downward and is fixed to the lower part of the intertrochanteric line, while the other is directed downward and laterally, and is attached to the upper part of the same line.

Between the two bands is a thinner part of the capsule. In some cases there is no division, and the ligament spreads out into a flat triangular band which is attached to the whole length of the intertrochanteric line. This ligament is frequently called the Y- ligament of Bigelow and its upper band is sometimes named the iliotrochanteric ligament (Gray 1858).

Gentle cross fibre frictions to the Golgi tendons of iliacus/psoas, as shown in Figure 6, will stimulate and create a proprioceptive response in muscle tension.



▲ Figure 6: Cross fiber friction to the Golgi tendon organs of psoas/iliacus

Massage and release the belly of iliacus/psoas as shown in Figure 7.



▲ Figure 7: Release iliacus and psoas muscle belly

Effects of the femoral head pushing on pectineus

When obturator externus is tight, it will force the femoral head against the pectineus muscle causing compression of the femoral triangle. This compression can create neural and vascular issues in the anterior thigh (for example, compression of the saphenous nerve). Symptoms and problems will occur approximately 10cm above the medial and lateral aspects of the knee.

Conclusion

Reassessment of the hip complex is required to assess if your treatment protocol has been successful. Reduction in pain and an increase in internal hip rotation is a good sign that your treatment protocol has been successful. A reduction in neural pain when palpating the saphenous nerve where it exits the fascia (approximately 10cm superior to the knee) would also indicate reduction in femoral triangle compression.

Once you have reduced symptoms, do not forget to look for the cause of the problem in the first place. There is a high chance that either iliacus or obturator externus were merely attempting to stabilise the hip due to sensory motor amnesia somewhere else within the pelvic girdle complex.

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Adherence to home exercises/ recommendations by complementary healthcare clients: a research project

by Clare Carey and Jessica Hough
(under the supervision of Joanna Smith)

Introduction

Complementary health practitioners often prescribe clients with exercises to perform at home to support the therapeutic interventions undertaken in the treatment session (Milroy, et al 2000). Given that many diseases are preventable, curable or at least treatable, patient adherence is often a crucial step towards improving treatment status and achieving good health (Morisky, 2009).

Research has demonstrated a positive relationship between the level of client adherence to exercise prescription and recovery from a variety of musculoskeletal conditions (Howard & Gosling, 2007).

Failure of clients to adhere to the prescribed exercise program is a common problem facing healthcare practitioners and it raises questions about the reasons behind non-adherence and what practitioners can do to improve adherence.

The aim of this research project was to determine the level of client adherence to prescribed home exercises/ recommendations in four different complementary health practices and to establish whether healthcare practitioners are doing enough to encourage adherence to exercise programs. The four complementary health modalities we investigated were Massage Therapy, Osteopathy, Chiropractic and Physiotherapy.

Contemporary research

Adherence

This paper makes specific mention of the difference between the terms 'adherence' and 'compliance'. Adherence assumes an active, voluntary and mutual relationship in which both the client and the healthcare provider work together to accomplish a desired therapeutic outcome (Miller, 2008). Compliance assumes that one person conforms or adapts to another's agenda, which has often resulted in negative implications.

The latter assumes that the client is a passive participant in the practitioner's care and should simply follow medical advice (Miller, 2008).

Current reported rate of adherence

Several studies have been conducted relating to adherence within a specific population of clients. No studies were found that targeted the general population. Adherence has been studied extensively in cardiac rehabilitation programs, personal training clients, in the treatment of rheumatoid arthritis, and in clients being treated for diabetes, obesity and depression. The rates of adherence in the reviewed literature ranged between 30 and 50%.

Motivators and barriers

One of the key issues is whether client non-adherence is a reflection on the treating practitioner or the attitude of the patient.

In many of the published studies, a variety of factors have been identified as either motivators (increasing adherence) or barriers (decreasing adherence) (Forkan et al, 2005).

There are two main reported motivators in relation to adherence to home care exercises:

- 1. Self-efficacy** is the strongest motivator for adherence: the individuals' belief in their capacity to succeed or perform at an appropriate level (Roberts & Dyer 2005) and the expectation that a specific consequence will result from specific actions (Forkan et al, 2005).
- 2. Memories or past experiences.** If the memories of the exercise prescription provide a pleasurable feeling, then the individual will be motivated to pursue the same activity in the future. On the other hand, if the experience was not pleasurable, the desire to engage in the activity will decrease and the client will therefore avoid participation (Milroy et al, 2000).

Barriers are categorised as either primary or secondary.

Primary barriers:

- Insufficient time
- Lack of social support
- No place to exercise
- No transportation
- Insufficient money
- Lack of self-efficacy

Secondary barriers:

- Change to health status
- Doing other forms of exercise
- Lack of motivation
- Didn't know how to do exercise
- Disinterest in exercise
- Felt it didn't help
- Didn't have anyone to exercise with
- Program was too long
- Program was too hard
- Didn't have required equipment
- Lack of energy
- Found program was boring
- Forgot
- Depression
- The practitioner did not stress the importance of adhering to the program

Methods

The way in which home exercises are prescribed can determine the rate of adherence. Cermake, Friedrich and Madebacher (1996) found that exercises based purely on written instructions were often performed inadequately and therefore led to poorer outcomes compared with exercises learned under the supervision and guidance of the treating practitioner.

Self-documenting has been shown to increase exercise adherence. Self-documentation systems such as exercise diaries assist clients to keep track of their daily goals and achievements. This makes the client more personally invested in their progress (Block & Hood-Gabrielson 2004).

Feedback

Duncan and Pozehl (2008) found that feedback plays an important role. Feedback assists the client to recognise their progress in the exercise and to identify the need for future changes. Individuals who received feedback on past efforts adhered with the exercise better than individuals who did not receive feedback.

Constructing the exercise program

Health practitioners have a responsibility to prescribe, promote and educate clients on the importance and value of exercise in relation to optimal physical function, wellness and quality of life (Forkan et al 2005). Forkan's health belief model proposes that the likelihood of an individual engaging in exercise is a function of personal beliefs about threat (e.g. symptoms worsening). Thus, when devising the homecare plan, practitioners need to properly assess the client's limitations and monitor their level of pain when prescribing exercises. Programs need to be designed to prevent relapse, which can occur as a result of any of the barriers listed above.

To achieve maximum adherence, Milroy (2000) suggests involving the client in the process by allowing them to choose appropriate exercises. This can be achieved by offering several alternatives that address the issue being treated. The practitioner then explains each exercise and asks the patient to select which one they feel most comfortable completing. Although there is no reported evidence that this particular method improves adherence, Milroy suggests this as a tactic for practitioners to try if they are faced with non-adherence (Milroy, 2000).

Relationship between exercise adherence and pain

There have been several studies conducted that assess the link between adherence to homecare exercises and an improvement of pain and function. Van Gool (2005) carried out a study on older adults with knee osteoarthritis, examining the effects of exercise adherence in improving physical performance, disability, pain, quality of life and depressive symptoms. The study explored the association between exercise adherence and concurrent changes in physical function, over short and long periods of time. The conclusion drawn was that higher exercise adherence is linked with greater physical improvements.

Hanney (2009) examined how fear of pain and movement contributes greatly to decreased activity levels. High-intensity aerobic exercise decreased pain, disability and psychological stress in those with chronic lower back pain.

Research method

A questionnaire was the selected method of data collection. It consisted of 17 open and closed questions, and was designed to take no more than 5 minutes to answer so that the subjects would have time to complete them in the clinic waiting room.

The participants were recruited from an Osteopathic, Chiropractic and Physiotherapy clinic in Canberra, and a Massage Therapy clinic in Invercargill, New Zealand. Participants were 18 years and over, and must have used a method of complementary healthcare at least once in the last 6 months.

Results

Demographics

A total of 89 participants completed the survey with the following distribution across the 4 clinics:

- Osteopathy clinic (n=44)
- Chiropractic (n=17)
- Physiotherapy (n=18)
- Massage Therapy (n=10)

68 of the participants were female and 21 were male. 50% of the participants were aged between 31 and 50. 56% of the participants reported receiving treatment for back pain. This was considered significant, however it was beyond the scope of the research to evaluate this or any other observed trends.

The number of participants reported using the following modalities (either simultaneously or at least once in the last 6 months):

Table 1.
Modalities used in 6 months

Massage Therapy	36.5%
Osteopathy	25.2%
Physiotherapy	12.6%
Chiropractic	12.6%
Acupuncture	6.2%
Personal Training	5.7%
Traditional Chinese Medicine	1.2%

This data shows that many clients were using more than one modality at a time. Although there was only 10 subjects from the massage therapy clinic, massage was reported to be the most used modality.

Table 2.
Clinic that provided participants with homecare

Osteopathy	35.4%
Massage Therapy	31.7%
Chiropractic	10.9%
Physiotherapy	22%

79.8% of participants reported being provided with homecare exercises from their treating practitioner. 4.2% of those who received exercise prescription reported that they didn't want it.

Of the 19.1% participants that did not receive homecare, 64.7% wanted prescription. Those participants that didn't receive exercise prescription and didn't want it (35.3%) stated that they knew the stretches and exercises needed to manage the treated condition already.

Table 3.
Type of homecare prescribed

Stretching	39.2%
Strengthening Exercises	19.9%
Heat	12.7%
Ice	9%
Regular Massage	8.4%
Rest	5.4%
Change to physical activity level	3.6%
Relaxation activities	1.8%

Table 4.
How the homecare was prescribed

Verbally	53%
Visually	41%
Diagram	3.4%
Reproduce for Practitioner	2.6%

Table 5.
Rate of adherence

Always	27.8%
Sometimes	63.9%
Rarely	6.9%
Never	1.4%

Table 6.
Reasons for non-adherence

Forgot	44.6%
Work Commitments	21.5%
Didn't think they would help	10.7%
Didn't want to	12.5%
Family Commitments	10.7%

Reasons for adherence

The open question in the survey relating to adherence garnered a range of responses:

- "Because it helps and prevented my muscles from getting worse"
- "Noticed improvement in muscle tension"
- "Aid with quicker recovery"
- "To reduce pain and necessity of treatment"
- "They are important in the overall treatment"
- "Convinced they are beneficial"

The common reason for adherence to exercises was that participants could see the benefit of them and their importance to the treatment plan.

Suggestions to help adherence

Participants were asked to suggest how their treating practitioner could increase their adherence to homecare. The majority of the participants stated that nothing could be done. However the following suggestions were recorded:

- 'Remind me regularly'
- "Give me a reminder – email, SMS"
- 'Provide written documentation for me to take home to show me how to do exercises'
- 'Really explain the benefits'
- 'Tell me why they will help'

Discussion

Client attitude

When asked if practitioners could be doing more to increase adherence, the majority of participants said "no" or didn't answer, which may indicate that they are satisfied with the method of giving homecare exercise/recommendations or that they aren't bothered by it.

This finding implies that a large portion of exercise adherence relies on the attitude of the client and not the healthcare practitioner doing more.

Gender differences

The majority of questionnaires were completed by females, suggesting that females visit complementary healthcare clinics more than males. In an Australian study conducted in 2000, it was reported that 23.3% (705) of respondents had visited at least one alternative healthcare practitioner in the past year and 57.7% of those were female (MacLennan, 2002).

Due to the uneven gender balance in the sample, we could not draw conclusions about possible adherence differences between genders.

Differences between modalities

Comparing the data between the 4 different modalities, the following trends were apparent:

- The chiropractic clients were recommended to self treat with massage more than the massage therapy clients.
- Physiotherapy clients were prescribed with strengthening exercises more than the the clients of other three modalities.
- Massage Therapy clients were recommended to increase their daily water intake more than the clients of the other three modalities.

Discrepancies

During the data analysis, we found that the wording of several questions was unclear to some of the participants, engendering contradictory answers in the questionnaires and inconsistencies in the data. For example, of the 89 participants, 71 reported being prescribed with homecare but 82 participants selected a modality from which their homecare was given. In spite of this weakness in design, it was still possible to obtain valuable data from the questionnaire.

Recommendations

We believe that there is potential to develop strategies to help clients remember to complete their homecare. The suggested method is to provide documentation for the client to take home.

Practitioners can also remind the client at each appointment, making sure that the client is performing the exercise correctly. Reminder emails and text messages could also be trialled as an adherence increasing strategy.

Conclusion

The purpose of the research was to gain insight into adherence to homecare exercises/recommendations and the reasons behind non-adherence. The second objective was to gain direct input from clients as to whether practitioners need to change their practise methods to help increase the rate of adherence. Data gathered from the questionnaire showed that clients generally did their homecare exercises/recommendations when they remembered. Potential strategies to help clients remember include providing the exercise in written form, sending reminder emails and text messages, and reviewing the exercises at their next appointment.

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Health Fund Status

HEALTH FUNDS AND SOCIETIES	CRITERIA
CBHS Health Fund Ltd	This fund recognises all AMT practitioner levels.
A.C.A Health Benefits Fund Cessnock District Health Benefits Fund CUA Health Limited Defence Health GMF Health GMHBA Heath Care Insurance Limited Health Partners HIF WA Latrobe Health Services (Federation Health) Mildura District Hospital Fund Navy Health Fund Onemedifund Peoplecare Health Insurance Phoenix Health Fund Police Health Fund Queensland Country Health Ltd Railway & Transport Health Fund Ltd St. Luke's Health Teachers Federation Health Teachers Union Health Transport Health Westfund	ARHG recognises all AMT practitioner levels. They require you to use their provider number. This number is AWOXXXXM, where the X's are your 4-digit AMT membership number.
NIB	This fund will recognise members with HLT50302/07 Diploma of Remedial Massage; HLT50102/07 Diploma of Chinese Remedial Massage; HLT50202/07 Diploma of Shiatsu and Oriental Therapies; Advanced Diploma of Remedial Massage (Myotherapy)
Victorian WorkCover Authority	This fund recognises Senior Level 1 and 2 members.
Australian Unity GU Health	These funds recognise members with HLT40302/07 and all Senior Level One and Two members.
HCF Manchester Unity	These funds recognise members with HLT50302/ HLT50307 Diploma of Remedial Massage Advanced Diploma of Applied Science (Massage) Diploma of Health Science (Massage Therapy) 21511VIC/21920VIC Advanced Diploma in Remedial Therapy (Myotherapy). Existing HCF providers remain eligible. Manchester Unity will recognise HLT50202/07 Diploma of Shiatsu.
MBF NRMA SGIC (MBF Alliances) SGIO (MBF Alliances)	These funds recognise members with the HLT 50302/07 Diploma of Remedial Massage. You must send a signed consent form to AMT. Existing Senior Level One and Two providers remain eligible.
Australian Health Management Group Medibank Private	These funds recognise Senior Level One & Two members.
HBF	HBF recognises Senior Level 2 members.
ANZ Health Insurance (HBA) Cardmember Health Insurance Plan (HBA) CSR Health Plan (HBA) HBA (formerly AXA) HealthCover Direct (HBA) Mutual Community (HBA) Overseas Student Health Cover (HBA) St George Protect (HBA) VSP Health Scheme (HBA)	These funds recognise members with HLT 50302/7 Diploma of Remedial Massage and HLT 50102/07 Diploma of Chinese Medicine Remedial Massage. Existing providers remain eligible.
The Doctor's Health Fund	Doctors' Fund recognises members with HLT 50302/07 Diploma of Remedial Massage, Advanced Diploma of Applied Science (Remedial Massage), Advanced Diploma of Soft Tissue Therapies, Advanced Diploma of Remedial Massage (Myotherapy) and Bachelor of Health Science (Musculoskeletal Therapy). All Senior Level One and Two members remain eligible. They require you to use their provider number. This number is AMXXXX, where the Xs are your 4-digit AMT membership number.

AMT has negotiated provider status on behalf of members with the Health Funds listed. All funds require a minimum of \$1 million insurance, first aid and CEUs.

To be eligible to remain on the above Health Fund lists you must:

1. Be financial and have a commitment to ongoing education (ie: an average of 100 CEUs per year)
2. Provide your clients with a formal receipt, either computer generated, or with rubber stamp or address label clearly indicating practitioner's name, AMT member number (eg: AMT 1-1234), practice address (no PO Box numbers) and phone number. Client's name, date of treatment, nature of treatment (ie: Remedial Massage), and particular health fund provider number may be handwritten.
3. Provide AMT Head Office with a practice address (or business address for mobile practitioners; no PO Boxes) - failure to supply these details to us will result in your name being removed from health fund listings.
4. Notify AMT HO of all relevant practice addresses.

Please check the AMT website for further information on specific Health Fund requirements:

www.amt.org.au



Calendar of Events

Courses accredited by AMT attract 5 CEUs per hour. Courses not accredited by AMT attract 1 CEU per hour. Please check dates and venues of workshops (using the contact numbers listed below).

December 2010		CEUs
1	South Sydney Branch Meeting. Hurstville. Ph: 0411 039 819	15
2-6	Somatic CST 3. Presented by Patricia Farnsworth. Sydney. Ph: 1800 101 105	175
3-5	Infant Massage Training. Presented by IMIS. Sydney. Ph: 1300 558 608	120
3-7	Neurostructural Integration Technique Basic. Presented by Ron Phelan. Sydney. Ph: 03 5255 5229	175
4-6	Traditional East-West Cupping. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	105
4-5	Myofascial Cupping. Presented by David Sheehan. Melbourne. Ph: 03 9481 6724	70
5	Melbourne Branch Meeting. Beaconsfield. Ph: 0401 256 015	15
January 2011		CEUs
9	WA Branch Meeting. Fremantle. Ph: 0402 230 961	15
16	Hunter Branch Meeting. Adamstown. Ph: 02 4953 2252	15
21-23	Infant Massage Training. Presented by IMIS. Sydney. Ph: 1300 558 608	120
February 2011		CEUs
2	South Sydney Branch Meeting. Hurstville. Ph: 0411 039 819	15
5-6	Dorn Spinal Therapy. Presented by Barbara Simon. Sydney. Ph: 0407 946 294	95
5-6	Remedial Cupping. Presented by Bruce Bentley and Shirley Gabriel. Sydney. Ph: 03 9576 1787	80
11-15	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley and Shirley Gabriel. Melbourne. Ph: 03 9576 1787	175
11-13	Infant Massage Training. Presented by IMIS. Melbourne. Ph: 1300 558 608	120
12-13	Dorn Spinal Therapy. Presented by Barbara Simon. Melbourne. Ph: 0407 946 294	95
12-13	Myofascial Cupping. Presented by David Sheehan. Melbourne. Ph: 03 9481 6724	70
18-20	Infant Massage Training. Presented by IMIS. Brisbane. Ph: 1300 558 608	120
22	AMT Illawarra Branch Meeting. Formal Meeting. Corrimal. Ph: 0417 671 007	15
25-27	Structural Assessments and Corrections of the Lower body (Onsen Vol.1). Presented by Jeff Murray. Tweed Heads. Ph: 07 5599 2514	105
26-27	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Canberra. Ph: 03 9532 8144	60
26-27	Remedial Cupping. Presented by Bruce Bentley and Shirley Gabriel. Hobart. Ph: 03 9576 1787	80
26-27	Myofascial Cupping. Presented by David Sheehan. Gold Coast. Ph: 03 9481 6724	70
March 2011		CEUs
1-3	Anatomy Trains and Body Reading. Presented by Tom Myers. Sydney. Ph: 02 9542 8277	105
3-7	Advanced Certificate in Integrated Cupping Therapy. Presented by Bruce Bentley and Shirley Gabriel. Cairns. Ph: 03 9576 1787	175
4-6	Soft Tissue Master Class - Head, Neck and Thorax. Presented by Tom Myers. Sydney. Ph: 02 9542 8277	105
4-6	Practitioner Assessment Skills. Presented by Ron Phelan. Black Rock. Ph: 02 5255 5229	105
5-8	Akupunkt Massage According to Penzel Course A. Presented by Rene Goschnik. Sydney. Ph: 02 9547 0158	200
9-11	Anatomy Trains and Body Reading. Presented by Tom Myers. Melbourne. Ph: 02 9542 8277	105
10-14	Neurostructural Integration Technique Basic. Presented by Ron Phelan. Perth. Ph: 02 5255 5229	175
12-13	Soft Tissue Master Class - Intrinsic Pelvis. Presented by Tom Myers. Melbourne. Ph: 02 9542 8277	70
12-13	Remedial Cupping. Presented by Bruce Bentley and Shirley Gabriel. Brisbane. Ph: 03 9576 1787	80
19-20	Remedial Cupping. Presented by Bruce Bentley and Shirley Gabriel. Melbourne. Ph: 03 9576 1787	80
20	Hunter Branch Meeting. Adamstown. Ph: 02 4953 2252	15
21-25	Somatic CST 1. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	140
25-27	Functional Assessments and Corrections of the Lower body (Onsen Vol.2). Presented by Jeff Murray. Tweed Heads. Ph: 07 5599 2514	105
25-29	Neurostructural Integration Technique Basic. Presented by Ron Phelan. Black Rock. Ph: 02 5255 5229	175
25-27	Infant Massage Training. Presented by IMIS. Perth. Ph: 1300 558 608	120
26-27	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Melbourne. Ph: 03 9532 8144	60
26-27	Ortho-Bionomy Fundamentals (Phase 4). Presented by Anthony Swan. Canberra. Ph: 0412 286 385	70
27	AMT Members' Day and Annual General Meeting. Heidelberg, Melbourne. Ph: 02 9517 9925	40
29	Illawarra Branch Meeting. Presentation. Corrimal. Ph: 0417 671 007	15

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CALL FOR NOMINATIONS FOR ASSOCIATION OFFICE BEARERS FOR 2011

Nominations are called for the following positions, which take effect from the close of the 2011 Annual General Meeting:

**President,
Vice-President,
Treasurer,
Secretary
and up to 5 other Directors**

Nominations shall be on the form or in the form prescribed below and close at the AMT office 3pm Friday 28 January 2011.

Where nominations equal vacancies on 28 January 2011 then those persons are deemed to be elected.

Where nominations exceed vacancies, a postal ballot of practitioner members that were financial on 1 January 2011 will be conducted during February. Where nominations are below vacancies, the differential shall be treated as casual vacancies at the Annual General Meeting.

Nomination for Office for the Association of Massage Therapists Ltd

I * (name) _____

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* All must be financial members of AMT



Master Class in Traditional East-West Cupping & Remedial Cupping

Cupping is a specialised method of treatment that requires expert instruction, backed by the kind of deep interest and decades of research and practice that inspired us to present the **World's First Cupping workshops**. After completing our Master Class in Traditional East-West Cupping and Remedial Cupping, students are also awarded an **Advanced Certificate of Integrated Cupping Therapy**.

Cupping has become one of the most popular practices for therapists and clients because it:

- Saves your hands from strain, injury and fatigue
- Feels great to receive and gets excellent results
- Time efficient and takes the hard work away from practice

Some of the highlights of the Master Class in Traditional East-West Cupping include:

A history of cupping ~ The most refined ways of applying flame method cups ~ The five vacuum levels ~ Diagnosis of cupping discolorations ~ Russian Cupping Massage ~ Eastern and Western cupping for colds ~ Tonification for lower back weakness ~ Flash cupping method to restore flaccid and weak soft tissue ~ Cupping combined with massage and stretching in prone and side-lying positions ~ Heated Cup Method ~ External Chinese herbal liniments to use with cupping.

"This was an incredible experience. I highly recommend Bruce's class to anyone wanting to gain enormous knowledge and skill in a short time. Bruce's methods and knowledge are extraordinary. Loved every minute of it!" Suzn Martinez, Licenced Massage Therapist from the Master Class in Phoenix, USA 2010

In our **Remedial Cupping**, we have developed superb treatments for myofascial and trigger point release plus strategies for deep chronic muscular pain and so much more - made possible by a new generation of cupping instruments. Now you can cup in places you would never thought possible.

Some of the highlights of the Remedial Cupping include:

Cupping for Facial Rejuvenation ~ Arm and Hand Rehabilitation ~ Cupping Foot Massage ~ The Cupping Detoxification Program ~ Cellulite, Stretch Marks and Scar Clearing System ~ Abdominal Cupping Massage ~ Hip and iliotibial band cupping release combined with stretching therapy ~ Cupping and Mobilizations ~ Self maintenance cupping for practitioners.

"I don't think I've ever spent one weekend learning so much in my life, and I'm sure this will take my massage practice to the next level at the same time as saving my body from the stresses of extra work. It was amazing." - Joanne Terrans, Remedial and Sports Massage Therapist from the Remedial Cupping (Sydney 2009)



Stretching the fascia with our new easy to apply flexible rubber cups - one of the four non-flame cupping instruments introduced in the Remedial cupping - and only available through Health Traditions.

Both the Master Class in Traditional East-West Cupping and Remedial Cupping courses, as well as our Gua Sha Day, gain CEU's for AMT members.

Australian School of Traditional Thai Massage

Traditional Thai Massage is a gentle and dynamic synthesis of massage and stretching. We were the first to teach Traditional Thai Massage in the West and remain the only school outside Thailand to be recommended by the Wat Pho School of Traditional Thai Massage (Headquarters of TTM in Thailand).

Our TTM workshops are CEU accredited for AMT members.

Courses throughout Australia, United States and Europe

"There is no doubt that Bruce Bentley is the foremost international expert on the history and practice of cupping."

- Steven Clavey, Editor of The Lantern: An International Journal of Traditional Chinese Medicine

"Bruce's vast knowledge on cupping is second to none and I highly recommend his courses."

- Heather Dallas, official massage therapist for the Great Britain Olympic Cycling Team, US, T-Mobile, the Women's Professional Cycling Team and Chinese, Giant Bicycles, Women's Professional Cycling Team.



Presenters: Bruce Bentley and Shirley Gabriel

Bruce began cupping during his five year doctors program in Traditional Chinese Medicine in Taiwan. Returning to Australia he completed his Masters thesis in Health Studies on cupping, has



practiced for over 30 years and has conducted research in cupping throughout Asia and Europe - in addition to teaching at the Australian School of Therapeutic Massage for 20 years. He is currently writing a book on cupping. Shirley is a cupping, therapeutic and Thai massage therapist.

Course dates in Australia for 2011

Melbourne

Jan 3 - 14	Certificate in Traditional Thai Massage
Jan 3 - 22	Diploma of Traditional Thai Massage
Feb 11 - 15	Advanced Certificate in Integrated Cupping Therapy*
March 19 & 20	Remedial Cupping
May 21 & 22	Traditional Thai Massage Workshop
July 2 & 3	Traditional Thai Massage Workshop
July 23 & 24	Remedial Cupping
Aug 14	Gua Sha Day
Oct 15 - 17	Master Class in Traditional East - West Cupping
Nov 5 - 6	Traditional Thai Massage Workshop
Nov 26 & 27	Traditional Thai Massage Workshop

Sydney

Feb 5 & 6	Remedial Cupping
May 13 - 17	Advanced Certificate in Integrated Cupping Therapy*
Aug 6 - 8	Master Class in Traditional East - West Cupping
Nov 19 - 20	Remedial Cupping

Brisbane

March 12 & 13	Remedial Cupping
Aug 19 - 23	Advanced Certificate in Integrated Cupping Therapy*

Cairns

March 3 - 7	Advanced Certificate in Integrated Cupping Therapy*
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Townsville

June 12 - 14	Chinese Remedial Massage and Gua Sha Workshop
June 16 - 20	Advanced Certificate in Integrated Cupping Therapy

Darwin

March 25 & 29	Advanced Certificate in Integrated Cupping Therapy*
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Hobart:

Feb 26 & 27	Remedial Cupping
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*This 5 day Advanced Certificate course comprises the Master Class followed by Remedial Cupping. Either class can also be done separately.

For further information and to enrol please visit
www.healthtraditions.com.au **For other queries email**
healthtr@iinet.net.au **or phone Bruce on 03 9576 1787**